STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C
	185446		07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

(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	F 000		
	A Standard Recertification Survey and Abbreviated Survey investigating KY#00020407 was initiated on 06/19/12 and concluded on 06/22/12. Deficiencies were cited with the highest Scope and Severity (S/S) of an "E". KY#00020407 was unsubstantiated with no deficiencies cited.		RECEIVED AUG 16 2013 BY:	
F 174 SS=E	483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY	F 174	F174 **Immediate Corrective Action for Residents Found To Be Affected**	
	The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.		• It is the policy of Bluegrass Care and Rehabilitation to ensure residents have the right to have reasonable access to privacy while using a telephone	
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to ensure residents had the right to have access to a telephone where calls could be made without being overheard as evidenced by residents had to use the telephone at the nurse's station or in a staff person's office during regular business hours.		• Resident A, B, E, and D continue to reside at the facility	
	The findings include:		• Resident A was notified that the facility would be installing a cordless phone at each nurses station for resident use and the phone would be installed on 08/02/2013 per the installer. Resident A expressed being pleased by this news and agreeable to use phone at nursing station until the cordless phone was installed.	
	Review of the facility's policy titled, "Telephone, Resident Use of", dated 06/07, revealed residents were to have "easy access" to telephones. Designated telephones were available to residents to make and receive "private" telephone calls. Telephones were to be in areas "that offer privacy and accommodate the hearing impaired and wheelchair bound residents".		• Resident B was notified that the facility would be installing a cordless phone at each nurse's station for resident use and the phone would be installed on 08/02/2013 per the installer. Resident B expressed being pleased by this news. Resident B agreed to use the telephone that was currently	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna Maynard BSN, DON for Jennie Hornsby LNHA — TITLE — (X6) DATE: 8/16/13

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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F 174 Continued From page 1

Interview, on 07/10/13 at 9:40 AM during the Group Interview, with Unsampled Resident A revealed the telephone service at the facility was "poor". He/She stated he/she had to use the telephone at the nurse's station where everyone could hear his/her conversations. He/She stated when he/she received a telephone call someone would have to come to his/her room, and if he/she was in bed would have to assist him/her up. Then he/she would have to go to the nurse's station and call the person back. He/She stated he/she would like to be able to talk in a more private area.

Observation, on 07/10/13 1:45 PM, revealed a resident using the telephone at the North Unit nurse's station with staff sitting at the station and another resident sitting in a wheelchair in the hallway near the resident on the telephone.

Observation, on 07/11/13 at 10:30 AM, revealed a resident using the telephone at the South Unit nurse's station with a staff person sitting at the station.

Observation, on 07/11/13 at 3:57 PM, revealed Unsampled Resident B using a telephone in the dining room near the doorway to the dining room which opened into the hallway.

Interview, on 07/11/13 at 4:08 PM, with Unsampled Resident B revealed there was nowhere private to have a telephone conversation in the facility. He/She stated he/she had to use the telephone in the dining room or the nurse's station. He/She stated if he/she wanted to have a private telephone conversation, he/she would have to pay for a cell telephone. Unsampled

F 174

available for use until the cordless phone was installed on 08/02/2013

- Resident D was notified that the facility would be installing a cordless phone at each nurse's station for resident use and the phone would be installed on 08/02/2013 per the installer. Resident D expressed being pleased by this news. Resident D agreed to use the telephone that was currently available for use until the cordless phone was installed on 08/02/2013

- Resident E telephone has been serviced and repaired. Resident was also informed the facility would be installing a cordless phone for resident use and the phone was installed on 08/02/2013 per installer.

Identification of Other Residents with the Potential to be affected

- To enhance currently compliant operations, under direction of the Administrator all staff will receive in-service training regarding the federal requirement of F Tag 174 and the facility's policy. The training will also include locations of accessible telephones where a resident can be ensured privacy, as well as the need to report a non-functioning telephone to the Administrator so repairs can be completed.

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F 174	Continued From page 2 Resident B stated he/she would like for there to be a cordless telephone for residents to use so there would be some way to have privacy when using the telephone. Interview, on 07/11/13 at 5:07 PM, with Unsampled Resident E revealed his/her cell telephone had not been working for approximately two (2) weeks. He/She stated he/she had missed communicating with his/her friends. Unsampled Resident E stated if he/she was in bed, he/she couldn't get up and go to the telephone at the nurse's station when his/her friends called. He/She stated it would be nice if there was a cordless telephone for residents to use if they didn't have their own telephone. The resident indicated he/she liked to have some privacy with his/her telephone calls. Unsampled Resident E stated overall he/she would just like to be able to talk to his/her friends. Interview, on 07/11/13 at 5:16 PM, with Unsampled Resident D revealed he/she had to go to the nurse's station to make or receive telephone calls. He/She indicated it was difficult for him/her to get to and from the nurse's station and he/she required assistance to do this. Unsampled Resident D stated he/she would like to have privacy with his/her telephone calls. He/She stated when he/she had telephone calls at the nurse's station he/she felt that others could hear his/her conversations. Interview, on 07/11/13 at 4:00 PM, with the Administrator revealed she had not been with the facility very long. She stated she was not aware if there were cordless telephones at the North and South Units for resident to use for privacy with	F 174	• All residents have the potential to be affected by the cited deficiency; every resident had their telephone checked by Social Services, Maintenance Director and Assistant Maintenance Director. These were checked 7/12/2013 through 8/14/2013 • All residents that had phones had them checked to ensure that they were in working order. No other residents voiced concern regarding privacy or accessibility of phones. **Measures Taken To Assure There Will Not Be a Recurrence** • Cordless Telephones were installed on 08/02/2013 for residents use on both nursing units. Under the direction of the Administrator telephones will be checked by the Maintenance Director or the Maintenance Assistant three times a week for 90 days then weekly to make sure that they are in working order and available for resident use. Social Services will compile a list of residents that have phones, and with new admits the list will be updates. **Monitoring Changes to Assure Continuing Compliance**	

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

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F 174	Continued From page 3 their telephone calls. The Administrator and surveyor observed the North and South Unit nurse's station where the Administrator was unable to locate cordless telephones. She inquired of the Assistant Director of Nursing (ADON) on the North Unit whether there were cordless telephones for residents to use. The ADON stated there had been cordless telephones before; however, they had been removed related to poor reception. The Administrator stated staff had let residents use their office telephones for privacy with telephones. Additional interview, on 07/11/13 at 5:55 PM, with the Administrator revealed the facility staff thought that if they let residents use their office telephones, going out and closing the door was giving them privacy with their telephone calls.	F 174	• To enhance currently compliant operations, under direction of the Administrator, all staff will receive in-service training regarding the federal requirement of F tag 174 and the facility's policy. The training will also include locations of accessible telephones where a resident can ensure privacy, as well as the need to report a non-functioning telephone to the Administrator so repairs can be completed. **Receive inservice training: 8/2/13 thru 8/10/13** **Date of Completion: Phones where installed on 08/2/2013**	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure services provided met professional standards of quality as evidenced by the facility's failure to ensure all Physician's Orders were followed by staff for five (5) of twenty-one (21) sampled residents (Residents #2, #6, #7, #8, and #9). Resident #7 had a Physician's Order for a wound	F 281		

