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 OFFICE OF INSPECTOR GENERAL
 DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 10/02/2014
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2014
NAME OF PROVIDER OR SUPPLIER HEARTLAND OF LOUISVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE 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)
F 000	INITIAL COMMENTS A Recertification Survey was initiated on 09/16/14 and concluded on 09/18/14 with deficiencies cited at the highest scope and severity of an "E".	F 000	The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.
F 222 SS=D	483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interviews, record review and review of the facility's policy Restraint Guidelines, it was determined the facility failed to ensure one (1) of twenty-four (24) sampled residents were not chemically restrained. On 07/06/14, Resident #19 was administered a forced injection of an antipsychotic medication and no evidence staff had implemented the care plan interventions to leave the resident and approach later before the forced injection was given. The findings include: Review of the facility's Restraint Guidelines, dated November 2013, revealed restraints were often applied as the result of a patient's behavior. The Mood and Behavior Practice Guide was utilized to provide guidance on determining the root cause of a patient's behavior and determining a patient focused plan of care that includes the least restrictive interventions to manage the behavior or identify any unmet	F 222	To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F222 It is practice of this facility to ensure the resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. 1. Resident #19 was reassessed for mood and behavior on 09/30/14. Resident #19 care plan was updated on 09/30/14. Licensed nurse caring for Resident #19 was in-serviced by the Interim Director of Nursing on 10/9/14 on the centers Restraint Guidelines, Resident Rights and Mood and Behavior Practice Guide.

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

TITLE

(X6) DATE

X Beverly M Edwards

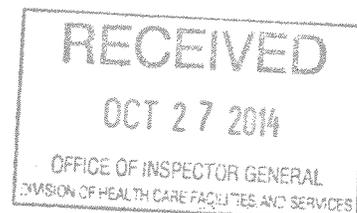
X Administrator X 10/24/14

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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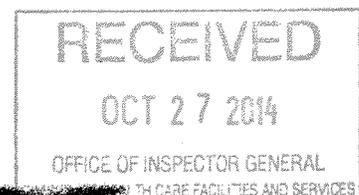
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F 222	<p>Continued From page 1</p> <p>patient needs. The attending physician is responsible for identification of the medical symptom requiring the use of the restraint. Whenever restraint use is determined as the only available intervention, the interdisciplinary team explains to the resident, family and responsible party how the use of the selected restraint would treat the resident's medical symptom and assists the resident in attaining or maintaining the highest practicable level of physical well-being. In addition, the potential negative consequences of restraint use are explained.</p> <p>Review of the clinical record revealed Resident #19 had resided at the nursing facility since August 2013 with diagnoses of Dementia with Behavioral Disturbance, Depressive Disorder, Anxiety Disorder, and Insomnia. The resident had been under the care of a Behavioral Healthcare Management Group since 08/29/14. This group initiated the diagnosis of Psychosis and ordered Remeron 7.5 mg (1) at bedtime on 02/24/14; Melatonin 5 mg (1) at bedtime on 03/31/14; Valium 5 mg (1) every eight (8) hours/PRN on 04/04/14; Ativan 0.5 mg twice a day (BID) as needed (PRN) on 06/05/14; and Haldol 1 mg (1) BID on 07/09/14.</p> <p>Review of the most recent annual Minimum Data Set (MDS) assessment, dated 08/12/14, revealed the facility assessed the resident to have a severe cognition loss with a Brief Interview for Mental Status (BIMS) score of two (2) out possible fifteen (15). The assessment determined the resident needed extensive assist from staff for bed mobility, transfers, dressing, locomotion, toilet use, and bathing. The resident was assessed to be non-ambulatory. The MDS assessment revealed the resident exhibited</p>	F 222	<p>2. Current residents and new admissions with behaviors have the potential to be affected by the alleged deficient practice. The Administrative Director of Nursing Services, Director of Care Delivery, and or House Supervisor will complete an audit utilizing the Psychoactive medication QAPI tool to ensure that residents with behaviors have appropriate care plan interventions in place to manage episodes of increased behaviors by 10/30/14. Areas of non-compliance will be corrected by the licensed nurses by 10/30/14.</p> <p>3. To ensure the deficient practice does not recur, residents with changes in behaviors and new admissions will be reviewed by the interdisciplinary team to ensure notification to the physician for further interventions has occurred and the plan of care updated. In addition the Administrative Director of Nursing Services, Director of Care Delivery, and or House Supervisor will in-service licensed nurses on the center's Restraint Guidelines including chemical restraints, resident rights, and the mood and behavior guidelines from 10/14/14 – 10/30/14. The Administrative Director of Nursing Services, Director of Care Delivery, and/or House Supervisor will specifically highlight the expectation to attempt care plan interventions before administering antipsychotic medications to residents. This education will be completed by 10/30/14.</p>		



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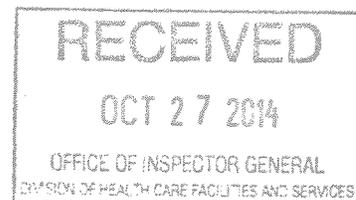
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F 222	<p>Continued From page 2</p> <p>physical and verbal behavioral symptoms toward others on one to three days during the seven day assessment period. Review of the Care Area Assessment (CAA) for mood and behaviors revealed these sections were not completed with only reference to Psych. and Neuropsychiatry services ordered.</p> <p>Review of the comprehensive care plan, revised 06/28/14, and 08/19/14, revealed the resident exhibited behaviors of wandering, verbal agitation with yelling, refusal of care, hitting/grabbing/spitting at staff, and risk for changes in mood related to the diagnosis of Psychosis. Care plan interventions stated staff was to allow the resident to wander on the secure unit; assess for physical/environmental changes that may precipitate change in mood; adapt environment related to noise levels; allow the resident time to respond to directions or requests; and if strategies are not working, leave and reapproach later. In addition, the staff would administer medications per physician orders and consult psychiatry as needed.</p> <p>Review of a general progress note, dated 07/06/14 at 4:59 AM, revealed the resident became very agitated and aggressive with staff when redirected from other residents' rooms. Two nurses took the resident in his/her room to calm down. The nurse documented the resident kicked and hit at the staff and would not allow them to come near. The nurse attempted to give Valium 5 mg (1) by mouth, but the resident refused. The physician was called and a one time order to give Haldol 4 mg IM was received. The nurse documented the resident was held down by staff and given the forced Haldol injection. The documentation stated the resident was left in the</p>	F 222	<p>4. The Administrative Director of Nursing Services, Director of Care Delivery, and/or House Supervisor will audit 10 Medication Administration Records of residents receiving antipsychotic medications 3 times a week for 4 weeks to ensure that care plan interventions have been implemented by licensed nurses as evidenced by documentation before antipsychotic medications are administered. The Administrative Director of Nursing Services, Director of Care Delivery and/or House Supervisor will report the results of the audits to Quality Assurance committee monthly for further review and recommendation.</p>	10/31/14.



