

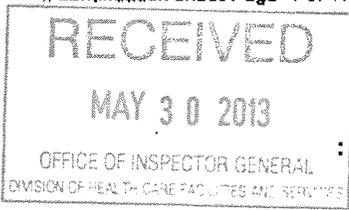
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/25/2013
NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1706 STEVENS AVENUE LOUISVILLE, KY 40205	
(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 standard health survey was initiated on 04/23/13 and concluded on 04/25/13 and a Life Safety Code survey was initiated on 04/24/13 and concluded on 04/24/13 with deficiencies cited at the highest scope and severity of an "F", with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition. This was a Nursing Home Initiative survey with entrance to the facility on Tuesday, 04/23/13 at 6:35 AM.	F 000	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, Highlands Health & Rehabilitation Center (HHRC) has taken or will take the following actions: F252	
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies, it was determined the facility failed to provide a clean safe comfortable and odor free environment. Four (4) of the fifty-eight (58) resident wheelchairs had torn arm rest padding or torn backs. Two (2) of the four (4) resident shower rooms were observed to have too low water temperatures. A strong pervasive urine odor was noted on one (1) of the four (4) nursing units. A community bathroom on one (1) unit of the (4) nursing units was observed to be soiled for several hours.	F 252	It is the policy of Highlands Nursing and Rehabilitation Center to provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. An addendum to facility Hot Water Testing & Regulation policy was implemented on 5/28/13 by the Administrator to reflect that water temperatures in areas accessible to residents should not exceed 110 degrees and should not fall below 100 degrees. Should temperatures get outside of the acceptable temperature range, corrective steps will be taken immediately by the Maintenance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: 5/30/13

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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NAME OF PROVIDER OR SUPPLIER

HIGHLANDS HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

1706 STEVENS AVENUE
LOUISVILLE, KY 40205

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F 252 Continued From page 1

The findings include:

1. Review of the facility's policy regarding Hot Water Testing & Regulations, dated 01/01/95, revealed hot water temperatures in the resident showers, whirlpools, and tubs should not drop below 105 degrees Fahrenheit and not go above 115 degrees Fahrenheit. Should temperatures get out of acceptable temperatures corrective steps should be taken.

Review of the facility's Water Temperature Test and Log Steps for hot water temperatures revealed the facility should ensure patient room water temperatures are between 110 and 120 degrees Fahrenheit (or as specified by state requirements). Any discrepancies should be noted and water heater settings adjusted as required and retested as necessary.

Review of the Shower Rooms weekly water temperature log from 02/06/13 through 04/23/13 revealed the water temperatures for the Shower Rooms on Hall 1-B and Hall 2-B were below 100 degree Fahrenheit on several occasions. On 02/06/13 on Hall 2-B the water temperature was 99.2 degrees Fahrenheit. On 02/14/13 on Hall 1-B the water temperature was 97.1. On 02/22/13 the water temperature on Hall 1-B was 98.3 degrees Fahrenheit and the water temperature for Hall 2-B was not recorded. On 03/04/13 the water temperature on Hall 1-B and on Hall 2-B was 95.8 degrees Fahrenheit.

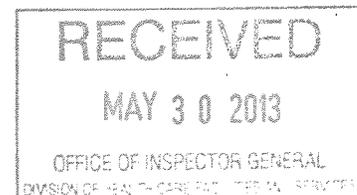
Observation, on 04/23/13 at 1:15 PM, of the Shower Room on Hall 2-B revealed the water temperature was 98 degrees Fahrenheit.

F 252

Director to return the water temperature to the acceptable range.

On 5/29/13, the Maintenance Director adjusted the water temperatures on Hall 1-B and 2-B to the appropriate range of 100-110 degrees. The master water temperature log was corrected by the Maintenance Director on 5/29/13 to reflect the proper water temperature range of 100-110 degrees as indicated in the facility policy addendum. Water temperatures on additional hallways were checked by the Maintenance Supervisor on 5/29/13 and found to be within the acceptable range.

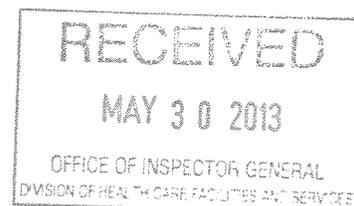
The Maintenance Director replaced the arm pads on the wheelchairs for residents in rooms 119-2, 243-1, and 249 on 5/9/13. The wheelchair back for room 208 will be replaced by the Maintenance Director no later than 5/31/13 as a special part had to be ordered for this particular chair. This part was ordered by the Maintenance Director on 5/13/13.



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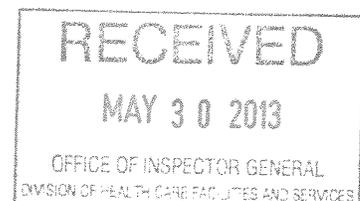
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F 252	Continued From page 2 Observation, on 04/24/13 at 9:45 AM, of the Shower Room on Hall 1-B revealed the water temperature was 98 degrees Fahrenheit. Observation, on 04/24/13 at 2:14 PM, of the Shower Room on Hall 2-B revealed the water temperature was 98 degrees Fahrenheit. Observation, on 04/25/13 at 9:30 AM, of the Shower Room on Hall 2-B revealed the water temperature was 98 degrees Fahrenheit. During the Quality of Life Assessment Interview, on 04/24/13 at 8:10 AM, Resident #7 revealed the water in the Shower Room on Unit 2-B was too cold at times. Interview with the Maintenance Director, on 04/25/13 at 10:00 AM, revealed he was uncertain what the water temperature in the Shower Rooms were suppose to be. 2. The facility did not provide a policy for the maintenance of resident wheelchairs. Observation, on 04/23/13 at 8:30 AM, during the initial tour revealed residents in Rooms 119-2, 243-1, and 249 had cracks and tears on their wheelchair arm pads. The resident's wheelchair in room 208 had a tear in the back of the chair. Interview with the Maintenance Director, on 04/25/13 at 10:00 AM, during the Environmental Tour of the facility revealed he was uncertain when the wheelchairs were last checked for maintenance. A maintenance log for the wheel chairs was requested, but not provided by the end	F 252	The Environmental Services Director toured Hall 2B on 4/25/13 after being alerted of the unpleasant odor. Room 232 was deep cleaned by the housekeeping staff and the mattress was discarded to the dumpster on 4/24/13. The men's community bathroom on 2-B was cleaned by the Director of Environmental Services on 4/24/13. A Review of Resident Equipment and a Housekeeping Review was initiated by the Administrator, Maintenance Director and the Environmental Services Director on 5/28/13. This review will be completed by 5/30/13. Any identified issues will be corrected by 5/31/13. The Maintenance Director received additional education by the Administrator on 5/23/13 regarding the appropriate water temperatures and the process to follow if temperatures fall outside of acceptable ranges. The Administrator will review the water		



