

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

PRINTED: 08/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

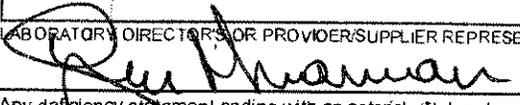
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185383	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/15/2013
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NAME OF PROVIDER OR SUPPLIER  HIGHLANDSPRING OF FT THOMAS	STREET ADDRESS, CITY, STATE, ZIP CODE 960 HIGHLAND AVENUE FORT THOMAS, KY 41075
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F 000	INITIAL COMMENTS  A Standard Recertification Survey was conducted 08/13/13 through 08/15/13. Deficiencies were cited with the highest Scope and Severity of a "E".	F 000	Without admitting or denying the validity or existence of the alleged deficiencies, Highlandspring provides the following plan of correction. However, the law requires us to prepare a plan of correction for the citation regardless of whether we agree with it.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  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 store food under sanitary conditions. Observations during initial tour revealed the ingredient bin scoop in food product, the food bin was sticky to the touch and there were numerous food products not dated or sealed in the walk-in freezer.  The findings include:  1. Review of the facility's guidelines titled, "Kitchen Equipment Cleaning Schedule", no effective date, revealed items were to be cleaned on Tuesday: Ingredient Bins and Lids.  Review of the facility's policy titled "Food Storage", effective date 05/2008, revealed it is	F 371	This plan of correction is not meant to establish any standard of care, contract, obligation or position and Highlandspring reserves all right to raise all possible contention and defenses in any civil or criminal claim action or proceeding.  THIS PLAN OF CORRECTION SERVES AS HIGHLANDSPRING OF FORT THOMAS CREDIBLE ALLEGATION OF SUBSTANTIAL COMPLIANCE AS OF SEPTEMBER 17 <sup>th</sup> 2013.  F371  Highlandspring procures food from sources approved or considered satisfactory by federal, state and local authorities; additionally, Highlandspring stores, prepares, distributes, and serves food under sanitary conditions.  On August 12 <sup>th</sup> , 2013 the noted storage bin was cleaned immediately by the dietary staff and the scoop was removed from the powdered milk bin.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CCHA	(X6) DATE 9/6/13
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  <b>HIGHLANDSPRING OF FT THOMAS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>960 HIGHLAND AVENUE FORT THOMAS, KY 41075</b>		
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F 371	<p>Continued From page 1</p> <p>the policy of this facility that food storage areas be maintained in a clean, safe, and sanitary manner. All packaged food, canned foods, or food items stored shall be kept clean and dry at all times.</p> <p>Observation during the initial kitchen tour, on 08/13/13 at 1:45 PM, revealed ingredient bin scoop laying in the dry powder milk and the outside of the ingredient bin had a sticky film to touch.</p> <p>Observation of ingredient bin scoop, on 08/14/13 at 9:20 AM, revealed ingredient bin scoop laying in the dry powder milk and the outside of the ingredient bin with a sticky film to touch.</p> <p>Observation of ingredient bin scoop, on 08/15/13 at 10:00 AM, revealed ingredient bin scoop laying in the dry powder milk.</p> <p>Interview with the Chef, on 08/15/13 at 10:00 AM, revealed the scoop should not be laying in the ingredient bin of the dry powdered milk and is not sanitary.</p> <p>2. Review of the facility's guidelines titled, "All Dietary Staff", no effective date, revealed All open food that is put in the walk in freezer needed wrapped, labeled and dated as well. Anything opened and not wrapped, labeled or dated was a violation of state regulations and we will be written up.</p> <p>Observation during initial kitchen tour, on 08/13/13 at 1:45 PM, revealed in the walk-in freezer, foods with no labeling opened and not dated. Frozen green beans were opened not labeled and not dated, two bags of tator tots were</p>	F 371	<p>All food has been labeled and dated appropriately in the walk in refrigerator. On August 12th, 2013 any opened items, not wrapped, labeled or dated being stored was discarded. A clean scoop will be provided each time bins are utilized and will be stored outside the bin containing food material.</p> <p>The Dietary staff was educated by the Chef regarding proper food preparation, storage and handling practices by September 16th, 2013. Topics include but are not limited to labeling, cleaning, dating, and monitoring refrigerated food, leftovers, use-by date, including freezing when applicable or discarding.</p> <p>The Chef audits the kitchen including storage areas during informal walking rounds.</p> <p>A Performance Improvement worksheet is being completed with a focus on storing food under sanitary conditions by the Chef or designee weekly for four weeks and then monthly thereafter. <b>SEE EXHIBIT A.</b> If issues are noted the chef or designee takes appropriate action at the time the concern is noted. Results of the PI worksheet will be reported to the QA committee for a determination of the need for further ongoing monitoring.</p>		