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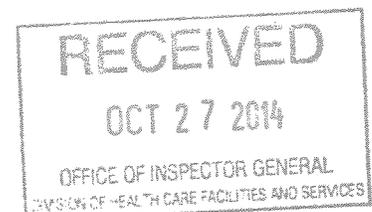
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F 222	Continued From page 3 room to calm down. However, there was no documented evidence the staff had implemented the care plan interventions to leave the resident and approach later before the forced injection was given. The progress note did not state the resident had a Psychotic episode or had hallucinations. Interview with the Unit Manager, on 09/18/14 at 2:15 PM, revealed she was not aware of the incident and could not recall if it was discussed in the Interdisciplinary meeting. She stated it was not a common occurrence to have staff members to hold down a resident to give medication. She stated if that was a new or escalated behavior, a behavioral assessment should have been completed with follow up within thirty (30) days for root cause of the behavior. She could not recall if an incident report was completed, but stated there should have been. She stated it was not the facility's protocol to force medicate and she did not know the definition of chemical restraint. Interview with the Interim Director of Nursing, on 09/18/14 at 2:55 PM, revealed she was unaware of the incident. When she reviewed the progress notes from 07/06/14, she said she would have to see if there had been an investigation of the event. She stated it was not the practice of the facility to force medicate. She reported she could not find any documented evidence the event was investigated.	F 222	F253 It is the practice of this facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. 1. The Maintenance Director cleaned air condition vents in Acadia dining/activity room, room 204, 210, 212, 222, 224, 313, 316, 422 and 424 to remove food particles and trash by 10/19/14. The Housekeeping Director and/or assigned Floor Maintenance Aide immediately cleaned the floor in room 319 on 09/17/14 to remove all food particles and debris. 2. Current and new admissions have the potential to be affected by the alleged deficient practice. The Maintenance Director, Maintenance Technician and/or House Keeping Director reviewed and cleaned if necessary air condition vents in the center to ensure that they do not contain food particles or trash by 10/22/14. To ensure the deficient practice does not recur, on 10/22/14, the Housekeeping Director added checking and cleaning the air conditioning vents for trash and food particles to the daily Housekeeping checklist. On 10/15/14, the Housekeeping Director inspected resident room floors for cleanliness.		
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.	F 253			



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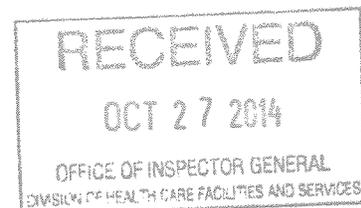
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F 253	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the daily housekeeping records, it was determined the facility failed to provide appropriate housekeeping and maintenance services in regard to cleaning Air Conditioning (AC) vents for three (3) of seven (7) units. (Unit 200, 300, and 400). The vents contained trash and food particles. In addition, Resident Room #319 had food particles on the floor from 09/16/14 to 09/17/14 of the three (3) survey of days. The facility failed to ensure AC vents and all room floors were clean and free of debris and food particles. The findings include: Observation of the Acadia unit, on 9/18/14 at 8:10 AM, revealed the AC vents in the dining room/activity room had food particles and trash inside of it. Observation of the 200 unit, on 9/18/14 at 8:15 AM, revealed room 204, 210, 212, 222, and 224, a total of five (5) rooms, had trash inside of the AC vents. Observation of the 300 unit, on 9/18/14 at 8:35 AM, revealed room 313, and 316, a total of two (2) rooms, had trash inside of the AC vent. Observation of the 400 unit, on 9/18/14 at 8:48 AM, revealed room 422, and 424, a total of two (2) rooms, had trash inside of the AC vent. Interview with the Director of Maintenance, on	F 253	3. To ensure the deficient practice does not recur, on 10/22/14, the Housekeeping Director added checking and cleaning the air conditioning vents for trash and food particles to the daily Housekeeping checklist. On 10/22/14, the Housekeeping Director educated Housekeeping staff to check and clean air condition vents in the center daily and as needed per notification from resident or staff to ensure that they do not contain food particles or trash. The House keepers will use the work order system to communicate air condition vents requiring more extensive cleaning to the Maintenance Director and/or Maintenance Technician. On 10/22/14, the Housekeeping Director educated Housekeeping staff to clean all areas of resident's rooms including but not limited to resident room floors to ensure that resident floors are cleaned thoroughly once a day and as needed.	