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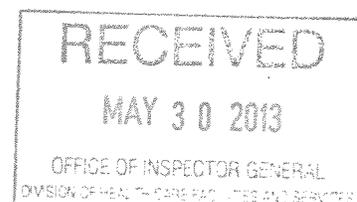
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F 252	<p>Continued From page 3 of the survey.</p> <p>Interview with the Administrator, on 04/25/13 at 2:00 PM, revealed the facility did not have a policy for wheel chair maintenance.</p> <p>3. Review of Unit 2-B's Housekeeping Routine revealed housekeepers should ensure there are no odors and assure there are no debris spills or bodily fluids in all resident and public restrooms.</p> <p>During initial tour of Hall 2-B, on 04/23/13 at 8:30 AM, a strong pervasive odor of musty/urine was noted in the corridor of Hall 2-B.</p> <p>Observation, on 04/24/13 at 12:15 PM, of Room 232 revealed a strong musty pervasive odor in the room. CNA #4, #5 and #6 were observed entering and leaving the Room 232 during this time to assist with transfers and tray delivery.</p> <p>Interview with CNA #4, on 04/24/13 at 12:20 PM, revealed Room 232 did have an unpleasant odor and residents should not have to eat their meals in a room with an unpleasant odor.</p> <p>Interview with CNA #6, on 04/24/13 at 2:50 PM, revealed she had noticed the odor when she entered the room to deliver a lunch tray. CNA #6 commented she was not trained on how to deliver a tray to a room with odors but was trained to deliver the trays quickly and accurately.</p> <p>Observation of the men's community bathroom, on 04/23/13 at 11:25 AM, 12:45 PM, 2:40 PM and at 3:00 PM, revealed a dark colored substance in the commode, a roll of toilet paper sat on the toilet paper holder with dark colored smears on</p>	F 252	<p>temperature logs weekly to ensure that the temperatures are acceptable and that adjustments have been made as needed.</p> <p>The Staff Development Coordinator provided additional education to all nursing staff by 5/31/13 regarding the appropriate process to follow when delivering resident trays.</p> <p>All housekeeping staff received education by the Environmental Services Director by 5/31/13 regarding the importance of following cleaning schedules on a daily basis and the procedure to follow if a particular task cannot be completed in a timely manner.</p> <p>The Administrator, DON, ADON and Staff Development Coordinator provided additional education to all staff by 5/31/13 regarding the importance of providing a safe, clean, comfortable and homelike environment.</p>		



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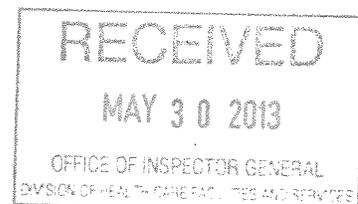
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F 252	Continued From page 4 the toilet paper, the same color as the substance in the commode. The commode seat had dark colored smears on both ends. Interview, on 04/24/13 at 9:15 AM, with the Housekeeper for the 2-B Unit revealed she had missed checking the community men's bathroom on her second scheduled check the day before on 04/23/13. The Housekeeper commented she had noticed the bathroom needed cleaning after lunch, but was too busy on the front hall to clean it. The Housekeeper revealed she should have reported the soiled bathroom to her supervisor. Interview with the Assistant Director of Nursing (ADON), on 04/23/13 at 3:40 PM, revealed any visitor, staff member or resident who was independent in toileting could have used the community men's bathroom on Unit 2-B. The ADON was unable to say how many residents or persons could possibly use the bathroom. Interview with the Environmental Services Director, on 04/25/13 at 10:00 AM, during the Environmental Tour revealed the Housekeeper on Unit 2-B should have informed her of the soiled bathroom and not left it soiled for any period of time.	F 252	The Administrator, Maintenance Director or Environmental Services Director will complete daily rounds (Monday-Friday) to ensure that the facility maintains a safe, clean, comfortable and homelike environment for the next four weeks. Thereafter, the review will be conducted no less than weekly. Any issues identified will be immediately corrected or communicated to the appropriate supervisor for correction. These reviews will be discussed at the monthly Continuous Quality Improvement (CQI) meeting for further monitoring and continued compliance.	6/1/13
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's	F 279	It is the policy of HHRC to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	