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F 281	Continued From page 4 treatment to his/her right lower extremity which included the use of a foam dressing to cover the wound; however, observation of the wound treatment, on 07/10/13, revealed the nurse failed to apply the foam dressing during the treatment. Resident #9 had a Physician's Order to place an alarm on the resident's wheelchair (to alert staff if the resident tried to get up out of the wheelchair); however, observation revealed staff did not ensure an alarm was in place. Resident #6 had a Physician's Order for a tube feed rate of 75 milliliters (ml) per hour; however, observation during survey revealed the tube feed rate was at 70 (ml) per hour. Resident #8 had a Physician's Order to contact the surgeon on 07/08/13; however, the surgeon was not contacted by staff until 07/10/13. Resident #2 had a Physician's Order to be gotten out of bed for lunch and dinner; however, observation during survey revealed staff failed to get the resident out of bed. The findings include: Interview with the Director of Nursing (DON), on 07/11/13 at 6:00 PM, revealed there was no facility policy on following Physician's Orders but her expectation was staff was to follow Physician Orders. 1. Review of the medical record revealed the facility admitted Resident #7 on 01/30/13 with diagnoses which included Muscle Weakness, Chronic Airway Obstruction, Quadriplegia,	F 281	**F281** **Immediate Corrective Action for Residents Found To Be Affected** • It is the policy of Bluegrass Care and Rehabilitation Center to ensure that services provided for each resident meet professional standards of quality. • Resident #7 continues to reside at the facility. The foam wound dressing was immediately applied and continues to the site as ordered by the physician. The ARNP and The Wound Care Physician assessed the resident on 7/11/13.	

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F 281	Continued From page 5 Diabetes Type II, and an Open Wound. Continued review of the medical record revealed the resident was re-admitted by the facility on 04/01/13 after being sent out, on 03/08/13, to the hospital with an infected and worsening right lower extremity wound. Review of Resident #7's July 2013 Physician's Orders revealed a wound treatment order, dated 06/24/13, to apply equal parts of Santyl and Bactroban to the right lower extremity wound, cover with a foam dressing, and secure with Kerlix daily and as needed. Observation of the wound treatment performed, on 07/10/13 at 10:50 AM, by Licensed Practical Nurse (LPN) #3 revealed the LPN applied the Santyl and Bactroban, but did not cover with a foam dressing before wrapping the site with Kerlix as ordered. Interview with LPN #3, on 07/10/13 at 12:03 PM, revealed she forgot to put the foam dressing on the wound site prior to securing with the Kerlix. The LPN stated she should have followed the Physician's Order (and applied the foam dressing). LPN #3 further stated she was supposed to follow the treatment order, but was distracted and forgot to put on the foam dressing. Continued interview with the DON, on 07/11/13 at 6:00 PM, revealed the nurse should have followed the Physician's treatment order for the wound. 2. Review of the medical record revealed the facility admitted Resident #9 on 01/30/13 with diagnoses which included Alzheimer's Disease,	F 281	Orders have been received and addressed. • Resident #9 continues to reside at the facility. The residents alarm was replaced immediately upon knowledge that alarm was not present. • Resident #6 continues to reside at the facility. The feeding tube rate was corrected immediately and continues as ordered by the physician. The resident was assessed by the Nurse Practioner and labs were ordered on July 11, 2013 and results called to MD/ARNP. Lab results received and new orders carried out. • Resident #8 continues to reside at the facility. The surgeon was notified and any additional orders for notification have been addressed. • Resident #2 continues to reside at the facility. The resident was assessed and stated meal location preference was in her room. Social Services discussed need to be up at meal time for socialization and resident understood consequences of not eating in a group setting. The facility will respect the resident's right to choose and will contact the physician. Responsible party was unable to be reached by phone so careplan letter was sent. Careplan scheduled for 08/06/2013.	

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F 281	Continued From page 6 Difficulty Walking, Cataract and Muscle Weakness. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 04/30/13, revealed the facility assessed the resident with moderate cognitive impairment. Continued review of the MDS revealed the facility had assessed the resident as needing extensive assist of one (1) staff person for transfers. Review or Resident #9's care plans revealed the facility care planned the resident as having the potential for falls, dated July 2013, due to decreased physical and cognitive function, decreased vision, and a diagnosis of Alzheimer's Disease. Review of Resident #9's Physician's Orders for July 2013 revealed an order, originally dated 03/14/12, to place a pressure sensor alarm to the resident's chair to alert staff of unsafe transfers. Review of the Treatment Administration Record (TAR) for July 2013 revealed staff was checking to see if the chair alarm was in place once daily. However, observations when Resident #9 was in his/her wheelchair, on 07/09/13 at 3:24 PM and 4:01 PM and on 07/10/13 at 10:30 AM, 11:56 AM, and 2:23 PM, revealed no pressure alarm was attached to the wheelchair. Interview, on 07/10/13 at 2:23 PM, with Certified Nursing Assistant (CNA) #4, who verified Resident #9 had no alarm attached to his/her wheelchair, revealed the resident was supposed to have a pressure alarm device. The CNA #4 stated the resident removed the alarm and staff tried to check to make sure the alarm was in place.	F 281		

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F 281	Continued From page 7	F 281		

Interview, on 07/10/13 at 2:39 PM, with Registered Nurse (RN) #2 revealed she did not see an alarm on Resident #9's wheelchair as ordered. The RN stated there should have been an alarm on the wheelchair. RN #2 further stated she was unaware the resident removed the alarm and should have been informed.

Interview with Licensed Practical Nurse (LPN) #7/Staffing Coordinator, on 07/11/13 at 12:50 PM, revealed the resident had a Physician's order for a chair alarm and when she checked the wheelchair on 07/10/13 at 7:15 AM the alarm was in place. When informed observations revealed the alarm was not attached to the residents wheelchair, the LPN stated the resident had a history of removing the alarm and hiding it. LPN #7 further stated they needed to educate staff to check the alarm during any care interventions with the resident. She stated if the alarm was not in place staff did not follow the orders.

Continued interview with the DON, on 07/11/13 at 6:00 PM, revealed the pressure alarm should have been attached to the wheelchair as ordered by the Physician.

3. Review of the medical record revealed the facility admitted Resident #6 on 01/16/13 with diagnosis of Acute Delirium, Functional Decline with recent fall, advanced Alzheimer's Dementia, hypertension, dehydration and Right CVA with Left hemiparesis. Further review of the medical record revealed Resident #6 was readmitted on 04/24/13 after peg tube placement.