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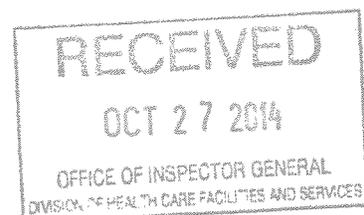
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F 253	Continued From page 5 9/18/14 at 1:45 PM, revealed he cleaned the AC vents every 3 months throughout the entire facility when he replaced the filters. Observation, on 09/16/14 at 11:15 AM, revealed food crumbs on the floor at the head of bed #2 and near the privacy curtain between bed #1 in Room 319. Observation, on 09/16/14 at 4:PM, revealed the food crumbs remained on the floor in Room 319. Observation, on 09/17/14 at 8:20 AM, revealed the food crumbs were still on the floor, same location, in Room 319. Interview with the unit housekeeper, on 09/17/14 at 9:15 AM, revealed she did not clean the floors in the residents' rooms. She stated a male housekeeper was responsible for cleaning the floors on the unit. Review of the daily sign-off sheet for floor cleaning on the Neuro Unit revealed no initials to indicate cleaning of residents' rooms (including Room 319) for the date of 09/16/14. Interview with the Director of Housekeeping, on 09/17/14 at 9:20 AM, revealed there was a male housekeeper that was assigned to clean the floors on the Neuro Unit and he would have been responsible to clean the floors.	F 253	4. The Maintenance Director, Maintenance Technician and/or Housekeeping Director will audit 10 air condition vents in the center 3 times a week for 4 weeks to ensure that air condition vents are free from food particles and trash utilizing the Housekeeping Services audit tool. The Maintenance Director will report the results of the audits to Quality Assurance committee monthly for further review and recommendation. The Maintenance Director, Maintenance Technician, Housekeeping Director and/or Lead Housekeeper(s) will audit 10 resident rooms 3 times a week for 4 weeks to ensure that areas of resident rooms including but not limited to resident room floors are cleaned thoroughly once a day and as need. The Assistant Administrator will report the results of the audits to Quality Assurance committee monthly for further review and recommendation.	10/31/14.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281			



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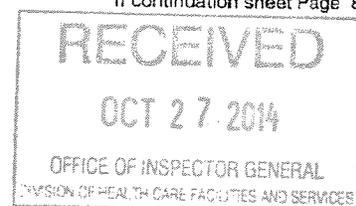
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F 281	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interviews, record review, review of the facility's admission policy and the Lippincott Manual of Nursing Practice, it was determined the facility failed to ensure one (1) of twenty-four (24) sampled residents (Resident #7) received post-surgical care in regard to staple removal and follow up care with the surgeon.</p> <p>The findings include:</p> <p>Review of the facility's admission policy, dated December 2009, revealed the nurse was to perform a physical evaluation of the new resident and notify the physician of the admission and obtain or verify orders.</p> <p>Review of the Lippincott Manual of Nursing Practice, 10th Edition, Chapter 2, page 15, Advocacy revealed the professional nurse has a duty to promote what is best for the patient and ensure the patient's needs are met.</p> <p>Review of Resident #7's clinical record revealed the facility admitted the resident on 09/09/14 with diagnoses of Abdominal Cellulitis with a Wound, Acute Kidney Failure, Atrial Fibrillation, Obesity and Diabetes Mellitus Type II. The physician ordered Negative Pressure Wound Therapy (wound vac) for an abdominal wound. Review of the discharge summary from the acute hospital revealed continued care was to be provide by the nursing facility; however, no post-surgical orders to remove the staples or follow up care was given.</p> <p>Review of the initial care plan, dated 09/09/14, revealed an omission of post-surgical follow up care and/or removal of staples. A skin integrity</p>	F 281	<p>F281</p> <p>It is the practice of this facility to ensure services provided or arranged by the facility meet professional standards of quality.</p> <ol style="list-style-type: none"> On 09/18/14, the Interim Director of Nursing contacted Dr. McMillan, the center's wound care physician to inform him of the need to remove surgical staples from Resident #7. Dr. McMillian evaluated Resident #7 on 09/22/14 however did not recommend removing the surgical staples and continues to follow Resident #7. The Director of Care Delivery in-serviced Registered Nurse #1 on 10/7/14 on proper wound care specifically related to follow up after post-surgical care. Current and new admissions with post-surgical wound orders have the potential to be affected by the alleged deficient practice. The Administrative Director of Nursing Services, Director of Care Delivery, and/or House Supervisor will review current residents with post-surgical wounds by 10/30/14 utilizing the Skin Alteration QAPI tool to ensure appropriate orders are in place to care for the surgical wound. Those areas found to be deficient will be corrected by the licensed nurses by 10/30/14. 		



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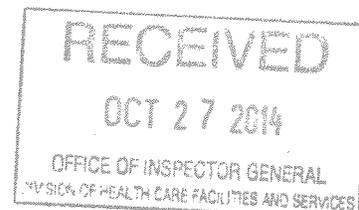
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F 281	Continued From page 7 care plan was developed on 09/16/14, but did not include post-surgical care or removal of staples. Observation of Resident #7, on 09/16/2014 at 8:20 AM, revealed the resident was sitting on the side of bed. A wound vacuum device was attached to the resident's abdominal wound. Interview with Resident #7, on 09/16/14 at 1:30 PM, revealed the resident was concerned about the lack of follow up care for the surgical wound that included staples. Observation of wound care, with Registered Nurse (RN) #1, on 09/17/2014 at 12:00 PM, revealed five (5) staples remained in the abdominal wound. The staples were observed to be under the Wound Vacuum device. Interview with RN #1, on 09/17/14 at 3:30 PM, revealed she was the nurse who conducted the admission assessment and other admission paperwork. She stated she was responsible for ensuring post surgical appointments were scheduled and obtaining physician orders for removal of staples or sutures. She stated this would be included in the initial care plan. RN #1 stated she thought the abdominal wound was a new surgical wound indicating that was why she did not call the surgeon for post-surgical orders that would include when to remove the staples. Interview with the 100 Unit Manager, on 09/17/14 at 9:18 AM, revealed the admitting nurse was responsible for ensuring follow up appointments were scheduled and obtain physician orders to address the resident's needs. That would include obtaining orders to remove staples or sutures. Interview with the Interim Director of Nursing, on 09/18/14 at 9:08 AM, revealed there was not a specific policy to address post-surgical care upon admission to the nursing facility. She stated the admitting nurse should have called the physician or surgeon to obtain orders to remove the staples	F 281	3. To ensure the deficient practice does not recur, the Facility Wound team comprised of the Administrative Director of Nursing Services, Director of Care Delivery and/or House Supervisor will evaluate new admissions and current residents with surgical wounds to ensure appropriate treatment orders are in place. In addition, the Administrative Director of Nursing Services, Director of Care Delivery and/or House Supervisor will in-service licensed nurses on follow up and treatment specifically as it relates to surgical wounds by 10/30/14. 4. The Administrative Director of Nursing Services, Director of Care Delivery and/or House Supervisor will audit new admissions and residents with changes in skin condition weekly x 4 weeks utilizing the skin alterations QAPI audit tool to ensure appropriate orders are in place and implemented. The Administrative Director of Nursing Services, Director of Care Delivery, and/or House Supervisor will report the results of the audits to Quality Assurance committee monthly for further review and recommendation.	10/31/14.	