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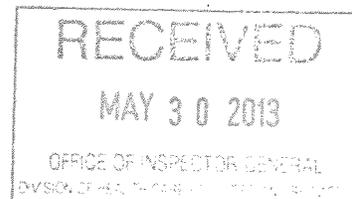
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F 279	<p>Continued From page 5</p> <p>medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to develop a care plan for bladder incontinence for one (1) of twenty-four (24) Sampled and three (3) Unsampled Residents. The staff failed to develop a care plan for Resident #21's incontinence after it triggered as an area of concern during the Minimum Data Set (MDS) process.</p> <p>The findings include:</p> <p>Review of the facility's Comprehensive Plan of Care policy, effective date 08/01/12, revealed each resident shall have a comprehensive care plan based on the comprehensive assessment (MDS) fully developed within seven (7) days after completion of the comprehensive assessment. The comprehensive plan of care will be updated to reflect the resident's current condition at least every ninety (90) days, or whenever significant</p>	F 279	<p>On 4/26/13, the MDSC developed a plan of care related to incontinence for resident #21. Interventions included, but were not limited to observing skin daily for irritation and redness, evaluating for symptoms of urinary tract infection as needed, evaluating for constipation if needed, assisting with perineal cleansing as needed, observing for acute behavioral changes that may include a urinary tract infection, assisting to bathroom or commode as needed, evaluating medications that may contribute to incontinence as needed, observing for signs of emotional distress with incontinence and assessing for environmental factors that may contribute to incontinence as needed.</p> <p>The DON provided additional education to the IDCPT by 5/24/13 regarding the importance of utilizing the results of resident assessments to develop a comprehensive plan of care that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs.</p>		



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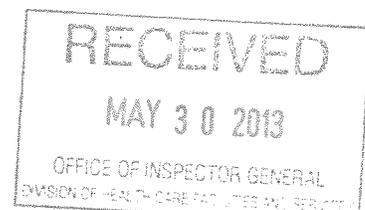
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F 279	Continued From page 6 changes occur. Clinical record review for Resident #21 revealed the facility admitted the resident on 04/08/98. An Annual MDS was completed on 09/11/12, for which the care area of bladder incontinence triggered and was identified with a check indicating a care plan was developed. Upon review of the care plan, there was not a care plan developed for bladder incontinence. Interview and care plan review with the MDS Coordinator for Resident #21, on 04/25/13 at 3:45 PM, revealed the care plan for bladder incontinence was not included in the comprehensive care plan. He reported it was the responsibility of the MDS Coordinator to develop the care plan based upon the triggered areas of the MDS. He stated this resident should have been care planned incontinence. He reported the purpose of the care plan is to put interventions in place to ensure the resident was provided with the care best suited to meet the needs of the resident. Interview and care plan review with the Director of Nurses (DON) for Resident #21, on 04/25/13 at 4:00 PM, stated the care plan for bladder incontinence was not included in the care plan. She reported it was the responsibility of the MDS Coordinator to develop the care plan based upon the triggered areas of the MDS. She stated this resident should have been care planned for incontinence since the care area triggered. The purpose of the care plan was to put interventions in place to ensure the resident received the needed care.	F 279	No later than 5/31/13, the IDCPT will review each resident's most current comprehensive assessment to ensure that all triggered areas have been addressed in the care plan process if the problem remains unresolved. Any identified area will be immediately corrected. The DON or ADON will audit at least three care plans per week to ensure that each resident has a plan of care that includes measurable objectives and timetables to meet the resident's medical, nursing and mental and psychosocial needs and that it describes the services that are needed to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The results of the care plan audits will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance. The CQI Committee members will determine, based upon results of the audits, how long the audits will		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280			



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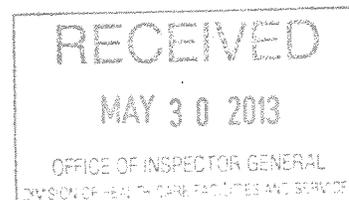
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F 280 SS=D	Continued From page 7 PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to revise the Nursing Care Plans for two (2) of the twenty-four (24) sampled and three (3) unsampled residents. The facility care planned Resident #18 for a Peripherally Inserted Central Catheter (PICC) on 01/01/13 for intervenous fluids. The resident was observed on 04/24-25/13 to not have a PICC line. In addition, a care plan for Resident #2 was not	F 280	continue. At a minimum, the audits will continue weekly for three months and monthly thereafter. F280 It is the policy of HHRC that a comprehensive care plan be developed within 7 days after the completion of the comprehensive assessment. The plan of care for Resident #18 was updated by the IDCPT on 4/25/13 to reflect the discontinuation of the PICC line. The plan of care was also reviewed by the IDCPT at the same time to ensure that all current interventions were reflective of the resident's current condition. The plan of care for Resident #2 was updated by the IDCPT on 4/25/13 to discontinue the use of non-skid strips at the bedside. Additionally, the IDCPT updated the plan of care for falls to include appropriate interventions including, but not limited to seat belt alarm to wheelchair, sensor pad to bed and placement in a low bed.	6/1/13	



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F 280	<p>Continued From page 8 revised after a fall dated 03/08/13.</p> <p>The findings include:</p> <p>Review of the facility's Comprehensive Plan of Care policy, effective date 08/01/12, revealed each resident shall have a comprehensive care plan fully developed within seven (7) days after completion of Minimum Data Set (MDS) assessment. The comprehensive plan of care will be updated to reflect resident's current condition at least every ninety (90) days, or whenever significant changes occur.</p> <p>Review of the facility's Notification of Changes policy, effective date 08/01/12, revealed the care plan will be revised as necessary.</p> <p>1. Review of the clinical record for Resident #18 revealed the facility admitted the resident on 12/23/10 with diagnoses of Toxic Metabolic Encephalopathy, Urinary Tract Infection and Diabetes. Review of the care plan dated 01/01/13 revealed the PICC protocol was still in effect.</p> <p>Observation of Resident #18, on 04/24/13 at 3:50 PM, revealed the resident was sitting in the wheelchair, wearing a short sleeve shirt without any visible external interavenous devices.</p> <p>Interview with License Practical Nurse (LPN) #1, on 4/25/13 at 3:20 PM, revealed the resident had not had a PICC line for fluids for quiet some time. She stated the care plan was designed for staff to be informed of the care the resident required. She further stated the unit manager or the MDS Coordinator was responsible for updating the care plan.</p>	F 280	<p>The MDS Coordinators received additional education by the DON on by 5/24/13 regarding the importance and responsibility of the MDSCs to review and revise the plan of care for each resident as changes occur. These changes shall be communicated via morning report, weekly Focus Committee meetings (a sub-committee of the monthly CQI Committee meeting) and other areas of communication as appropriate.</p> <p>No later than 5/31/13, the IDCPT will review the plan of care for each resident to determine that all care plans are up to date and reflective of the current needs of the resident.</p> <p>The DON or ADON will review at least three care plans per week to ensure that revisions have been made to the plan of care as changes occur with the resident's condition.</p>