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F 371	Continued From page 2 not labeled or dated, a bag of opened frozen food item not labeled, unidentifiable, not dated, and a pan of three frozen meat products not labeled or dated.  Interview with the Chef, on 08/15/13 at 10:00 AM, revealed all foods should be dated and wrapped and sealed in the freezer area and he is responsible for checking the freezer. He further revealed it is the staffs' and his responsibility to make sure all food items are dated, labeled and sealed.	F 371	Chef to monitor compliance.  Compliance date 9/17/2013.	9/17/13	
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	F 441	Highlandspring has an infection control program designed to provide a safe, sanitary and comfortable environment and help to prevent the development and transmission of disease and infection.  Resident #8 no longer resides at the facility.  LPN #3, LPN #4 and STNA #4 were in-serviced by Director of Nursing on 8/15/13, on the importance of following the facility's "Hand Hygiene Policy and Procedure", in particular during med pass or direct care, to prevent the development and transmission of disease and infection.  Each resident currently requiring catheter care will be assessed for signs and symptoms of Urinary tract infections by September 16 <sup>th</sup> , 2013.		

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F 441	<p>Continued From page 3</p> <p>from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility's policy, it was determined the facility failed to establish and maintain an Infection Control program to prevent the development and transmission of disease and infection for one (1) of twenty-four (24) sampled residents (Resident #8).</p> <p>During observation of bowel incontinence care/urinary catheter care to Resident #8 the State Trained Nurse Aide (STNA) failed to cleanse his hands after removing potentially contaminated gloves and donning a clean pair of gloves during the procedure. Additionally, a nurse entered the resident's room and failed to cleanse her hands prior to putting on gloves and having direct contact with Resident #8.</p> <p>In addition, during observation of the medication pass, the nurse failed to wash or sanitize hands between residents.</p> <p>The findings include:</p>	F 441	<p>Licensed nursing staff will be observed for compliance with hand washing during medication administration pass by September 16<sup>th</sup>, 2013.</p> <p>As a component of their routine duties, Unit Managers/Supervisors make direct observations of care provided by with the observation of the resident on a periodic basis. Additionally, the Director of Nursing, ADON and Administrator make informal rounds to assure the infection control procedures within the facility are being maintained. If concerns are noted during the rounds, interventions will be taken at that time that may include additional one on one education.</p> <p>Mandatory Nursing Staff in-service was held on 8/29/13 and 8/30/13 by the Director of Nursing. Topics included, but were not limited to, Hand Hygiene Policy and Procedures and infection control practices.</p>	

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F 441	Continued From page 4  Review of the facility's policy "Hand Hygiene Policy and Procedure", undated, revealed the purpose of effective hand hygiene was to reduce the incidence of healthcare-care associated infections. Review of the procedures revealed handwashing/rubbing was required routinely for decontaminating hands in the following clinical situations: before having direct contact with patients, when moving from a contaminated body site to a clean body site during care, after removing gloves, and after a med pass is completed with one resident and before commencing a med pass with the next resident.  Review of the facility's policy "Peri Care", revised date 11/2012, revealed pericare was performed to promote good hygiene as well as to reduce the risk of infection. Pericare was to be performed after each occurrence of bladder and/or bowel incontinence in such a manner as to prevent infection of the urinary tract. Under the policy's Procedure section after removing the excess bowel movement the next procedure was to remove gloves wash hands and apply clean gloves.  1. Review of Resident #8's medical record revealed the facility admitted the resident on 09/16/11 with diagnosis which included Agitation secondary to Dementia, Hyperlipidemia, Hypertension, Glaucoma, Benign Prostatic Hyperplasia (BPH= enlarged prostate), Urinary Retention, Hx of Stroke, Chronic Kidney Disease, and Leukocytosis. Review of the Quarterly Minimum Data Set (MDS), dated 07/24/13, revealed the facility assessed Resident #8 as moderately cognitively impaired with impaired decision making.	F 441	A Performance Improvement Worksheet will be utilized to monitor compliance to ensure "Hand Hygiene Policy "is followed. <b>SEE EXHIBIT B.</b> Performance Improvement worksheet will be completed by the Director of Nursing or designee. PI worksheet is completed weekly times four weeks then monthly thereafter. If concerns are noted the monitor will take appropriate action at the time the concern is noted. Results of the PI worksheet will be reported to the QA committee for a determination of the need for further ongoing further monitoring.  Director of Nursing to monitor.  Compliance Date 9/17/13	9/17/13	

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F 441 Continued From page 5

F 441

Continued review of the medical record revealed the monthly Physician Orders for Resident # 8, dated August 2013, included an order for an Indwelling Foley Catheter (Urinary device) and for catheter care, by staff, every shift.