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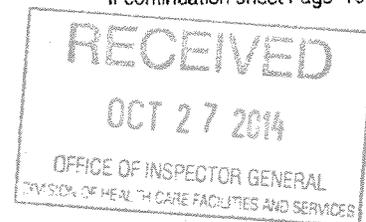
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F 281	Continued From page 8 and schedule a post-surgical visit. When it was brought to her attention, she searched the medical record for orders to remove the staples and could not find any. She called the surgeon and he released care to the Wound Care Center's physician to address the staples and follow-up visit. She revealed she had not monitored admission orders to ensure nurses completed all the necessary paperwork and obtained additional physician orders to address the resident's needs. Interview with surgeon, on 09/18/14 at 11:50 AM, revealed the resident had surgery with placement of staples on 08/26/14. He stated he would normally recommended a post-surgical visit one (1) to two (2) weeks after surgery. He indicated the staples would be removed per the surgeon at that visit.	F 281	F329 It is the practice of this facility that each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combination of the reasons above.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329	Based on comprehensive assessment of a resident, it is the practice of this facility to ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions; and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	



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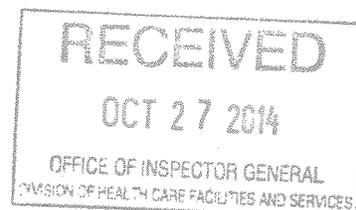
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2014
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F 329	Continued From page 9 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy Psychopharmacological Medication Use, it was determined the facility failed to have adequate monitoring for one (1) of twelve (12) residents on antipsychotic medication out of a total sample of twenty-four (24) residents (Resident #19). The facility staff administered multiple doses of an as needed (PRN) Lorazepam to Resident #19 without documentation of effectiveness or the indication for use of the drug. The findings include: Review of the facility's policy titled Psychopharmacological Medication Use, dated 12/01/07, revealed the facility staff would monitor the resident's behavior pursuant to the facility policy using a behavioral monitoring chart or behavioral assessment record for residents receiving psychopharmacological drugs for Organic Mental Syndrome with agitated or psychotic behaviors. Review of the facility's Mood and Behavior Practice Guide, issued March 2011, revealed non-pharmacologic approaches used as initial interventions could minimize the need for medications; permit use of the lowest dose; or result in the discontinuation of the medication. When using interventions a non-confrontational style tends to be more successful and shows	F 329	1. Resident #19 medications was reviewed by 09/30/14 by the licensed nurse and the attending physician to ensure appropriate, assessment and care plan was updated to reflect the non-pharmacological interventions to be utilized prior to administration of the anti-anxiety medications. The licensed nurses caring for resident #19 on 07/04/14, 08/06/14, 08/07/14, and 08/13/14 were in-serviced beginning on 10/9/14 - 10/20/14 by the Interim Director of Nursing and/or Director of Care Delivery on the mood and behavior practice guide specifically as it applies to documentation of non-pharmacological interventions attempted prior to administration of as needed anti-anxiety medications. 2. Current residents and new admissions on anti-anxiety PRN medications have the potential to be affected by the alleged deficient practice. The Administrative Director of Nursing Services, Director of Care Delivery, House Supervisor and/or other assigned licensed nurses will review residents receiving as needed anti-anxiety medications utilizing the Psychoactive Medication QAPI tool to ensure that licensed nurses are documenting their effectiveness and indicating why they were administered by 10/30/14. Areas found to be deficient will be corrected by the licensed nurses by 10/30/14.	



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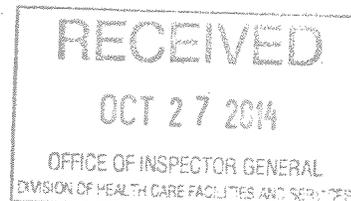
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F 329	Continued From page 10 respect for the patient. Progress notes written by Nursing, Social Services, and Activity staff could identify the effectiveness of the interventions and any change seen in the frequency of the behavior symptom. In conjunction with implementing the comprehensive care plan, update the Patient Information Worksheet with current interventions to promote a coordinated effort among caregivers. Review of the clinical record for Resident #19 revealed the facility admitted the resident on 08/15/13 with diagnoses of Pain in Thoracic Spine, Muscle Weakness, Osteomyelitis, Dementia, Symbolic Dysfunction, Thoracic Disc Disorder, Anemia, Hypertension, and Coronary Artery Disease. Review of the September, 2014 medication orders revealed Resident #19 was prescribed Haldol 1 mg two times a day (BID) for Psychosis; Mirtazepine 7.5 mg at bedtime (HS) for depression; Diazepam 5 mg every eight (8) hours PRN for Anxiety; and Lorazepam 0.5 mg twice a day PRN for Anxiety. Observation of Resident #19, on 09/18/14 at 4:00 PM, revealed the resident was propelling self in a wheelchair throughout the secure unit. Review of the medication administration record (MAR) for July 2014 and August 2014 revealed Resident #19 was administered the PRN Lorazepam 0.5 mg on 07/04/14 at 8:00 PM; 08/06/14 at 8:00 PM; 08/07/14 at 8:00 PM; and 08/13/14 at 3:00 PM. There were no entries in the record documenting the effectiveness of the PRN Lorazepam. Further review of the clinical record revealed there were no entries in the nurses notes documenting the resident's anxiety symptoms, non-pharmacological interventions, administration of the PRN Lorazepam, or the effectiveness of the medication. Interview with the Unit Manager (UM) for the 400 Unit, on 09/18/14 at 2:15 PM, revealed the	F 329	3. To ensure the deficient practice does not recur, new admissions upon admission and then quarterly and current residents quarterly will have their anti-anxiety medications reviewed by the attending physician to ensure medication is clinically indicated. In addition the Administrative Director of Nursing Services, Director of Care Delivery and/or House Supervisor will review the current psychotropic assessment and care plan quarterly as appropriate to ensure current interventions in place are appropriate. The Administrative Director of Nursing Services, Director of Care Delivery and/or House Supervisor will in-service licensed nurses by 10/30/14 on the Mood and Behavior Practice Guide specifically as it applies to documentation of non-pharmacological interventions attempted prior to administration of as need anti-anxiety medications by 10/30/14. 4. The Administrative Director of Nursing Services, Director of Care Delivery and/or House Supervisor will audit 10 residents weekly x 4 weeks that receive anti-anxiety as needed medications to ensure non-pharmacological interventions and effectiveness of medication is noted in the clinical record. The Administrative Director of Nursing Services, Director of Care Delivery and/or House Supervisor will report the results of the audits to Quality Assurance committee monthly for further review and recommendation.	10/31/14.	