Record review of facility's policy and procedure

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F 281	Continued From page 8 titled, "Nasogastric/Gastrostomy Tube Feedings", with an Effective Date of 12/2012, revealed under procedure for checking placement of tube feeding prior to feeding, on page two, follow the amount of formula, rate and hours of administration ordered by Physician. Record review of the Physician's Orders, dated 07/03/13 at 3:55 PM, revealed the Dietitians' recommendation to advance the tube feeding rate to 75 ml/hr of Jevity 1.5 x 16 hours with 30 ml of Promod per g-tube daily. Record review of the Medication Administration Record (MAR), with a generation date of 06/27/13, revealed discontinuation of order for Jevity 1.5 at a rate of 70 ml/hr x 16 hours (off 6:00 AM to 2:00 PM) dated of 07/03/13. Record review of the MAR 07/03/13, revealed Jevity 1.5 70 ml/hr x 16 hours (off 6:00 AM to 2:00 PM) had been signed and dated since 07/03/13. Observation, on 07/09/13 at 3:07 PM, tube feeding rate 70 ml/hr of Jevity 1.5 closed system with date of 07/09/13 and timed at 2:00 PM. Observation, on 07/09/13 at 4:05 PM, tube feeding rate 70 ml/hr of Jevity 1.5 closed system with date of 07/09/13 and timed at 2:00 PM. Observation, on 07/09/13 at 5:25 PM, tube feeding rate 70 ml/hr of Jevity 1.5 closed system with date of 07/09/13 and timed at 2:00 PM. Interview, on 07/10/13 9:40 AM, with the Registered Dietitian revealed Resident #6 should	F 281		

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F 281	Continued From page 9 be on Jevity 1.5 at 75 ml/hr. She also revealed she had not been informed of any problems with tolerance to the tube feeding at the new rate. Interview, on 07/10/13 at 9:50 AM, with RN #1 revealed the MAR's current order for Resident #6's tube feeding had been advanced to 75 ml/hr of Jevity 1.5 and further revealed he/she was tolerating the tube feeding. Interview by phone, on 07/11/13 at 3:25 PM, with LPN #6 revealed she was assigned Resident #6 on 07/08/13 and 07/09/13. She revealed she received shift report prior to starting her shift and information was also located on the MAR. She further revealed she received report that Resident #6 was ordered tube feeding at 70 ml/hr but could not remember for sure if there had been any changes to the Physician's orders which were usually flagged in the chart and a 24 hour sheet was used to record information for shift change and was not aware of any order change for Resident #6. Interview with the DON, on 07/11/13 at 6:00 PM, revealed her expectation of staff were to follow Physician's Orders. 4. Record review revealed the facility admitted Resident #8 on 07/01/13 with diagnoses which included recent below the Left Knee Amputation, Peripheral Vascular Disease, Osteomyelitis, End Stage Renal Disease, Diabetes, and received dialysis. Review of the Nurse's Notes for Resident #8, dated 07/07/13 at 7:55 PM, revealed the on-call surgeon gave a telephone Physician's Order for	F 281	**Identification of Other Residents with the potential to be affected** • All Residents have the potential to be affected by the cited deficiency, 100% of all resident orders were reviewed by Assistant Director of Nursing (ADON), Unit Manager (UM), Minimum Data Set Coordinator's (MDS), Wound Care Nurse (WCC), Staff Development Coordinator (SDC), Director of Nursing (DON). Care plans were updated to reflect the orders, and SRNA care plans reviewed for accuracy. The DON (Director of Nursing)/ADON (Assistance Director of Nursing) will formulate list of residents with a dressing change, alarms, tube feedings and special instructions. **Measures Taken To Assure There Will Not Be a Recurrence** • MD orders will be reviewed and compared to the medication record (MAR) and treatment record (TAR) by the Assistant Director of Nursing (ADON), Unit Manager (UM), Director of Nursing (DON), Staff Development Coordinator (SDC), Wound Care Nurse (WCC) and Minimum Data Set Coordinators (MDS). • To enhance currently compliant operations, under the direction of the DON (Director of Nursing) all licenses staff and SRNA's will receive in-service training on F Tag 281 with an	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C
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BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

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F 281	Continued From page 10 staff at the facility to contact the resident's primary surgeon on the morning of 07/08/13. Further review of the Nurse's Notes revealed no documented evidence of the completion of the order to contacted the primary surgeon on 07/08/13. Interview with Primary Surgeon's office nurse, on 07/10/13 at 11:25 AM, revealed as far as she was able to determine, no phone call was received from the facility regarding Resident #8. The Nurse stated no documentation of conversations which should have been in the resident's chart if the facility had called to discuss this resident. Interview with Assistant Director of Nursing (ADON), on 07/10/13 at 2:40 PM, revealed there should have been documentation in Resident #8's chart if the call was made to the primary surgeon's office. Further interview with ADON, on 07/11/13 at 09:30 AM, revealed the facility should had contacted the primary surgeon's office, according to the Physician's order in the chart, on 07/08/13. 5. Review of the medical record for Resident #2 revealed the facility admitted the resident on 07/20/12 with diagnoses which included a history of Cardiovascular Accident with Hemiplegia, Difficulty Walking and Alzheimer's Dementia. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 03/26/13 revealed the facility assessed Resident #2 with a Brief Interview for Mental Status (BIMS) score of eleven (11) out of fifteen (15), which indicated the resident was moderately impaired cognitively. Further review of the MDS revealed the facility assessed Resident #2 to require extensive assist of one (1) to two (2) staff for his/her Activities of	F 281	emphasis on dressing changes, alarms, tube feeding settings, physician notification and residents needing to be out of bed. In-service training initiated on 7/11/2013 through 8/1/2013	

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	185446		07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