Continued review of Resident #8's medical record revealed the resident was care planned for Foley Catheter use and the interventions included the provision of catheter care each shift. In addition, the resident was care planned for bowel incontinence and to provide pericare after each incontinence episode.

Observation, on 08/15/13 at 11:49 AM, of incontinent and catheter care provided by STNA #4, revealed after the cleaning of a bowel movement the aide removed his gloves and put on a new pair of gloves, without cleaning his hands, and began to provide catheter care. In addition, after cleaning the catheter side the aide removed his gloves, did not clean his hands, and put on a new pair of gloves prior to putting on a brief.

Interview with STNA #4, on 08/15/13 at 12:16 PM, revealed he had realized, during his care of Resident #8, he had forgotten to always wash his hands after removing dirty gloves prior to putting on clean gloves when he provided bowel/catheter care to Resident #8. The STNA reported it was a (potential) cross contamination issue. The STNA stated by not washing his hands after providing bowel care prior to providing Foley Catheter Care could have put the resident at risk for a urinary tract infection.

Continued observation, on 08/15/13 at 12:07 PM,

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F 441 Continued From page 6  
revealed Licensed Practical Nurse (LPN) #4 entered Resident #8's room and put on clean gloves, but did not clean her hands. The nurse then proceeded to assess the skin site where the urinary catheter device entered Resident # 8's urinary tract.

Interview with LPN #4, on 08/15/13 at 12:12 PM, revealed she did not wash her hands upon entering Resident #8's room before putting on gloves to assess Resident #8. The LPN stated it was an infection control risk to not clean hands prior to putting on the gloves and assessing Resident #8. The LPN further stated she was supposed to wash her hands upon entering Resident #8's room.

Interview, on 08/15/13 at 3:06 PM, with Registered Nurse (RN)/Unit Manager (UM) #2, revealed when staff removed dirty gloves they are supposed to wash hands prior to putting on clean gloves. She stated it was an infection control issue.

Interview, on 08/15/13 at 3:28 PM, with the Infection Control Nurse (ICN) revealed staff were supposed to wash their hands between glove changes. The ICN stated because of the risk of cross contamination and infection, the aided should have washed his hands, after cleaning the bowel movement, before donning the clean gloves. In addition, she stated staff were supposed to wash hands before patient contact because of the potential risk of cross contamination. She further stated, the nurse should have washed her hands before putting on the gloves and assessing the site.

Interview, on 08/15/13 at 7:41 PM, with the

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F 441	Continued From page 7  Director of Nursing (DON) revealed staff were supposed to wash hands between glove changes and upon entering a residents room to provide care they were supposed to wash their hands or use hand sanitizer. The DON further stated the LPN had reported to her she had just washed her hands prior to leaving another resident's room and entered Resident #8's, but didn't clean her hands prior to assessing the resident because the nurse was nervous.  2. Observation, on 08/14/13, of LPN #3 during medication pass revealed the LPN did not wash hands in between residents when giving medications. At 9:05 AM, the LPN gave oral medications and Flonase nose spray to an unsampled resident. While in the room, the nurse assisted the resident with buttoning his/her clothing. The nurse then left the room without washing her hands and proceeded to prepare and then give medications, at 9:15 AM, to an unsampled resident. While in that room, the nurse adjusted the resident's bed and again did not wash her hands after leaving the room. The nurse went into the hall stopped and patted a resident on the shoulder and then prepared medications and then gave the medication to another unsampled resident without washing her hands.  Interview, on 08/14/13 at 9:20 AM, with LPN #3 revealed she normally sanitized her hands in between each resident when giving medications, but was nervous when being observed by the surveyor.  Interview with Unit Manager (UM)/LPN #2, on 08/15/13 at 9:08 AM, revealed she was not aware the nurse failed to wash/sanitize hands between	F 441			