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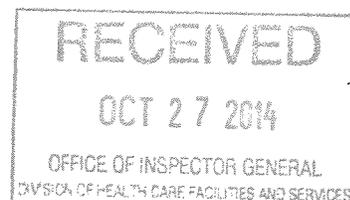
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F 329	Continued From page 11 assigned nurse was responsible for assessing potential causes of the resident's behavior(s) and attempting non-pharmacological interventions prior to administering a PRN psychoactive medication. The UM further revealed the nurse was also responsible for re-evaluating the resident and documenting in the clinical record the findings of the assessment, attempted interventions, and effectiveness of the medication. She stated she conducted random audits of the nursing documentation and reviewed the behavior/psychoactive notes daily. The UM revealed there was no documentation of her audit findings. She stated resident behaviors were reviewed and monitored by the interdisciplinary team (IDT). Interview with the Director of Care Delivery (DCD) and acting Director of Nursing (DON), on 09/18/14 at 2:55 PM, revealed the assigned nurse was responsible for monitoring and documenting resident behaviors in the clinical record. The DCD stated the nurse was also responsible for completing a behavior assessment and documenting on the 24-hour report sheet any resident who exhibited new or escalating behaviors.	F 329			
F 372 SS=E	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure garbage was properly disposed and the dumpsters were	F 372	F372 It is the practice of this facility to dispose of garbage and refuse properly. 1. On 09/18/14, the Maintenance Director immediately cleaned the dumpster area and closed both side doors and lid door. 2. Current residents and new admissions have the potential to be affected by the alleged deficient practice. On 09/18/14, the Maintenance Director immediately cleaned the dumpster area and closed both side doors and lid door.		



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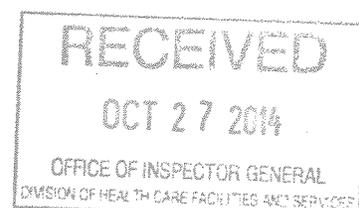
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F 372	<p>Continued From page 12</p> <p>maintained to prevent the harborage of pests for two (2) of two (2) dumpsters/compactors.</p> <p>The findings include:</p> <p>The facility did not have a policy for monitoring of the dumpsters.</p> <p>Interview with the Director of Maintenance, on 9/18/14 at 1:45 PM, revealed the facility did not have a policy for waste and garbage disposal. He stated that staff had not been trained on keeping the dumpster area clean and no one up until now had been assigned to monitor the dumpster area for proper disposal.</p> <p>Observation of the facility's dumpster area, on 09/18/14 at 8:40 AM, revealed paper towels and 3 sets of gloves lying on the ground in front of the cardboard dumpster. All dumpster doors were closed. A facility staff member was observed pushing a cart filled with cardboard boxes through the parking lot towards the dumpster area.</p> <p>Observation of the dumpster area, on 9/18/14 at 8:53 AM, revealed the cardboard dumpster and the garbage dumpster had both side doors and the lid door opened. There was debris and trash on the ground around both dumpsters as well as a broom and dust pan inside the dumpster area. The main gate of the dumpster area was open.</p> <p>Interview with the Director of Maintenance, on 9/18/14 at 9:00 AM, revealed it was the responsibility of any staff that used the dumpsters to keep it clean and to sweep up any trash. He stated that he kept a broom and dust pan in that area for staff to use for any trash or debris that</p>	F 372	<p>3. To ensure the deficient practice does not recur, on 10/22/14, the Administrator developed a schedule indicating when and who should check the dumpster to ensure that the dumpster area remains clean and the side and lid doors remain closed. The schedule specifies that the Housekeeping Director, Housekeeping Aide, Dietary Director and/or Dietary Aide will check the dumpster 4 times daily to ensure that the dumpster area remains clean and both the side and lid doors are closed. The Administrator, Assistant Administrator, Maintenance Director, Director of Nursing, Dietary Director, Director of Care Delivery, House Supervisor, and/or House Keeping/Laundry Director will in-service Dietary, Housekeeping and Maintenance staff to ensure that the dumpster area remains clean and the side and top lid doors remain closed by 10/30/14. The topics in which housekeeping, dietary and maintenance staff will be in-serviced on are as follows: To ensure that the gate to the dumpster and the side doors and lid remain closed. To ensure that all trash to be disposed must be placed in the dumpster in an attempt to prevent trash from spilling onto the ground. To ensure that a broom and dust pan is located inside the dumpster area to use for any trash that may fall on the ground.</p>		



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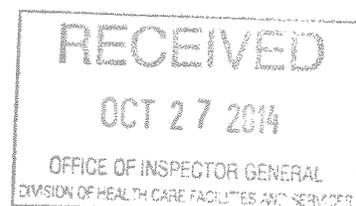
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F 372	Continued From page 13 fell on the ground. He stated that staff should always close both dumpsters doors and the main gate after use.	F 372	4. The Maintenance Director and/or Housekeeping Director will audit the dumpster area 3 times a week for 4 weeks to ensure the area remains clean and the side and top lid doors remain closed. The	10/31/14.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the 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.	F 431 Assistance Administrator and/or, Maintenance Director will report the results of the audits to Quality Assurance committee monthly for further review and recommendation. F431 It is the practice of this facility to 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. It is the practice of this facility that drug 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.			