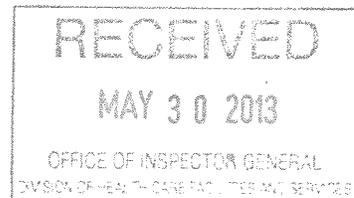
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/25/2013
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NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205
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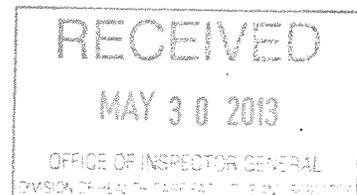
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F 280	Continued From page 9 Interview with the MDS Coordinator, on 4/25/13 at 3:30 PM, revealed the Unit Manager was responsible for the day to day updating of the care plan. He stated he was responsible for ensuring the accuracy of the care plan with the assessment periods. He further stated the plan of care was not revised to reflect the resident's status change. Interview with the Director of Nursing (DON), on 04/25/13 at 4:30 PM, revealed the MDS Coordinator was responsible to update and revise the care plans. The DON revealed any changes should be caught during the care plan conference. The DON revealed she did not attend the care plan meetings. However, the DON revealed she attended the morning meetings where all orders and condition changes are discussed regarding each resident and revealed any changes to the care plan should be made at that time. The DON revealed she had completed random chart audits, but did not know why the care plan changes were not caught and updated appropriately. 2. Clinical record review for Resident #2 revealed the facility readmitted the resident on 12/10/12 with diagnoses of a Left Above the Knee Amputation, dated 06/2012 and a Right Above the Knee Amputation, dated 12/2012. The most recent Annual MDS was dated 04/12/13 and a care plan was completed. The Fall Investigation Form, undated, revealed the fall was dated as of 03/08/13 at 5:15 AM and identified extrinsic factors of environment due to the resident was a Bilateral Amputee and the patient removed the alarm.	F 280	The results of the care plan audits will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance. The CQI Committee members will determine, based upon results of the audits, how long the audits will continue. At a minimum, the audits will continue weekly for three months and monthly thereafter.	6/1/13



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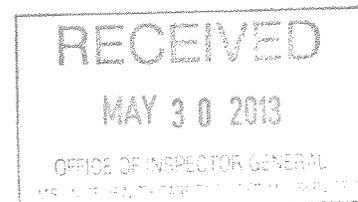
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F 280	Continued From page 10 The current care plan, revised and updated 04/24/13, revealed problem #5 was Falls with an onset dated 07/14/10. Non skid strips to bedside remained as a fall intervention. The resident was a Bilateral Amputee since 12/2012 and non-ambulatory. The care plan intervention of an alarming safety device to bed and chair did not address placement or location of the alarming device to ensure the alarming device would remain effective for this resident. The facility did not initiate new Interventions to prevent further falls. Interview with the MDS Coordinator, on 04/25/13 at 3:45 PM, stated the care plan was the responsibility of the MDS Coordinator to revise the care plan based upon the triggered areas of the MDS. He reported the purpose of the care plan was to put interventions in place for the care of the resident to ensure the resident was provided with the care best suited to meet the needs of that resident. He stated care plans and interventions were reviewed to ensure the care plan was current and updated. Interview with the Director of Nurses (DON), on 04/25/13 at 4:00 PM, stated it was the responsibility of the MDS Coordinator to develop and revise the care plan based upon the triggered areas of the MDS and changes in status. She stated this resident's care plan should have been revised to address the fall and the prevention of further falls. The purpose of the care plan was to put interventions in place to ensure the resident received the needed care.	F 280			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431			



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F 431	<p>Continued From page 11</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility</p>	F 431			