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F 441	Continued From page 8 residents on 08/14/13 medication pass observation. She further stated it was her expectation staff wash/sanitize hands between residents.  Further interview with the ICN, on 08/15/13 at 4:12 PM, revealed during medication pass the the facility's practice was to perform hand washing or hand hygiene between residents. She stated the nurse failed to follow this practice and should have performed hand hygiene or handwashing between residents when she passed medication.	F 441		
F 497 SS&D	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE  The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.  This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of facility's policy, it was determined the facility failed to ensure each nurse aide received no less than twelve (12) hours of in-service education per	F 497	F497  Highlandspring completes a performance review of every nurse aide at least once every 12 months, as well as regular in-service education based on the outcome of these reviews. In-service training is sufficient to ensure the continuing competence of nurse aides, and is no less than 12 hours per year; addresses areas of weakness as determined in nurse aide' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.  Employee #1 was removed from the schedule 8/15/13 until all in-services completed as required on 8/16/13.	

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F 497	<p>Continued From page 9</p> <p>year. Review of one (1) of six (6) employee files revealed one aide had not received the required twelve (12) hours of in-service education each year.</p> <p>The findings include:</p> <p>Review of the Carespring Health Care Management document, dated 11/2005, revealed mandatory inservices that were required. The in-service coordinator was to notify the supervisor when the inservices were due. The supervisor was responsible for notifying staff and to make sure inservices were completed.</p> <p>Review of sampled employee #1 revealed there was no documented evidence the aide had received the required twelve (12) hours of in-service training each year after orientation. The records showed the aide completed new hire orientation in 2009, received three hours of inservice training in 2010, no evidence of any training in 2011 and no evidence of any inservice education since 7/2/2012.</p> <p>Interview, on 8/15/13 at 7:15 PM, with Licensed Practical Nurse (LPN) #5 revealed she reviewed the Orientation Skills checklist, used with new hires on initial orientation and if there was a problem with with skills after orientation, she did additional training. The LPN stated the facility recognized January to December as the year and the aide training must be completed each year. The LPN further stated a list was printed weekly of staff who were late or near late on required inservices and the list went to the supervisor. She stated it was the Administrator's discretion to send warning / take staff off schedule if the inservices were not completed as required. She</p>	F 497	<p>100% audit of all current nursing assistants was completed by the Administrative Assistant on 8/16/13 to verify all nurse aides met the required in-service training hours and evaluation. Any nurse aides requiring in-service training were removed from the schedule until compliant.</p> <p>Nurse aides and nursing managers were in-serviced on August 29<sup>th</sup> 2013 by Director of Nursing. This education reviewed importance of required in-service training for all Nursing Assistants. In-services are logged in a database monthly. Reports are automatically generated and directly sent to the Administrative Assistant of any nurse assistant due for in-servicing/evaluation. The Administrative Assistant reviews this report monthly in Department Head meeting with the Administrator and Director of Nursing to ensure compliance. This procedure is ongoing.</p> <p>Administrator to monitor.</p> <p>Compliance date 9/17/13.</p>	9/17/13	

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NAME OF PROVIDER OR SUPPLIER  HIGHLANDSPRING OF FT THOMAS	STREET ADDRESS, CITY, STATE, ZIP CODE 960 HIGHLAND AVENUE FORT THOMAS, KY 41075
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F 497	Continued From page 10 further stated she did not know how the employee fell through the cracks and did not receive the mandatory inservices.  Interview, on 8/15/13 at 7:20 PM, with Registered Nurse / Unit Manager #2 revealed she had just been made was the employee's inservices were not completed. She stated they were told anyone late cannot work until the inservices were completed. She further stated she was unaware of any list of staff who required inservices.	F 497		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of facility's policy, it was determined the facility failed to ensure each resident's medical record was complete and accurately documented for four (4) of twenty-four (24) sampled residents (Residents #5, #8, #10, and #11). Sampled Residents #8, #10, and #11 had no documented evidence of	F 514	F514  Highlandspring maintains clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.  Resident #8 is no longer in the facility.  Resident #5, #10 and #11's ADL record was reviewed immediately on 8/15/13. Additionally the Medication administration record for residents #5, #10 and #11 have documented late entries to accurately reflect their record bowel movements as well as an assessment by RN staff to verify they did not have any negative clinical outcome.	