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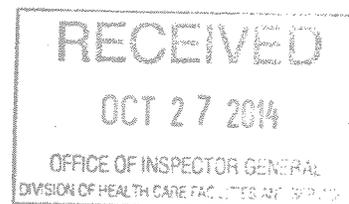
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F 431	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles, it was determined the facility failed to ensure medication, laboratory, and treatment supplies were not expired for one (1) of four (4) nursing units (200 Unit). The 200 Unit medication room had expired syringes, Hemoccult cards, safety needles, IV cannulas, IV extension set, blood culture bottle, and Vacutainers. In addition, the 200 Unit supply room had expired dressings, and packages of Tegaderm foam available for use. The findings include: Review of the facility's policy Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles, dated 12/01/07, revealed the facility would destroy or return all discontinued, outdated/expired, or deteriorated drugs or biologicals in accordance with Pharmacy return/destruction guidelines. Further review of the policy revealed facility personnel would inspect the nursing station storage areas for proper storage compliance on a regularly scheduled basis. Observation of the 200 Unit medication room, on 09/16/14 at 2:35 PM, revealed there were twenty-two (22) 5 milliliter (ml) syringes of Heparin intravenous (IV) lock flush solution expired October 2013; sixty-two (62) Hemoccult cards expired August 2014; forty-six (46) 1-inch safety needles expired January 2014; two (2) leuer lock IV cannulas expired October 2012; one (1) small-bore IV extension set expired June 2012; and one (1) aerobic blood culture bottle expired 07/17/14. Further observation revealed	F 431	In accordance with State and Federal laws, it is the practice of this facility to store all drugs and biological in locked compartments under proper temperature controls, and permit only authorized personnel to have access to keys. It is the practice of the facility to 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. 1. On 09/17/14, the Director of Care Delivery and/or licensed nurse checked 200 medication room to discard expired medications. In addition, on 09/17/14, the Central Supply Clerk immediately checked the 200 unit supply room to discard expired unit supplies. 2. Current residents and new admissions have the potential to be affected by the alleged deficient practice. On 09/16/14 - 09/18/14, the Director of Nursing, Director of Care Delivery and/or licensed nurse checked the medication room for 200 unit and the remaining units (100, 300,400) to ensure that they do not contain expired medications. On 09/16/14 - 09/30/14, the Director of Nursing, Director of Care Delivery, Central Supply Clerk and/or licensed nurse checked the supply room for	



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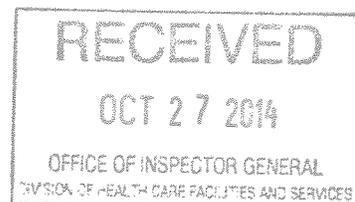
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F 431	Continued From page 15 fifty-six (56) Sodium Citrate Vacutainers with the following expiration dates: thirty (30) expired in February 2014; twenty-one (21) expired in April 2014; and five (5) expired in May 2014. In addition, the 200 Unit supply room had one (1) expired package of alginate hydrocolloid dressing, and four (4) expired packages of Tegaderm foam available for use. Interview with the Registered Nurse (RN) Supervisor, on 09/16/14 at 2:45 PM, revealed there was no staff assignment to check the medication or storage room for expired supplies. The RN stated each nurse was responsible for checking his/her assigned medication cart daily for expired medication. She further stated the use of expired medication and/or supplies could potentially result in abnormal lab values or IV related infections. The RN revealed the Unit Manager for the 200 Unit was currently on leave of absence. Interview with the Director of Care Delivery (DCD) and acting Director of Nursing (DON), on 09/17/14 at 3:35 PM, revealed the evening shift nurses on each unit were responsible for checking the medication rooms, refrigerators, and treatment carts for expired medications and supplies. She further revealed central supply was responsible for checking expiration dates on the treatment supplies stored in the 200 Unit storage closet. The DCD stated the previous DON had conducted audits of the medication rooms, but did not know the frequency of those audits. The DCD did not provide evidence of those audits. Interview with the Central Supply Clerk, on 09/18/14 at 1:15 PM, revealed she was responsible for all ordering and stocking of supplies for the facility. She revealed she was also responsible for auditing stored supplies for expiration dates. The supply clerk stated she	F 431	200 unit and the remaining units (100, 300,400) to ensure that they do not contain expired supplies. 3. To ensure the deficient practice does not recur, the Administrative Director of Nursing Services, Director of Care Delivery and/or House Supervisor will implement a schedule by 10/30/14 to check medication carts and medication rooms weekly for expired medications. The Administrative Director of Nursing Services, Director of Care Delivery and/or House Supervisor will educate licensed nurses by 10/30/14 to check the expiration date of medication before the med is dispensed. The Administrative Director of Nursing Services, Director of Care Delivery and/or House Supervisor will in-service licensed nurses by 10/30/14 to check medications for expiration dates prior to administration. The Interim Director of Nursing and/or Director of Care Delivery in-serviced the Central Supply Clerk on 09/18/14 to check the supply room on units for expired supplies weekly. 4. The Administrative Director of Nursing Services, Director of Care Delivery, House Supervisor, licensed nurse and/or Pharmacist will audit the medication carts, medication rooms, and central supply 3 times a week for 4 weeks to ensure that we do not have any expired medications within the center. The Director of Nursing and/or Director of Care Delivery will report the results of the audits to Quality Assurance committee monthly for further review and recommendation.	10/31/14.	