(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 281	Continued From page 11 Daily Living (ADLs). Review of the July 2013 monthly Physician's Order revealed an order for Resident #2 to be up in a chair and to the dining room for meals, at least lunch and dinner. Review of the July 2013 State Registered Nursing Assistant (SRNA) Care Plan Record revealed no documented evidence of the Physician's Order for Resident #2 to be up in a chair and to the dining room for meals, at least lunch and dinner. Observations, on 07/09/13 at 4:30 PM, 5:15 PM, 5:37 PM, and 6:06 PM revealed Resident #2 to be lying in bed. Observation revealed Resident #2 received his/her dinner meal tray at 6:06 PM. Observation, on 07/10/13 at 8:05 AM revealed Resident #2 to be lying in bed with the head of the bed elevated with his/her breakfast meal tray in front of him/her on the overbed table. Observation, on 07/10/13 at 4:50 PM, revealed Resident #2 to be lying on the bed with his/her eyes closed. Interview, on 07/11/13 at 2:25 PM, with CNA #7 revealed she was assigned to work on Resident #2's hall that day. She stated she had never gotten Resident #2 up for meals since she had been working at the facility. CNA #7 stated she had been employed for approximately two (2) months. She stated she was not aware of an order for Resident #2 to be up and to the dining room for meals. CNA #7 reviewed the CNA Care Plan Record and stated there was no information related to the order for Resident #2 to be up out of bed and to the dining room for meals.	F 281	**Monitoring Changes to Assure Continuing Compliance** • A Quality Assurance program was implemented under the supervision of the Director of Nursing to monitor pressure sore prevention of residents receiving Oxygen via nasal cannula and tubing. Current residents were identified and a list compiled. New residents will be added to the list during review of physician orders in the morning Clinical meeting. The residents will be monitored 3 times weekly for 4 weeks. Weekly for 4 weeks. And then monthly ongoing. Monitoring results will be brought to the monthly Quality Assurance meeting for further review, analysis, corrective action and recommendation as needed The committee will review monthly and follow up until at such time consistent substantial compliance has been achieved as determined by the committee. The Quality Assurance Committee (Consisting of a blend of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185446		C 07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 281	Continued From page 12 Interview, on 07/11/13 at 2:43 PM, with CNA #5 revealed he had cared for Resident #2; however, was unaware of an order for him/her to be up and to the dining room for meals, at least lunch and dinner. Interview, on 07/11/13 at 2:30 PM, with LPN #4 revealed Resident #2 sometimes got up for meals; however, the resident refused "a lot". LPN #4 stated she was aware of the Physician's Order for the resident to be up and to the dining room for meals, at least lunch and dinner. She stated she had not documented Resident #2's refusals to get up; however, should have. Interview, on 07/11/13 at 2:55 PM, with the North Unit Assistant Director of Nursing (ADON) revealed she thought the Physician's Order for Resident #2 to be up and to the dining room for meals was on the SRNA Care Plan Record so the CNA's knew to try and get the resident up for meals. The ADON reviewed the July 2013 SRNA Care Plan Record and stated she could not find the information located on it. The ADON indicated Resident #2 refused at times and stated this should be documented. She stated the Physician's Order should be followed and any refusals documented.	F 281	Nurse, Wound Care Nurse, Human Resource Director, Dietary Manager, Rehab Service Manager, Business Office Manager, Activities Director, Admissions Director, Social Service Director, Plant Operations Director, Environmental Service Director, Pharmacy Services Consultant, Lab Service Manager, Medical Records Director, Staff Development Coordinator and the Chaplain) Completion Date: 8/15/2013	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314		

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	185446		07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 13 services to promote healing, prevent infection and prevent new sores from developing. 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 ensure residents who entered the facility without pressure sores did not develop pressure sores for one (1) of twenty-one (21) sampled residents (Resident 6). Observation during a skin assessment revealed Resident #6 had oxygen (O2) tubing pulled tightly across his/her face and ears. The skin assessment revealed the resident to have open areas at the top of each ear which were assessed to be Stage II pressure sores. The findings include: The facility did not provide a policy specific to pressure sore prevention. Review of the policy titled, "Skin Management and Prevention At-A-Glance" undated, revealed Certified Nursing Assistants (CNA's) were to complete a total body skin observation during showers/baths. CNA's were to observe the resident's skin during routine care. Any concerns were to be documented on a "Skin Alert Sheet" and findings reported to the charge nurse. Review of Resident #6's medical record revealed an admission date of 01/16/13 and a readmission date of 04/24/13 with diagnoses which included Alzheimer's Dementia, Chronic Obstructive Pulmonary Disorder (COPD) and Stage IV Pressure Sore on the left medial and lateral foot.	F 314	**F314** **Immediate Corrective Action For Residents Found To Be Affected** • It is the policy of Bluegrass Care and Rehabilitation Center to ensure pressure sore prevention and provide necessary treatment and services to promote healing and preventions. • Resident #6 continues to reside at the facility. Treatment orders were obtained for the pressure area over both ears. Areas behind both ears are resolved as of 7/22/2013.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185446		C 07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 14 Review of the Annual Minimum Data Set (MDS) Assessment, dated 05/02/13, revealed the facility assessed Resident #6 to be moderately impaired cognitively and required extensive assist to total dependence on staff for Activities of Daily Living. Further review of the MDS revealed the facility assessed Resident #6 to be at risk for pressure sores. Review of the Comprehensive Plan of Care, updated 07/13, revealed Resident #6 was at risk for skin breakdown related to diagnoses of Alzheimer's Dementia and history of Cardiovascular Accident. Interventions included to observe skin during personal care. Review of the Potential for Ineffective Breathing Pattern Plan of Care, dated 07/13, revealed Resident #6 required the use of oxygen (O2). Review of the interventions included no documented evidence to monitor the O2 nasal cannula tubing to ensure Resident #6 did not develop pressure sores from it. Review of the Weekly Skin Rounds form, dated 07/02/13, revealed no documented evidence Resident #6 had open areas over his/her ears. Review of the Nurse's Notes revealed no documented evidence of open areas over Resident #6's ears where the O2 nasal cannula tubing rested. Review of the July 2013 monthly Physician's Orders revealed an order for Resident #6 to have oxygen (O2) at two (2) liters per minute per nasal cannula. Observation, on 07/10/13 at 3:30 PM, of Resident #6's head to toe skin assessment performed by	F 314	**Identification of Other Residents with the Potential to be affected** • All residents had a complete head to toe skin assessment performed to determine if any unidentified skin impairments were present. Audit was completed on 08/05/2013 with no other areas identified. • All residents have the potential to be affected by the cited deficiency, including residents wearing oxygen with nasal tubing , the DON developed a list of residents receiving Oxygen administration using a nasal cannula and tubing to be checked for potential skin breakdown. Any new resident orders for Oxygen administration using a nasal cannula and tubing will be reviewed during the morning Clinical meeting and added to the DON's monitoring list. **Measures Taken To Assure There Will Not Be a Recurrence** • To enhance currently compliant operations, under the supervision of the DON, all staff was in-serviced on F 314 with emphasis on observing residents wearing oxygen nasal cannulas and tubing and the tubing being pulled to tightly. Also, licensed staff and SRNA's were in serviced on the facility policy on pressure sore prevention and observing and communicating information correctly. Inserviced 7/11/2013 to 8/2/2013	

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

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	185446		07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEGRASS CARE & REHABILITATION CENTER	3575 PIMLICO PARKWAY LEXINGTON, KY 40517