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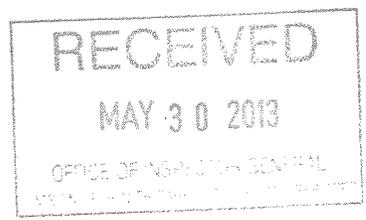
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NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205
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F 431	Continued From page 12 failed to ensure safe, secure storage of drugs for one (1) of the eight (8) medication carts. The facility failed to separate medications by routes of administration. The findings include: Review of the facility's policy, titled ID1: Storage of Medications, not dated, revealed orally administered medications were kept separate from externally used medications. In addition, medication storage conditions were to be monitored on a monthly basis and corrective action would be taken if problems were identified. Observation, on 04/24/13 at 9:30 AM, during the med pass on Hallway 2 B, revealed four (4) packages of Lovenox 40 mg/0.4 ml for subcutaneous administration; two (2) partially full bottles of Kayexalate liquid, one (1) bottle of 100% Polyethylene Glycol, one (1) bottle of Guaifenesin 100 mg/5 ml syrup, and twenty-three (23) Lidoderm 5% patches were stored in one drawer of the medication cart on the 2B hallway. The medications were not separated by dividers within the drawer. Interview, on 04/24/13 at 9:35 AM, with Licensed Practical Nurse (LPN) #3, revealed all liquid medications were typically stored in a locked side compartment of the medication cart, and a separate compartment was designated for injectable medications. However, both of these compartments were full so the drawer designated for patches was used as an additional storage space. LPN #3 stated pharmacy delivered medications daily, but nurses were responsible for ensuring safe and secure storage of the	F 431	F431 It is the policy of HHRC that drugs and biological used in the facility must be labeled and stored in accordance with currently accepted professional principles. The medication cart on Hallway 2B was reorganized by the Pharmacist on 4/24/13. All other medication carts were reviewed by the Pharmacist on 4/24/13 and any issues identified were immediately corrected. Medication rooms and refrigerators were also visually reviewed on 4/23/13 and 4/24/13 by the Pharmacist to ensure that all drugs and biologicals were labeled and stored in accordance with State and Federal laws. The DON, ADON or Staff Development Coordinator provided additional education to all licensed staff by 5/31/13 regarding the importance of maintaining a system of labeling and storing biological drugs according to State and Federal laws.	
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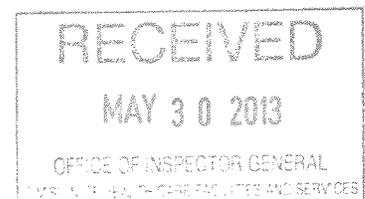
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NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1706 STEVENS AVENUE LOUISVILLE, KY 40205		
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F 431	<p>Continued From page 13</p> <p>resident's medications. LPN #3 stated medications administered by different routes should be stored separately.</p> <p>Interview, on 04/25/13 at 4:00 PM with the pharmacist from Med Care (the facility's contractor for pharmaceutical services), revealed in order to be in compliance with federal regulations for safe medication storage, medications administered via different routes should be stored separately. At a minimum, the drawer should contain dividers to separate the medications.</p> <p>Further interview with the facility's consulting Pharmacist, on 04/25/13 at 4:15 PM, revealed medication carts are inspected monthly by a pharmacy technician looking for inappropriately stored medications, expired medications, and the opened dates. The Pharmacist revealed the technician utilized a computerized checklist during the audit which included any findings on the report.</p> <p>Interview with the Pharmacy Technician, on 04/29/13 at 12:00 PM, revealed a facility med cart audit was completed on 04/23/13.</p> <p>Review of the Consultant Pharmacist Report on Medication Systems and Procedures revealed the above findings were not noted on the report.</p> <p>Interview, on 04/25/13 at 4:25 PM, with the Assistant Director of Nurses (ADON) revealed she expected the charge nurses, who also passed medications, to ensure medications were properly organized and stored in the medication carts. The ADON stated the potential for</p>	F 431	<p>The DON, ADON, or Unit Coordinator will audit the medication carts and medication storage areas three times per week for four weeks and then weekly thereafter to ensure that drugs and biologicals are stored in accordance with applicable laws.</p> <p>The results of these audits will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.</p>	6/1/13	

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NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1708 STEVENS AVENUE LOUISVILLE, KY 40205	
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F 431	Continued From page 14 medication errors increased when medications administered via different routes were stored together.	F 431	F520	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility	F 520	It is the policy of HHRC to maintain a quality assessment and assurance committee, referred to as the Continuous Quality Improvement committee consisting of the DON, the Medical Director and at least three other members of the facility's staff. This committee will meet at least quarterly. The Medical Director will attend the Continuous Quality Improvement Committee meeting on 5/22/13. His role and expected involvement in the committee was explained to him by the Administrator on 4/24/13. The Area Administrator provided additional education to the Administrator on 5/17/13 regarding the importance of involving the Medical Director in the CQI process. The CQI minutes and associated action plans and/or policies for January through April of 2013 will be reviewed	



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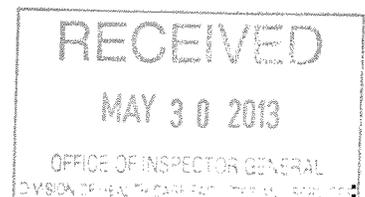
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NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40206		
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F 520	<p>Continued From page 15 to ensure the Quality Assurance/Quality Improvement committee met at least quarterly and consisted of a physician designated by the facility.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Facility Committees, dated 07/01/05, revealed the Continuous Quality Improvement Committee served as a platform for problem-solving between all employees. The Administrator shall oversee the development and maintenance of functional committees in the facility.</p> <p>Interview with the Administrator, on 04/25/13 at 3:00 PM, revealed the facility did not have a Quality Assurance/Quality Improvement (QA/QI) meeting at least every quarter and did not have a physician assigned by the facility in attendance. The Administrator revealed an assigned physician had not been in attendance since September 2012.</p> <p>Review of the QA/QI attendance sheets revealed the physician did not attend the QA/QI meeting in August 2012, November 2012, January 2013, and February 2013. No attendance sheet was noted for October 2012 or December 2012.</p> <p>Continued interview with the Administrator revealed a QA/QI meeting was held monthly; however, they did not have a meeting in October or December. In Addition, the facility did not invite the assigned physician to the QA/QI meeting held in January 2013 that included the facility's new corporate representatives. The Administrator revealed the importance of the</p>	F 520	<p>with the Medical Director and updated to reflect his input and guidance by the Administrator by 5/31/2013.</p> <p>The Administrator will fax the sign in sheet to the Area Administrator on a monthly basis in order to assure that meetings are being held consistently and that the Medical Director is involved on no less than a quarterly basis.</p> <p>Any concerns identified by the Area Administrator with the CQI Committee meetings will be discussed with the Regional Quality Assurance Nurse and additional recommendations will be forwarded to the facility for implementation.</p>	6/1/13	



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NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205		
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F 520	Continued From page 16 Medical Director attending the QA/QI meeting was to provide an interdisciplinary approach that ultimately affected the residents. The Administrator revealed he had spoken with the physician on several occasions about attending meetings, but did state he was ultimately responsible to ensure the entire team was present during QA/QI meetings. Interview with the Medical Director, on 04/25/13 at 4:40 PM, revealed he was new to the role of Medical Director and had not attended any of the meetings since assuming the position in December 2012. The Medical Director revealed he was not aware of the requirements for QA/QI and did not understand his obligation to the QA/QI committee.	F 520			