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F 514	Continued From page 11 bowel movements for periods from four (4) to seven (7) days in their medical chart, but review of the facility's 24 hour reports revealed each sampled resident had a bowel movement during those time intervals. In addition, Resident #5 had no documented evidence of bowel movements for five (5) days; however, two shift periods had no bowel monitoring recorded during the interval.  The findings include:  Review of the facility's policy: "Bowel Monitoring", revised date 01/2008, revealed the resident's bowel elimination would be recorded each shift. Under the policy's "Procedure" direct care staff were to monitor the resident for bowel movement(s), and document in the ADL charting. Further review of the procedure section revealed the charge nurse would review the residents' records to evaluate any resident who had not had a bowel movement in a consecutive three-day period.  1. Review of Resident #5's medical record revealed the facility admitted the resident on 06/06/13 with diagnoses which included Hypertension, Diabetes Type II, Hyperlipidemia (high lipids), Gastroesophageal Reflux Disease (GERD), Diverticulosis (condition which occurs when pouches form in the intestine), Cholelithiasis (gallstones), Urinary Retention, Generalized Weakness, and Dementia.  Review of Resident #5's medical record revealed the Admission Minimum Data Set (MDS), dated 06/18/13, noted the resident was assessed by the facility as moderately cognitively impaired. Further review of the MDS revealed the resident was assessed by the facility as being occasionally	F 514	Each resident's ADL record was reviewed for the past two weeks to ensure appropriate documentation by Assistant Director of Nursing by September 16 <sup>th</sup> 2013. If no bowel movement documented in the ADL record, interventions were implemented.  Nursing Staff were in-serviced on 8/29/13 on the importance of compliance related accuracy of medical record. In-service completed by Director of Nursing.  A Performance Improvement Worksheet with a focus on nurse aide charting is being completed by the Director of Nursing or designee weekly times four weekly then monthly thereafter. If issues are noted the monitor will take appropriate action at the time the concerns noted. Results of the PI worksheet will be reported to the QA committee for a determination of the need for further ongoing further monitoring <b>SEE EXHIBIT C</b> .  Director of Nursing will monitor.  Compliance date 9/17/13	9/17/13

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NAME OF PROVIDER OR SUPPLIER  <b>HIGHLANDSPRING OF FT THOMAS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>960 HIGHLAND AVENUE FORT THOMAS, KY 41075</b>
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F 514	<p>Continued From page 12</p> <p>incontinent of bowel and needed extensive assistance of one staff with toileting.</p> <p>Further review of Resident #5's medical record revealed from 07/14 - 18/13 there were no bowel movements documented. However, on 07/15/13 (11 PM - 7 AM shift) and on 07/17/13 3 PM-11 PM shift there was no evidence of bowel movement monitoring recorded by facility staff.</p> <p>2. Review of Resident #8's medical record revealed the facility admitted the resident on 09/16/11 with diagnosis which included Agitation secondary to Dementia, Hyperlipidemia, Hypertension, Glaucoma, Benign Prostatic Hyperplasia (BPH= enlarged prostate), Urinary Retention, Hx of Stroke, Chronic Kidney Disease, and Leukocytosis. Review of the Quarterly Minimum Data Set (MDS), dated 07/24/13, revealed the facility assessed Resident #8 as moderately cognitively impaired with impaired decision making.</p> <p>Further review of Resident #8's medical record revealed monthly Physician Orders, August 2013, included one (1) tablet of Senokot (a drug used to treat constipation) 50-8.6 milligrams (MG) twice a day. In addition, the resident had an order for Milk of Magnesia Suspension 400/5 milliliters (ml) as needed for constipation</p> <p>Further review of Resident #8's medical record of the documentation for the resident's bowel movements revealed for July 2013 the facility had no documentation of a bowel movement from July 09-15, seven (7) days, the resident had no Bowel Movement recorded. However, review of the facility's 24 hour report, dated July 13, 2013, revealed the resident had a bowel movement</p>	F 514		
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F 514	<p>Continued From page 13 which was not recorded in the medical record.</p> <p>Interview, on 08/15/13 at 6:50 PM, with Maria Brooks, Registered Nurse (RN) / Unit Manager (UM) revealed the facility has a computer system to track resident bowel movements. The RN / UM stated if a bowel movement had not been entered into the system for three (3) days, the system will trigger a report to alert the nurses on the floor. She stated the nurses follow-up on the report and provide treatment as needed. She further stated at times staff are not recording resident bowel movements or sometimes when aides entered a bowel movement in the computer, the tracking documentation showed no bowel movement for a resident.</p> <p>Interview, on 08/15/13 at 4:57 PM, with the Director of Nursing (DON) revealed she was aware sampled residents bowel monitoring documentation showed the residents having intervals of no bowel movements and stated it was mostly a documentation problem. The DON stated a daily list of residents were generated from the ADL charting for any resident who had not had a bowel movement documented for six (6) consecutive shifts. She stated the report went to the dietician, Assistant Director of Nursing, the DON and ultimately Administrator if needed. She further stated the facility was aware sometimes the nurse investigated or was aware a resident did have an undocumented BM but failed to go back and document. The DON stated the facility didn't feel they had any residents who had gone days with out a BM that had not been addressed. The DON further stated there were no negative outcomes because the situation is monitored by many staff.</p>	F 514			