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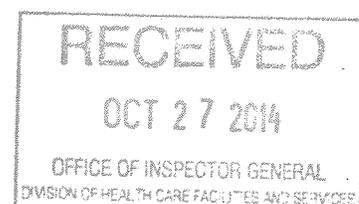
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F 431	Continued From page 16 tried to remember to check supplies for expiration dates once a week. She revealed she was scheduled to work in central supply three days a week, but sometimes was pulled away to do other tasks.	F 431	F441 It is the practice of this facility to 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.		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	t. Resident #13 was discharged from the center on 10/7/14. On 10/7/14, Director of Care Delivery in-serviced Registered Nurse #1, the licensed nurse caring for Resident #7 and Resident #13, on the center's infection control program in regard to wound care. The specific policies in which Registered Nurse #1 was in-serviced by the Director of Care Delivery are Dressing Change: Nonsterile (clean) and sterile (aseptic) and Hand Hygiene. On 10/1/14, Registered Nurse #1, licensed nurse caring for Resident #7 and #13 also participated in a wound vacuum training given by Kinecti Concepts Incorporated. (Wound Care Company). On 09/25/14, the Director of Care Delivery in-serviced Licensed Practical Nurse #3, licensed nurse caring for un-sampled resident C, on the center's infection control program in regard to food handling. The specific policy in which Licensed Practical Nurse #3 was in-serviced by the Director of Care Delivery is Serving Food Properly.		



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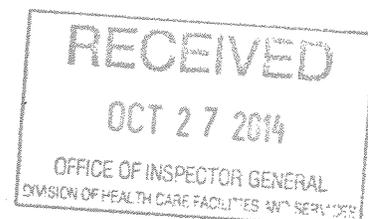
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2014	
NAME OF PROVIDER OR SUPPLIER HEARTLAND OF LOUISVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220		
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F 441	<p>Continued From page 17</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and review of the facility's policies Dressing Changes for Non-sterile and Sterile, Hand Hygiene and the Infection Control Manual, it was determined the facility failed to consistently implement their infection control program in regard to wound care and food handling for two (2) of seven (7) sampled residents, observed for wound care, of the total sample of twenty-four (24) residents and one (1) of three (3) unsampled residents. Resident #7 and #13 and Unsampled Resident C. The facility staff failed to perform hand hygiene between glove changes and touched the cleaned wound with contaminated gauze used to clean the surrounding area of the wound of Resident #13. The facility failed to follow policy and procedure for wound vac treatment for Resident #7. In addition, staff used ungloved hands to touch Unsampled Resident C's food.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Dressing Change for Nonsterile (clean) and Sterile (aseptic), dated December 2009, revealed dressing changes are performed according to physician's orders. The policy instructed the nurse to perform hand hygiene before applying gloves. The soiled dressing was to be removed</p>	F 441	<p>2. Current residents and new admissions receiving wound care and a meal tray have the potential to be affected by the alleged deficient practice. Utilizing the Pressure Ulcer and Skin Alteration QAPI tool, the Administrative Director of Nursing Services, Director of Care Delivery and/or House Supervisor will review current residents by 10/30/14 to determine which residents have wound treatments to ensure appropriate treatments, assessments and care plans are in place. Those areas found to be deficient will be corrected by the licensed nurses by 10/30/14.</p> <p>3. To ensure the deficient practice does not recur, the Administrative Director of Nursing Services, Director of Care Delivery and/or House Supervisor will ensure that upon hire and annually, licensed nurses will complete a dressing change skills validation to ensure appropriate infection control guidelines are adhered to. In addition, the Administrative Director of Nursing Services, Director of Care Delivery and/or House Supervisor will ensure upon hire facility staff responsible for serving resident meals will be in-serviced on the correct procedure for delivery of meals and maintaining infection control guidelines. The Director of Nursing, Director of Care Delivery and/or House Supervisor will in-service licensed nurses on the center's infection control program in regard to wound care by 10/30/14. The Director of Nursing, Director of Care Delivery and/or House Supervisor will in-service nursing staff on the center's infection control program in regard to food handling by 10/30/14.</p>	



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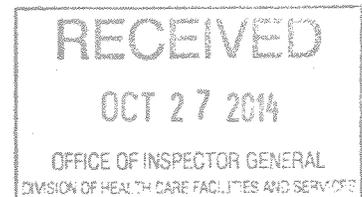
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F 441	Continued From page 18 with the gloves then the gloves are to be removed and discarded in the trash. Instructions to perform hand hygiene was listed next in the policy. The policy stated to establish a clean field by covering the bedside table with paper towels or a clean towel. Clean gloves were to be applied and the wound cleansed according to physician's orders. Removal of gloves and hand hygiene were to be performed next. The policy instructed the staff to put on clean gloves to apply and secure the dressings according to physician's orders. The policy instructed the nurse to remove the gloves, discard and perform hand hygiene. Review of the facility's policy titled: Hand Hygiene, dated December 2009, revealed hand hygiene applied to hand washing, antiseptic hand wash, and antiseptic hand rub (alcohol sanitizer). The policy instructed staff to perform hand hygiene before applying and removing gloves, after direct contact with patient's intact skin, and after contact with inanimate objects (including medical equipment). Review of the facility's Infection Control Manual, issued May 2013, page 28, titled Wound Management with guidelines for performing treatments revealed the manual instructed staff to adhere to principles of infection control: separate clean and dirty; provide barrier field for treatment supplies; appropriate use and changing of gloves; appropriate cleaning of wound (center of wound to outside perimeter); cleansing of scissors; hand washing; and disposal of soiled dressings. This included negative pressure wound therapy (wound vac). Section 5 of the facility's Infection Control Manual (food services) revealed food preparation, holding and service practice included use of utensils or gloves to avoid touching food	F 441	4. The Director of Nursing, Director of Care Delivery and/or House Supervisor will audit 10 patients with wound treatments 3 times a week for 4 weeks to ensure that resident wound treatments are administered according to the center's infection control program. The Director of Nursing, Director of Care Delivery and/or House Supervisor will audit one meal service 3 times a week x 4 weeks to ensure that residents are served properly according to the center's infection control program. The Director of Nursing, Director of Care Delivery and/or House Supervisor will report the results of the audits to Quality Assurance committee monthly for further review and recommendation.	10/31/14.