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NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205
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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: 1967, 1974, 2011</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Three (3) stories, Type II Protected.</p> <p>SMOKE COMPARTMENTS: Twelve (12) smoke compartments. Four (4) compartments per floor.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors. Upgraded in 2009</p> <p>SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system. New service installed in 2011.</p> <p>GENERATOR: Type II, 260KW generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was initiated on 04/23/13 and concluded on 04/24/13. Highlands Nursing & Rehabilitation Center was found not in compliance with the Requirements for Participation in Medicare and Medicaid. The facility has one-hundred and fifty-four (154) certified beds and the census was one-hundred and twenty-two (122) on the days of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, Highlands Health & Rehabilitation Center (HHRC) has taken or will take the following actions:</p> <p>K029</p> <p>Highlands Health and Rehabilitation Center strives to ensure compliance with NFPA 101 Life Safety Code Standards requiring a one hour fire rated construction or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas.</p> <p>The Maintenance Director replaced the door closure on 5/3/13. The Maintenance Director repaired the unsealed penetrations in the concrete masonry walls in the Elevator Room on 4/23/13.</p>	
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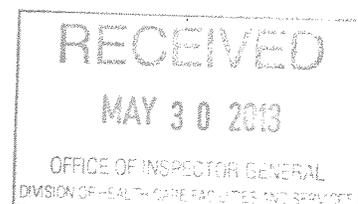
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X [Signature]</i>	TITLE <i>X Administrator</i>	(X6) DATE <i>X 5/30/13</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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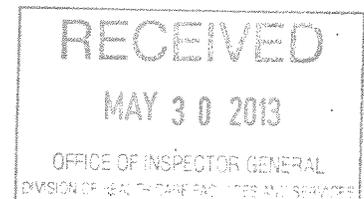
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NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205		
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K 000 K 029 SS=D	Continued From page 1 Fire) Deficiencies were cited with the highest deficiency identified at an "F" level. NFPA 101 LIFE SAFETY CODE STANDARD 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 NFPA standards. The deficiencies had the potential to affect one (1) of twelve (12) smoke compartments, residents, staff and visitors. The facility has one-hundred and fifty-four (154) certified beds and the census was one-hundred and twenty-two (122) on the days of the survey. The facility failed to ensure all self closures functioned properly and failed to ensure penetrations of walls were sealed properly. The findings include:	K 000 K 029	The Maintenance Director was reeducated by the Administrator on by 5/24/13 regarding the requirements to ensure that all self-closures function properly and all wall penetrations are properly sealed. The Maintenance Director completed an audit on by 5/24/13 of all walls and all door closures. The Maintenance Director will continue to perform this audit monthly to ensure that all self-closures function properly and that all wall penetrations are properly sealed. The Maintenance Director will also review walls affected by work from outside vendors immediately following the completion of the work. Outside vendors will be advised by the Maintenance Director that he is to be notified prior to and following any scheduled work to be completed.		



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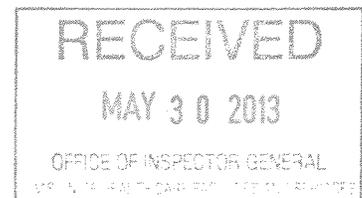
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2013
NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205		
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K 029	Continued From page 2 1. Observation, on 04/23/13 at 9:15 AM, with the Maintenance Director revealed the door to the Dry Storage Room located within the Kitchen, had a self-closing device installed on the door, but would not close completely. Interview, on 04/23/13 at 9:15 AM, with the Maintenance Director revealed he was not aware the door to the Dry Storage Room located within the Kitchen, would not close completely. The door closer installed on the door was old and in need of adjusting to make it function properly. 2. Observation, on 04/23/13 at 9:30 AM, with the Maintenance Director revealed the Elevator Equipment Room, located on the Ground Floor, had two unsealed penetrations in the concrete masonry walls, compromising the required one-hour wall rating. Interview, on 04/23/13 at 9:30 AM, with the Maintenance Director revealed he was not aware of the penetrations in the wall not being sealed properly. He indicated the facility was currently being renovated and a sanitary pipe line had been replaced and a new electrical conduit was added within the room. He acknowledged the penetrations are required to be sealed with material equal to the rating of the walls penetrated. Reference: NFPA 101 (2000 Edition).	K 029	Results of the audits of all walls and door closures will be forwarded by the Administrator or Maintenance Director to the Continuous Quality Improvement (CQI) Committee for further recommendations and continued monitoring for compliance.	6/1/13	



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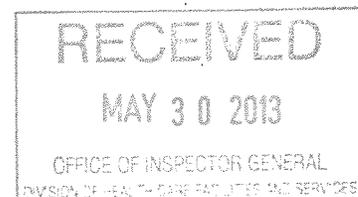
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K 029	Continued From page 3 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029			
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.	K 050			



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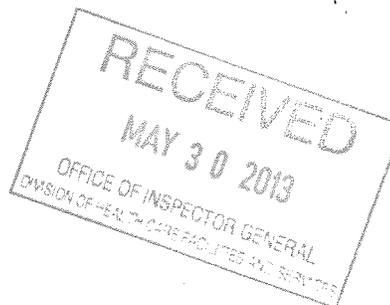
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K 050	<p>Continued From page 4</p> <p>The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect each of the twelve (12) smoke compartments, residents, staff, and visitors. The facility has one-hundred and fifty-four (154) certified beds and the census was one-hundred and twenty-two (122) on the days of the survey.</p> <p>The findings include:</p> <p>Record review, on 04/23/13 at 2:25 PM, with the Maintenance Director revealed fire drills were being conducted quarterly, on each shift, but times were not being documented on the forms provided for review.</p> <p>Interview, on 04/23/13 at 2:25 PM, with the Maintenance Director revealed he was using a new form provided since the facility changed ownership in September of 2012. The new form did not have a space on the form to indicate the</p>	K 050	<p>K050</p> <p>Highlands Health and Rehabilitation Center strives to ensure compliance with NFPA 101 Life Safety Code Standards requiring that fire drills be held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine in accordance with 19.7.1.2.</p> <p>The Maintenance Director completed fire drills for all shifts and documented the time each drill was conducted by 5/31/13.</p> <p>The Administrator updated the fire drill form to include an area to document the times each fire drill is conducted by 5/29/13.</p> <p>By 5/24/13 the Maintenance Director was re-educated by the Administrator regarding requirements that fire drills must be conducted at random times and that the time each fire drill is conducted must be documented.</p>	