(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 314	Continued From page 15 Licensed Practical Nurse (LPN) #2 revealed Resident #6 to have O2 nasal cannula tubing to be pulled tightly across the resident's face and over his/her ears. During the skin assessment the LPN removed the O2 nasal cannula tubing from over Resident #6's ears. Observation revealed Resident #6 to have open areas over his/her bilateral ears. Interview, on 07/10/13 at 3:30 PM during the head to skin assessment, with LPN #2 revealed she was not aware of Resident #6 having open areas over his/her bilateral ears. She stated she thought the open areas were Stage II pressure sores. Interview, on 07/10/13 at 3:53 PM, with the Advanced Registered Nurse Practitioner (APRN) revealed she should be notified of any change in a resident's status so appropriate treatment could be ordered. Interview, on 07/10/13 at 4:13 PM, with Registered Nurse (RN) #1 who was the Charge Nurse, revealed she was not aware of open areas over Resident #6's bilateral ears. She stated she thought the areas should have been observed during the resident's routine care by the Certified Nursing Assistants (CNA's). Interview, on 07/10/13 at 4:16 PM, with CNA #1 revealed he was assigned to care for Resident #6. He stated he was not aware Resident #6's O2 nasal cannula tubing was pulled tight. CNA #1 stated he was not aware the resident had open areas over his/her bilateral ears. Further review of the record revealed a Wound	F 314	**Monitoring Changes to Assure Continuing Compliance** • All residents will have a head to toe skin assessment performed at least weekly by nursing to identify any skin impairments. The skin assessments will be reviewed daily five times a week in clinical meeting, any areas identified will be addressed immediately. • The residents will be monitored by the DON/ADON three times weekly for four weeks, weekly for four weeks and then monthly ongoing. Any deficiencies will be corrected immediately. • A Quality Assurance program was implemented under the supervision of the Director of Nursing to monitor pressure sore prevention of residents receiving Oxygen via nasal cannula and tubing. Current residents were identified and a list complied, new residents will be added to the list during physician order review in the morning Clinical meeting. The residents will be monitored three times weekly for four week, weekly for four weeks, and monthly ongoing. Monitoring results will be brought to the monthly Quality Assurance meeting for further review, analysis, corrective action and recommendations as needed. Completion Date: 8/15/2013	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 07/11/2013
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517	

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F 314	Continued From page 16 Care Specialist Physician's Note dated 07/11/13 which revealed Resident #6 had Stage II pressure sores over his/her bilateral ears which were "due to O2 tubing". Interview, on 07/11/13 at 6:00 PM, with the Director of Nursing (DON) revealed she would expect the CNA's to observe residents' ear area when they were washing their faces. She stated staff was trained to observe residents' skin.	F 314		
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 and review of the facility's policy, it was determined the facility failed to prepare, distribute and serve food under sanitary conditions as evidenced by three (3) dietary staff not following proper hand washing techniques by turning off the faucets with washed wet hands and dried their hands with a paper towel. The Findings include: Review of the facility's dietary policy and	F 371	F371 **Immediate Corrective Action for Residents Found To Be Affected** • It is the Policy of the Bluegrass Care and Rehabilitation Center to store, prepare, distribute and serve food under sanitary conditions. **Identification of Other Residents with the Potential to be affected** • All residents have the potential to be affected by the cited deficiency. All staff was inserviced on proper hand washing by Staff Development Coordinator, Assistant Director of Nursing, Director of Nursing, Environmental Director, Dietary Manager, Wound Care Nurse, on 07/11/2013 to 08/02/2013	

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	185446		07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371 Continued From page 17

procedure titled, "Hand Washing", effective date: December 2010, revealed the procedural steps to wash hands. According to the policy, staff is to follow procedural steps when they wash their hands. The procedural steps included step #6 to dry hands with disposable towel and step #7 using towel, turn off faucet. Don't touch the faucet with bare hands.

Review of the dietary in-service sheet, dated 05/29/13-06/09/13, revealed dietary staff educated on food handling-washing hands between glove use and glove change and hand washing between each food prep.

Observation in the kitchen during the lunch meal, on 07/09/13 at 12:15 PM, revealed three (3) dietary staff using improper hand washing technique by turning off faucets with bare washed hands and used paper towels to dry their hands.

Observation, on 07/09/13 at 12:17 PM, revealed Dietary Aide #9 with improper hand washing technique by turning off faucets with washed bare hands and drying hands with a paper towel.

Observation, on 07/09/13 at 12:20 PM, revealed PM Cook #8 with improper hand washing technique by turning off faucets with washed bare hands and drying hands with a paper towel.

Observation, on 07/09/13 at 12:25 PM, revealed AM Cook #7 with improper hand washing technique by turning off faucets with washed bare hands and drying hands with a paper towel.

Observation, on 07/09/13 at 4:40 PM and again at 4:45 PM, revealed Dietary Aide #9 with improper

F 371

- To enhance currently compliant operations, under the direction of the Dietary Manger, all Dietary staff was in serviced on 07/11/2013 thru 08/02/2013, on the procedural steps of hand washing with emphasis on using a paper towel to turn off the water faucet. A return demonstration was required of all dietary staff.

Measures Taken To Assure There Will Not Be a Recurrence

- Because all residents have the potential to be affected by the cited deficiency, a monitoring tool was developed to observe all staff with emphasis on dietary staff during meal preparation. The Dietary manager will monitor hand-washing every meal, three times daily for 5 days, then three times weekly for four weeks, weekly for four weeks, and then randomly every month on going. All staff will be monitored three times a week times four weeks, weekly times four weeks, then monthly on-going. Any deficiencies will be addressed.

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F 371	Continued From page 18 hand washing technique by turning off faucets with washed bare hands and drying hands with a paper towel. Observation, on 07/10/13 at 9:05 AM, revealed Cook #7 with improper hand washing and turned off the faucets with his washed bare hands and dried hands with a paper towel. Interview, on 07/10/13 at 9:05 AM, Cook #7 revealed he should have turned off the faucets with the paper towels after he dried his hands. Interview, on 07/10/13 at 8:50 AM, with the Dietary Manager revealed she discussed sanitation and food handling every six (6) months and tries to correct problems or concerns with on the spot training but does not keep any documentation of this on the spot training. Continued interview, 07/11/13 at 11:50 AM, with the Dietary Manager revealed she did spot checks for hand washing and if done improperly had staff re-wash their hands. She further revealed if staff turned the faucets off with bare hands they had broken the barrier against bacteria and had re-infected their hands by turning off the faucets with their bare hands.	F 371	**Monitoring Changes to Assure Continuing Compliance** • Monitoring results will be brought to the Quality Assurance Committee for review, analysis, corrective action, and recommendations monthly until at such time consistent substantial compliance has been achieved as determined by the committee. Completion Date: 8/15/2013	
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	F 441		