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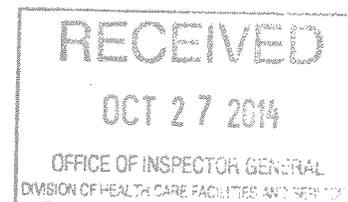
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F 441	<p>Continued From page 19 directly.</p> <p>1. Review of Resident #13's clinical record revealed the facility admitted the resident from an acute hospital on 09/11/14 with diagnoses of Multiple Sclerosis, Epidural Abscess, Periphery Neuropathy, Diabetes, Above the Knee Amputation (left leg), and Methicillin Resistant Staphylococcal Aureus (MRSA) in the spine. The facility assessed the resident to be alert and oriented with no cognitive impairment. During the course of the hospital stay, the resident had surgery to remove a vertebra disk that was infected where a port had been inserted. The resident received Vancomycin intravenous (IV) for the MRSA and would continue to receive at the nursing facility until 09/23/14. The resident developed a bulla (blister) to the right heel and the area was debrided by the Wound Care Center on 09/15/14. The Wound Care Center physician ordered wound treatment for the right heel to be completed every other day.</p> <p>Observation of the wound care treatment for the right heel, on 09/17/14 at 11:38 AM, revealed RN #1 washed her hands and donned clean gloves. The nurse did not provide a barrier field for wound care supplies. She placed the spray bottle of Normal Saline (NS) cleanser on the floor beside the resident's foot. The nurse removed the soiled dressing from the right foot. The nurse removed her gloves then put on clean gloves without performing hand hygiene. The nurse measured the wound then cleansed the wound with NS sprayed on a 4 x 4 gauze. The nurse used the same gloves to clean the upper portion of the large wound with the NS saturated gauze. She cleaned the same area several times, touching the gauze all over the wound. She did</p>	F 441		



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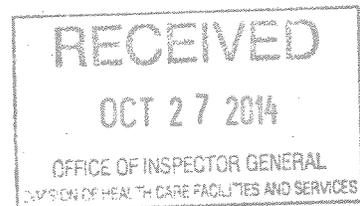
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F 441	<p>Continued From page 20</p> <p>not use circular movement cleaning from the middle of wound outward. The nurse then took another gauze soaked with NS and cleaned the smaller wound. She patted the open wound area several times touching the cleaned area with the same gauze she used to clean other areas of the heel. She continued to pat the open wound several times with the same gauze she had cleaned other areas with. The nurse removed her gloves, but didn't perform hand hygiene. The nurse put on clean gloves then applied Silver alginate dressing and covered with a Mediplex dressing. She then wrapped the foot with Kerlix gauze. The nurse removed her gloves, put up supplies and used hand sanitizer to clean her hands.</p> <p>Interview with RN #1, on 09/17/14 at 4:03 PM, revealed she should have washed her hands between glove change, but she had forgot. She stated she had been trained to wash hands after each glove change and indicated she would cleanse the wound using circular movement from the center of the wound to the outer part of the wound and then the surrounding area. She could not recall if she used this technique. She stated since the resident was in a wheelchair, she forgot and placed the spray cleanser on the floor beside the resident's foot. She indicated she had been trained on proper wound care technique and had been observed during her orientation two years ago. She revealed she obtained most of her training online with modules.</p> <p>Review of the facility's training attendance matrix for nurses, not dated, revealed no training had been provided for wound care. Interview with the Director of Nursing (DON), on 09/18/14 at 12:37 PM, revealed she could not find any additional</p>	F 441			



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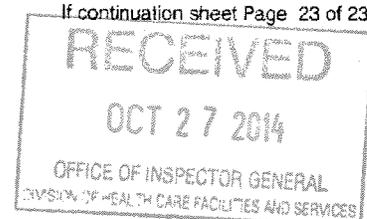
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F 441	Continued From page 21 training records and found no evidence that RN #1 was trained on appropriate wound care. She found most training was completed online; however, the facility had no staff development department to monitor the training. She revealed this was her first week as DON and she was still getting familiar with the facility's policies and procedures. 2. Review of Resident #7's clinical record revealed the facility admitted the resident on 09/09/2014 with the following diagnoses: Abdominal Cellulitis with a Wound, Acute Kidney Failure, Atrial Fibrillation, Obesity and Diabetes Mellitus Type II. The resident utilized a Wound Vacuum Assisted Device. Observation of Resident #7's wound care, performed by RN #1 on 09/17/14 at 12:00 PM, revealed the nurse failed to clean the scissors and provide a barrier field for the wound care supplies. Interview with RN #1, on 09/17/14 at 3:30 PM, revealed the nurse had no formal training on the use of the Wound Vacuum Assisted Device. She assumed the resident showering before wound care was adequate cleaning, but provided no explanation for lack of cleansing scissors or providing a barrier field. Interview with Director of Nursing (DON), on 09/17/14 at 4:07 PM, revealed no formal wound care training had been provide during the general orientation for nurses. The DON stated she expected proper wound care and technique to be a standard of nursing practice. 3. Observation of the evening meal, on 09/16/14 at 6:35 PM, in the Arcadia locked unit, revealed Licensed Practical Nurse (LPN) #3 touching six (6) pieces of bread with his bare hands, when performing meal set up for Unsampled Resident C.	F 441		



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F 441	Continued From page 22 Interview with LPN #3, at the time of the observation, revealed he was unsure if he had ever been trained on proper assist with meals. He further stated he had never heard that using bare hands to handle food was a problem. Interview with the DON, on 09/17/14 at 4:07 PM, revealed the subject of Infection Control regarding food handling was covered in general orientation. Review of the Job Description for LPN #3, dated 03/16/08, revealed a general nursing care responsibility was to demonstrate knowledge and appropriate use of the facility's Infection Control Manual. Review of A Performance Appraisal for LPN #3, dated 08/22/13, revealed the nurse was successful in performing all duties according to the job description.	F 441			



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NAME OF PROVIDER OR SUPPLIER HEARTLAND OF LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE 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: 1970</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story with a partial basement, Type III (211)</p> <p>SMOKE COMPARTMENTS: Eleven (11) on the Ground Floor and two (2) in the Basement.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Automatic (dry) sprinkler system, hydraulically designed. Upgraded in 2010.</p> <p>GENERATOR: Type II, 150 KW generator installed in 2006. Fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey, utilizing the 2786S short form, was conducted on 09/16/14. The facility was found in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000		

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

TITLE

(X6) DATE

Beverly M. Edwards

Administration

10/24/14

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.

OCT 27 2014