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F 514	Continued From page 14 Interview, on 08/15/13 at 7:20 PM, with the Administrator revealed staff were supposed to enter bowel movements into the computer system and if a resident had no bowel movements recorded for a certain time interval a report was generated to notify the nurses. The Administrator stated nurses enter into the system if there was an intervention or the problem had been resolved. The Administrator further stated if the resident had a bowel movement that was not recorded in the system the nurses can't go back and document the bowel movement on the day it occurred, but should have documented in the medical record under the nursing note. She stated it was the documentation piece, in the medical record, that was missing and none of the residents had any negative outcome. She further stated the nurses should have gone back and documented in the nursing note.	F 514			

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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1992, 2006 Survey under: 2000 existing Facility type: S/NF Type of structure: Two (2) stories Type II (222) with partial basement. Smoke Compartment: Fifteen (15) smoke compartments Fire Alarm: Manual initiating devices located at exits. Smoke detectors located in all corridors and resident rooms. Heat detectors located in boiler room, laundry/wash room, and kitchen. Sprinkler System: Complete automatic (dry and wet) sprinkler system. Generator: Type II diesel installed 1992 A standard Life Safety Code survey was conducted on 08/14/13. Highlandspring of Fort Thomas was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census the day of the survey was one hundred twenty-three (123). The facility is licensed for one hundred forty (140). The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). The highest s/s was at "F" level.	K 000		
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no	K 073	No furnishings or decorations of highly flammable characteristics shall be used without being properly fire treated and documented.  On August 14, 2013, The Maintenance Director ensured all decorations were removed immediately and sprayed with FireTect Safe-T-Guard flame retardant or removed from the facility.	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE LINA	(X6) DATE 9/6/13
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 073	<p>Continued From page 1</p> <p>combustible decorations were used in the facility, according to NFPA standards. The deficiency had the potential to affect all smoke compartments, all residents, staff, and visitors. The facility is certified for one hundred forty (140) beds with a census of one hundred twenty-three (123) on the day of the survey. The facility failed to ensure decorations brought into the facility were being properly fire treated and documented.</p> <p>The findings include:</p> <p>Observation, on 08/14/13 between 10:00 AM and 2:00 PM, with the Maintenance Director, revealed wreaths/decorations were on doors throughout the facility to include the following rooms:</p> <p>2304, 2306, 2308, 2310, 2312, 2315, 2101, 2103, 2107, 2116, 2114, 2112, 2108 on the second floor. Also the living room windows had wood decorations hanging on them. The first floor rooms identified were 1306, 1308, 1312, 1314, 1315, 1309, 1101, 1113, 1115, 1110, 1106, 1104. The facility had no documentation of flame retardant being applied to the items.</p> <p>Interview, on 08/14/13 at 2:00 PM, with the Maintenance Director revealed he was aware decorations were required to be treated with a fire retardant spray and he does treat these items with the correct product but did not keep a record of what he treats and at what location. He also stated that the facility did not have a policy on decorations.</p> <p>Interview, on 08/14/13 at 2:15 PM, with the Administrator revealed she would get this corrected and have a written policy created.</p>	K 073	<p>Maintenance Director and IPS (Activities) Director were educated on life safety code as it is related to using only fire retardant decorations. This was done by the Administrator on August 13<sup>th</sup> 2013</p> <p>The existing policy regarding facility furnishings reads: "all facility furnishings and equipment will be reviewed to determine if they meet fire retardant characteristics and flame spread necessary for continued fire safety. All materials must meet the requirements of the NFPA. The Maintenance Director was inserviced on this policy by Corporate Maintenance Director on August 13<sup>th</sup> 2013.</p> <p>The Maintenance Director or assistant completes monthly safety rounds. Compliance with fire retardant decorations will be monitored during these safety rounds. See Exhibit D</p> <p>Maintenance Director will monitor</p>	9/17/13

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K 073	Continued From page 2  Reference: NFPA 101 (2000 Edition)  19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073			