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F 441	Continued From page 19 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to 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	F 441	**F441** **Immediate Corrective Action for Residents Found To Be Affected** • It is the policy of Bluegrass Care and Rehabilitation Center to maintain an infection control,	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 20 infection for two (2) of twenty-one (21) sampled residents (Residents #7 and #6) as evidenced by two (2) different nurses during the performance of skin assessments failing to wash their hands prior to donning new gloves after assessing the residents perineal and buttocks before continuing on with the assessment. In addition, observation during initial tour, on 07/09/13, revealed unlabeled and uncovered wash basins on the floor, bagged bed pans on the floor, nasal cannulas and a Bi-PAP mask not bagged, and toothbrushes out on the bathroom sink not in containers. The findings include: Review of the facility's policy "Hand Washing and Use of Gloves", effective date 12/2010, revealed to prevent the spread of infections, Hand Washing was the single most important measure of preventing the spread of infections. 1. Review of the medical record revealed the facility admitted Resident #7 on 01/30/13 with diagnoses which included Muscle Weakness, Chronic Airway Obstruction, Quadriplegia, Diabetes Type II, and an Open Wound. Continued review of the medical record revealed the resident was re-admitted by the facility on 04/01/13 after being sent out, on 03/08/13, to the hospital with an infected and worsening right lower extremity wound. The wound was cultured and the organism was identified as Methicillin-Resident Staphylococcus Aureus (MRSA). Observation of a skin assessment performed on	F 441	program and to prevent the spread of infection. • Resident #6 continues to reside at the facility. Resident #6 was reassessed for redness, drainage and foul odor and presented without signs and symptoms of infection, by the Wound care doctor and ARNP on 7/11/13. • Resident #7 continues to reside at the facility. Resident #7 was reassessed by the Wound care doctor and the ARNP on 07/11/13 for redness, drainage and foul odor and presented without signs and symptoms of infection • A review of the facilities Infection Control Program, including the tracking and trending report was completed by the Director of Nursing/ Staff Development Coordinator on 7/31/13 to identify any further breach of infection per the infection control policy. No residents were identified as being at risk from this audit. • To enhance currently compliant operations, under the direction of the DON, all licensed staff and SRNA's will receive in-service education regarding federal requirements of tag F441. The in-service will also include an emphasis on hand-washing and donning gloves, with a return	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C
	185446		07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

(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 441	Continued From page 21 Resident #7 by Registered Nurse (RN) #2, on 07/10/13 at 10:50 AM, revealed the nurse changed gloves after assessing under the resident's breasts, she assessed the vaginal area and changed gloves, and changed gloves after assessing the resident's anal area; however, the nurse did not wash her hands after removing her gloves prior to donning new gloves. Interview, on 07/10/13 at 11:21 AM, with RN #2 revealed she changed gloves after looking under the resident's breasts due to contact with moisture, after examining the vaginal area, and again after examining the anal area before completing the examination of the resident's lower extremities. The RN stated after completing the skin assessment, she washed her hands and re-gloved to assist with wound care. RN #2 stated she was not sure of the facility's expectation for hand washing after removing gloves, but when performing skin assessments they were expected to change gloves after observing the vaginal area and again after observing the anal area. 2. Observation, on 07/10/13 at 3:30 PM, of Resident #6's head to toe skin assessment revealed RN #1 assessed the resident's head and upper body. The RN assessed the resident's perineal area, removed her gloves, washed her hands and donned new gloves. RN #1 assisted with turning Resident #6 over, assessed the resident's buttocks and anal area, then proceeded to assess the resident's legs and feet, completed the skin assessment, adjusted Resident #6's gown and covers, all without removing her contaminated gloves, washing or sanitizing her hands and donning new gloves.	F 441	demonstration and will review procedural steps for infection control during wound dressing changes. In service was done on 07/11/2013 thru 08/2/2013. To assure continuing compliance, the Director of Nursing /Assistant Director of Nursing/Staff Development Coordinator will observe two skin assessments daily, five times weekly for four weeks then three times a week for four weeks, then random checks will occur monthly on-going. Monitoring results will be will be brought to the monthly Quality Assurance meeting for further review, analysis, corrective action and recommendations as needed. • Residents in rooms #53,#54,#55,#57,#62,#64, and #65 were assessed for signs and symptoms of infection related to cited observation and none were observed to have any signs and symptoms of infection . The residents continue to reside at the facility. **Identification of Other Residents with the Potential to be Affected** • All residents have the potential to be affected by the alleged deficient practice, a full house review was conducted and all oxygen tubing and cannulas nebulizer tubing and mask, bi-	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185446		C 07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441 Continued From page 22

Interview, on 07/10/13 at 3:40 PM, with RN #1 revealed she should have removed her dirty gloves, washed her hands and donned new gloves after assessing Resident #6's anal and buttock areas.

Interview, on 07/11/13 at 5:23 PM, with the Infection Control (IC) Nurse revealed staff received training on skin assessments during orientation and on an as needed basis. She stated during the training nursing staff was trained on how to incorporate infection control procedures during head to toe skin assessments. The IC Nurse stated after nurses assess the vaginal and anal areas they should wash their hands and don a new pair of gloves. She stated it was important for infection control.

3. Observation during initial tour, on 07/09/13, of resident's rooms revealed the following:
Room 53 had oxygen tubing and nasal cannula uncovered, and covered bed pan on the floor.
Room 54 had a toothbrush unlabeled and uncovered on the bathroom sink.
Room 55 had a nebulizer machine mask and Bi-PAP mask uncovered.
Room 57 had a wash basin unlabeled and uncovered on the floor.
Room 62 had a wash basin unlabeled and uncovered on the floor.
Room 64 had a toothbrush unlabeled and uncovered on the bathroom sink.
Room 65 had a wash basin unlabeled and uncovered on the floor.

Interview with LPN #7, on 07/09/13 at 10:25 AM, 10:50 AM and 11:04 AM, revealed the oxygen

F 441

pap masks, and was basins were placed in plastic bags. Toothbrushes were placed in toothbrush holders. Bedpans were removed from the floor and placed in bags.

Monitoring Changes to Assure Continuing Compliance

- Under the direction of the Director of Nursing, all licensed staff and SRNA's will receive inservice training from 7/11/2013 to 8/2/2013 on the need to place oxygen tubing and masks and washbasins in plastic bags, the need to place toothbrushes in toothbrush holders, and not place bedpans on the floor and store them in plastic bags. A schedule will also be provided for cleaning and changing the equipment.

Monitoring Changes to Assure Continuing Compliance

- A Quality Assurance program was developed for monitoring purpose. The Director of Nursing/ Assistant Director of Nursing/ Staff Development Coordinator/Department Managers will monitor each room for five days, then three times weekly for four weeks, weekly for four weeks, then monthly on-going. Any deficiency will be corrected immediately. The monitoring results will be brought to the monthly Quality Assurance Committee for further review analysis, corrective action and recommendations monthly until at such time consistent substantial

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C
	185446		07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 23 tubing, nebulizer machine and Bi-PAP masks should be covered and the wash basins and covered bed pans should not be on the floor. She stated it was an infection control problem. Interview with Assistant Director of Nursing (ADON) #2, on 07/09/13 at 10:35 AM, revealed all personal care items should be labeled. She stated that toothbrushes should be in a bag for infection control purposes and they were uncovered. Continued interview, on 07/11/13 at 5:23 PM, with the IC Nurse revealed personal items such as toothbrushes and wash basins should be bagged and lalled and the toothbrushes should have been placed in toothbrush holders. In addition she stated, CPAP/nebulizer masks, and nasal cannula oxygen tubing should be in plastic bags. She stated this was an expectation related to cleanliness and infection control.	F 441	compliance has been achieved by the committee. Completion Date: 8/15/2013	
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.	F 514		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185446		C 07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 24	F 514		

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are accurately documented for one (1) of twenty-one (21) sampled residents (Resident #15). Resident #15's medical record did not accurately reflect the resident's hearing deficits.