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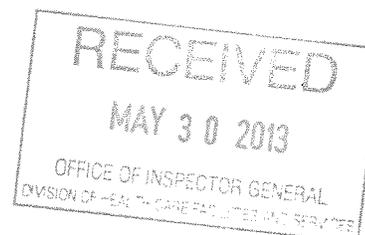
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K 062	<p>Continued From page 6</p> <p>Interview, on 04/23/13 at 9:30 AM, with the Maintenance Director revealed he was not aware that sprinkler heads of mixed response ratings were prohibited to be installed in the same smoke compartment.</p> <p>2. Observation, on 04/23/13 at 12:50 PM, with the Maintenance Director revealed the Storage Room located within the Toilet Room behind the Nurses' Station on the First Floor of Building C, did not have an escutcheon plate installed on the sprinkler head. Escutcheon plates are required to prevent smoke from entering the space above the ceiling.</p> <p>Interview, on 04/23/13 at 12:50 PM, with the Maintenance Director revealed the facility had all of the ceiling tiles replaced throughout the Building as a part of the renovation project.</p> <p>3. Observation, on 04/23/13 at 1:00 PM, with the Maintenance Director revealed the Storage Room located within the Clean Linen Room on the First Floor of Building C was not protected by sprinkler coverage.</p> <p>Interview, on 04/23/13 at 1:00 PM, with the Maintenance Director revealed he was not aware of the Storage Room not being protected by sprinkler coverage and may have been a result of the ceiling tile replacement project.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>2-2.1.1* Sprinklers shall be inspected from the</p>	K 062	<p>The two sprinkler heads of mixed response ratings identified in the Staff Break Room were replaced on 4/29/13 by Brown Sprinkler Company so that all sprinkler heads in the same smoke compartment were of the same response rating. On 4/25/13, the Maintenance Director installed an escutcheon plate on the sprinkler head located in the Storage Room within the Toilet Room behind the Nurses Station on the First Floor of Building C. Sprinkler coverage was provided to the Storage Room located within the Clean Linen Room on the First Floor of Building C on 4/29/13 by Brown Sprinkler Company.</p> <p>The Maintenance Director was reeducated by the Administrator on by 5/24/13 regarding the requirements related to sprinkler heads of mixed response in the same smoke compartment, the necessity of escutcheon plates for sprinkler heads, and providing sprinkler coverage for all rooms.</p>	



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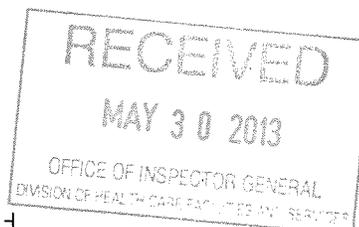
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K 062	Continued From page 7 floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 062	The Maintenance Director will audit all sprinkler heads monthly for 6 months to ensure that there are no sprinkler heads of mixed response in the same smoke compartment, that all sprinkler heads have escutcheon plates, and that sprinkler coverage is provided for all rooms. The results of this audit of all sprinkler heads will be forwarded by the Administrator or Maintenance Director to the Continuous Quality Improvement (CQI) Committee for further recommendations and continued monitoring for compliance.	6/1/13
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	K147 Highlands Health and Rehabilitation Center strives to ensure compliance with NFPA 101 Life Safety Code Standards requiring electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code 9.1.2.	



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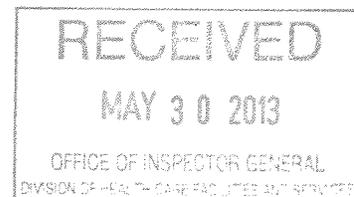
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K 147	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards and failed to ensure the staff was knowledgeable of the requirements. The deficiency had the potential to affect one (1) of twelve (12) smoke compartments, residents, staff, and visitors. The facility has one-hundred and fifty-four (154) certified beds and the census was one-hundred and twenty-two (122) on the days of the survey. The findings include: 1. Observation, on 04/23/13 at 8:05 AM, with the Maintenance Director revealed a refrigerator was plugged into a long extension cord extending to another wall within the Business Office located on the Ground Floor of Building C. Interview, on 04/16/13 at 8:05 AM, with the Maintenance Director revealed he was unaware the extension cord was being used to power the refrigerator located in the Business Office. 2. Observation, on 04/23/13 at 8:10 AM, with the Maintenance Director revealed a refrigerator, a microwave oven and an extension cord was plugged into a power strip within the Therapy Office located on the Ground Floor of Building C. Interview, on 04/23/13 at 8:10 AM, with the	K 147	The Maintenance Director removed the extension cord located on the Ground Floor of Building C in the Business Office on 5/3/13. The Maintenance Director removed the power strip from the Therapy Office located on the Ground Floor of Building C on 4/23/13. The Administrator reeducated the Maintenance Director on by 5/24/13 of the necessity to ensure that the facility is free of extension cords and multiple outlet adapters. The Maintenance Director will audit all areas of the facility monthly for 6 months to ensure that no power cords or multiple outlet adapters are in use in the facility. The results of this audit related to power cords and multiple outlet adapters will be forwarded by the Administrator or Maintenance Director to the Continuous Quality Improvement (CQI) Committee for further recommendations and continued monitoring for compliance.	6/1/13