The findings include:

Review of the facility's policy titled, "Health Information Management", dated March 2013, revealed the facility would maintain accurate medical records.

Record review revealed the facility re-admitted Resident #15, on 02/02/09, with diagnosis which included Senile Delusion, Morbid Obesity, Depressive Disorder, Benign Hypertension, Chronic Pain, Venous Insufficiency, Anxiety, Hearing Loss, Chronic Airway Obstruction, Edema, and Hyperlipidemia.

Review of Resident #15's Annual Minimum Data Set (MDS) Assessment, dated 04/03/13, revealed the facility assessed the resident as having moderate difficulty with hearing. In addition, the MDS assessment revealed Resident #15 had difficulty with making himself/herself understood. Also, the assessment revealed Resident #15 had an impaired ability to understand others. Resident #15's Brief Interview for Mental Status (BIMS)

F514
Immediate Corrective Action For Residents Found To Be Affected

- It is the policy of Bluegrass Care and Rehabilitation Center to maintain

  Clinical records on each resident according to accepted profession standards and practices.

- Resident #15 continues to reside at the facility. Resident #15 reads lips and communicates with pencil and paper. Resident #15 has an appointment with the audiologist on 7/19/13 to assess hearing impairment.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C
	185446		07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 25 section of the MDS assessment revealed he/she had severe cognitive impairment. Review of Resident #15's Care Area Assessment (CAA), dated 04/17/13, revealed he/she had moderate difficulty with hearing. The CAA also revealed Resident #15 had a cognitive deficit related to impaired communication skills. Review of Resident #15's Nurse Practitioner note, dated 05/27/13, revealed Resident #15 was very hard of hearing. Review of Resident #15's plan of care, revised 07/13, revealed he/she had impaired communication due to hearing problems. The stated goal of the plan of care revealed Resident #15 would be able to communicate his/her needs. Interventions listed on the plan of care included the use of a writing pad, signs, gestures, anticipating resident's needs, standing where resident could see caregiver's face, and speaking clearly/slowly. Review of the Activity Progress Notes, dated 01/04/13, 04/03/13, and 07/09/13, revealed Resident #15 was very hard of hearing. Review of the Nutritional Progress Notes, dated 07/01/13, revealed Resident #15 was very hard of hearing and required written communication. Review of the Weekly Summary notes for Resident #15, dated 07/05/13, 06/28/13, 06/21/13, 06/14/13, 06/07/13, 05/31/13, 05/10/13, 04/12/1, and 04/05/13 revealed he/she was documented to have adequate hearing.	F 514		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185446		C 07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 26 Review of the Weekly Summary noted for Resident #15, dated 05/24/13, 05/17/13, 05/03/13, and 04/26/13 revealed he/she was documented to have moderate hearing difficulty. Observation, during initial tour on 07/09/13, revealed Resident #15 gestured for the surveyor to use a communication book to communicate with him/her. The communication book was on Resident #15's over-bed table with writing utensils attached. Observation, on 07/11/13 at 1:55 PM, revealed Resident #15 used a communication book to communicate with the surveyor and did not respond to verbal communication. Interview with Certified Nursing Assistant (CNA) #5, on 07/11/13 at 2:55 PM, revealed he used a writing book to communicate with Resident #15. CNA #5 reported Resident #15 could respond verbally, but had problems hearing which required the use of non-verbal communication. CNA #5 reported the hearing deficit was a persistent problem for Resident #15. Interview with CNA #6, on 07/11/13 at 3:04 PM, revealed she had been working with Resident #15 since August 2012. CNA #6 reported during this time Resident #15 had continued to exhibit hearing problems that required the use of a communication book, non-verbal gestures, and slow speech to accommodate lip reading. Interview with Licensed Practical Nurse (LPN) # 3, on 07/11/13 at 3:00 PM, revealed Resident #15 was care planned related to hearing impairment. LPN #3 reported Resident #15's Weekly	F 514	**Identification of Other Residents with the Potential to be Affected** • All residents with hearing deficiencies have the potential to be affected by the cited deficiency; a list of residents with impaired communications issues was generated through the MDS. All residents' medical records were reviewed on 7/11/2013 through 08/14/2013 by Assistant Director of Nursing, Director of Nursing, Medical Records Director, Minimum Data Set Coordinator, Wound Care Nurse and Staff Development Coordinator and corrections made as needed. **Measures Taken To Assure There Will Not Be a Recurrence** • To enhance currently compliant operations, under operations, under the direction of the Director of Nursing, Licensed Staff, Social Services, Activities, and Dietary will receive inservice training that included accuracy and completion of all components of the medical record.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C
	185446		07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 27 Summary notes should not indicate adequate hearing, and she further reported Resident #15's hearing loss was present upon admission. LPN #3 reported a communication book as well as gestures were used to communicate with Resident #15 on a daily basis. Interview with MDS Nurse #1, on 07/11/13 at 3:15 PM, revealed Resident #15 was hard of hearing. MDS Nurse #1 reported she last assessed Resident #15 to have moderate hearing difficulty during his/her last MDS assessment. MDS Nurse #1 stated she based her assessment on staff interactions Resident #15. Interview with Assistant Director of Nursing (ADON) #1, on 07/11/13 at 3:25 PM, revealed Resident #15 was hearing impaired since admission. ADON #1 reported staff used a note pad, gestures, and lip reading (in direct view) to communicate with Resident #15. In addition, ADON #1 reported she expected staff to mark moderate difficulty on the Weekly Summary Notes, to indicate Resident #15's hearing loss. ADON #1 stated it was important for medical records to be accurate to ensure proper care of the residents. Interview with the Director of Nursing (DON), on 07/11/13 at 4:29 PM, revealed she believed Resident #15's hearing loss was "selective hearing." The DON stated she was unaware if Resident #15 had an actual medical diagnosis of hearing loss. The DON reported medical records personnel conducted audits on resident medical charts, but was unsure of exact type/schedule of audits. The DON reported the Weekly Summary notes were completed by the nurse assigned to	F 514	Inservice done from 7/11/2013 to 8/2/2013. **Monitoring Changes to Assure Continuing Compliance** • A Quality Assurance program was developed under the supervision of the Director of Nursing. The Medical Record of each identified resident will be reviewed weekly according to the weekly summary scheduled for four weeks, then five identified residents weekly for four weeks, then monthly ongoing, Any newly identified residents will be identified at the morning Clinical meeting and through the quarterly MDS. Monitoring results will be brought to the monthly Quality Assurance Committee for further review, analysis, corrective action and recommendations monthly until at such time consistent substantial compliance has been achieved as determined by the committee. Completion date: 8/15/2013	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C
	185446		07/11/2013