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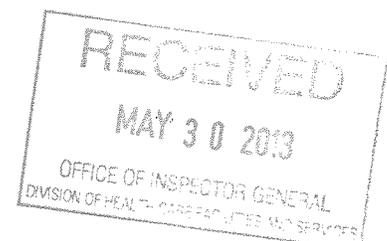
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K 147	Continued From page 9 Maintenance Director revealed he was aware of the requirement for the usage of power strips; however, he was not aware of a refrigerator, a microwave oven and an extension cord being plugged into a power strip within the Therapy Office. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	K154 Highlands Health and Rehabilitation Center strives to ensure compliance with NFPA 101 Life Safety Code where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1		
K 154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on Interview and facility Policies and Procedures review, it was determined the facility failed to develop a fire watch policy in accordance with NFPA standards. The deficiency had the potential to affect each of the twelve (12) smoke	K 154	The Administrator implemented a Fire Watch Policy in accordance with NFPA 101 Life Safety Code requirements by 5/31/13. The Area Administrator reeducated the Administrator of the necessity of a Fire Watch Policy which meets the requirements of NFPA 101 Life Safety Code on 5/17/13. By 5/24/13, the Administrator educated the Maintenance Director and the Staff Development Coordinator as to the content and implementation of the Fire Watch Policy.		



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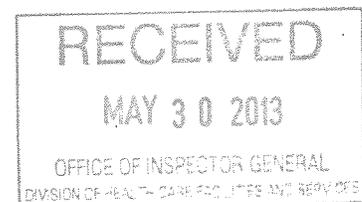
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K 154	<p>Continued From page 10</p> <p>compartments, residents, staff, and visitors. The facility has one-hundred and fifty-four (154) certified beds and the census was one-hundred and twenty-two (122) on the days of the survey.</p> <p>The findings include:</p> <p>Review of the facility's Policies and Procedures, on 04/23/13 at 3:30 PM, with the Maintenance Director revealed the facility failed to provide a written policy outlining an approved fire watch system in the event of the sprinkler system being shut down for four (4) or more hours in a twenty four (24) hour period.</p> <p>Interview, on 04/23/13 at 3:30 PM, with the Maintenance Director revealed he would confirm with the Administrator if a Fire Watch Policy was implemented by the new Owner's Corporate Policies.</p> <p>Further interview, on 04/24/13 at 8:00 AM, with the Administrator confirmed an approved Fire Watch Policy had not been implemented by the new Ownership of the Facility. A partial Fire Watch Policy from the previous Ownership had been provided but was determined to be incomplete.</p> <p>Reference; NFPA 101 (2000 edition)</p> <p>9.7.6* Sprinkler System Shutdown.</p> <p>9.7.6.1 Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour</p>	K 154	<p>The Staff Development Coordinator will complete education for all facility staff of the Fire Watch Policy by 5/31/13.</p> <p>The Administrator will audit the facility Life Safety Policies by 5/31/13 to ensure they are complete and in accordance with the requirements of NFPA 101 Life Safety Code by 5/31/13. Any additional policies added will be reviewed prior to implementation by the Administrator to ensure they are complete and in accordance with the requirements of NFPA 101 Life Safety Code.</p> <p>The results of this audit of all Life Safety Policies will be forwarded by the Administrator to the Continuous Quality Improvement (CQI) Committee for further recommendations and continued monitoring for compliance.</p>	6/1/13



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K 154	Continued From page 11 period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service.	K 154	K155 Highlands Health and Rehabilitation Center strives to ensure compliance with NFPA 101 Life Safety Code where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8	
K 155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on interview and facility Policies and Procedures review, it was determined the facility failed to develop a fire watch policy in accordance with NFPA standards. The deficiency had the potential to affect each of the twelve (12) smoke compartments, residents, staff, and visitors. The facility has one-hundred and fifty-four (154) certified beds and the census was one-hundred and twenty-two (122) on the days of the survey. The findings include: Review of the facility's Policies and Procedures, on 04/23/13 at 3:30 PM, with the Maintenance Director revealed the facility failed to provide a written policy outlining an approved fire watch system in the event of the fire alarm system being shut down for four (4) or more hours in a twenty four (24) hour period.	K 155	The Administrator implemented a Fire Watch Policy in accordance with NFPA 101 Life Safety Code requirements by 5/31/13. The Area Administrator reeducated the Administrator of the necessity of a Fire Watch Policy which meets the requirements of NFPA 101 Life Safety Code on 5/17/13. By 5/24/13, the Administrator educated the Maintenance Director and the Staff Development Coordinator as to the content and implementation of the Fire Watch Policy.	



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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2013
NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1706 STEVENS AVENUE LOUISVILLE, KY 40205	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 155	Continued From page 12 Interview, on 04/23/13 at 3:30 PM, with the Maintenance Director revealed he would confirm with the Administrator if a Fire Watch Policy was implemented by the new Owner's Corporate Policies. Further interview, on 04/24/13 at 8:00 AM, with the Administrator confirmed an approved Fire Watch Policy had not been implemented by the new Ownership of the Facility. A partial Fire Watch Policy from the previous Ownership had been provided but was determined to be incomplete. Reference; NFPA 101 (2000 edition) 9.6.1.8* Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.	K 155	The Staff Development Coordinator will complete education for all facility staff of the Fire Watch Policy by 5/31/13. The Administrator will audit the facility Life Safety Policies by 5/31/13 to ensure they are complete and in accordance with the requirements of NFPA 101 Life Safety Code by 5/31/13. Any additional policies added will be reviewed prior to implementation by the Administrator to ensure they are complete and in accordance with the requirements of NFPA 101 Life Safety Code. The results of this audit of all Life Safety Policies will be forwarded to the Continuous Quality Improvement (CQI) Committee for further recommendations and continued monitoring for compliance.	6/1/13