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F 514	Continued From page 28 complete the form. The DON reported the nurse completing the Weekly Summary form may have only worked with the resident for one day of the week that was reviewed, so she expected staff to reflect assessment findings accurately. The DON reported it was important to have accurate medical records to "show a whole picture of the patient". Interview with Medical Records Personnel #1, on 07/11/13 at 4:40 PM, revealed she audited resident records for completeness. However, Medical Records Personnel #1 reported she believed the nurses were responsible for ensuring accuracy of the clinical portions of the record.	F 514		

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

PRINTED: 07/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185446	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

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K 000	INITIAL COMMENTS	K 000		
	Building: 01			
	Plan Approval: 6/15/77			
	Survey under: NFPA 101 (2000 Edition)			
	Facility type: SNF/NF			
	Type of structure: Type V (111) Unprotected			
	Smoke Compartment: Six (6)			
	Fire Alarm: Complete Fire alarm System			
	Sprinkler System: Complete Sprinkler System (Dry)			
	Generator: Type II Diesel and Type II Natural Gas			
	A standard Life Safety Code survey was conducted on 07/09/13. Bluegrass Care and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred twenty-four (124) beds and the census the day of survey was one hundred four (104).			
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		
	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1, 19.2.1			

RECEIVED
AUG 16 2013
BY: _____

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Donna Maynard, BSN, DON for Jennie Hornsby LNHA — 8/16/13

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

Aug. 16. 2013 4:33PM No. 6207 P. 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185446		07/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 038	Continued From page 1	K 038		
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, thirty (30) residents, staff, and visitors. The facility is licensed for one hundred twenty-four (124) certified beds with a census of one hundred four (104) on the day of the survey. The findings include: Observation, on 07/09/13 at 12:44 PM, with the Maintenance Director, revealed the exit discharge walkway leading away from the Northwest Hall Exit Door and ramp was grass and did not have a durable surface to the public way. Interview, on 07/09/13 at 12:44 PM, with the Maintenance Director revealed the walkway was to be replaced last year but kept being put off to a later date. He also stated that it was to be a part of a bigger project for this year to include parking lot and walkways. Interview, on 07/09/13 at 2:35 PM, with the Administrator revealed work to be completed this summer includes a new parking lot and walkways that would correct this issue. Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously		K 038 **Immediate Corrective Action for Residents Found To Be Affected** ♦ It is the policy of Bluegrass Care and Rehabilitation to ensure that exit access is arranged so that exits are readily accessible at all times. ♦ The exit discharge walkway leading away from the Northwest hall Exit door has been constructed according to K038	

Aug. 16. 2013 4:33PM No. 6207 P. 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185446		07/09/2013

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K 038	Continued From page 2	K 038		

maintained
free of all obstructions or impediments to full instant use in
the case of fire or other emergency.
7.5.1.1 Exits shall be located and exit access shall be arranged
so that exits are readily accessible at all times.
7.7.1* Exits shall terminate directly at a public way or at an
exterior exit discharge. Yards, courts, open spaces, or other
portions of the exit discharge shall be of required width and
size to provide all occupants with a safe access to a public way.
Exception No. 1: This requirement shall not apply to interior exit discharge
as otherwise provided in 7.7.2.
Exception No. 2: This requirement shall not apply to rooftop exit discharge
as otherwise provided in 7.7.6.
Exception No. 3: Means of egress shall be permitted to terminate in an
exterior area of refuge as provided in Chapters 22 and 23.

Reference: CMS S&C letter 5-38
Q2: Are exit discharges required to have a hard surface pathway to the public way? This is in reference to tag K-38 and previous guidance.
A2: Previous interpretive guidance on this subject dated 07/07/93 (under tag K-32) is still acceptable. In that guidance we stated that our response to the question was " Yes, if there is much rain or snow and if patients are expected to exit or be evacuated in wheelchairs or beds. " This would include residents using walkers. Grass or soil may be acceptable if weather

Identification of Other Residents with the Potential to be Affected

- All residents, staff and visitors have the potential to be affected by the citied deficiency, all exit walkways were assessed. No further violations were found.

Measures Taken To Assure There Will Not Be a Recurrence

- Under the supervision of the Administrator the Maintenance Director or the Maintenance Assistant will review the walkways and parking lots monthly times 90 days then quarterly and report any identified concerns for plan of action/correction.

Monitoring Changes to Assure Continuing Compliance

- Maintenance Director or Maintenance Assistant will review walkways and parking lots monthly with report presented to the quarterly Quality Assurance Committee for review and follow up until such time consistent substantial compliance has been achieved as determined by the committee.

Date of Completion: 08/15/2013

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185446		07/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

(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 038	Continued From page 3 conditions permit. This determination is left up to the judgment of the surveyor as to the local weather conditions and the difficulty that a resident or patient may encounter while traversing between the building and the public way. Section 7.7.1 NFPA 101 of the LSC (2000 edition) requires that " Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. " An appendix note to 7.7.1 states that the exit discharge is not required to be paved but that it must give safe access to a public way and references section 7.1.10. Section 7.1.10 of NFPA 101 of the LSC (2000 edition) requires that the means of egress be continuously maintained free of all obstructions or impediments to full and instant use in the case of fire or emergency. An appendix note to 7.1.10 specifically points out that accumulations of snow and ice are an impediment to free movement in the means of egress. CMS believes that a usable exit discharge is a fundamental and important life safety feature and contributes to the safety of staff and residents in an emergency. The use of the Fire Safety Evaluation System (FSES) is inappropriate as there is no equivalent to being able to exit the building at all times in an emergency.	K 038		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in	K 056		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185446		07/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

(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 056	Continued From page 4 accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The findings include: Observation, on 07/09/13 at 12:53 PM, revealed one (1) overhang that was located outside of the employee exit, extended out from the building sixty-five inches that was made of combustible materials and were not sprinkler protected. Interview, on 07/09/13 at 12:53 PM, with the Maintenance Director revealed the overhang was made of combustible materials and he was not aware the overhang needed to be sprinkler protected and he thought all the overhangs were identified. Interview, on 07/09/13 at 2:40 PM, with the Administrator revealed she had only been filling in at this facility until a permanent replacement starts in about two weeks but the sprinkler head will be installed as required by code.	K 056	K056 **Immediate Corrective Action for Residents Found To Be Affected** • It is the policy of Bluegrass Care and Rehabilitation to provide complete sprinkler coverage for all portions of the physical plant. • The overhang located outside of the employee exit, extending out from the building sixty five inches, had a sprinkler installed on 7/18/13. The sprinkler system is functioning properly. **Identification of Other Residents With The Potential to be Affected** • Because all residents, staff and visitors have the potential to be affected by the cited deficiency, all overhangs were assessed and found to be in compliance with K056. The sprinkler system continues to be monitored according to the facility's maintenance prevention program. **Measures Taken To Assure There Will Not Be a Recurrence** • Under the supervision of the Administrator, the Maintenance Director or the maintenance assistant will audit the facility to	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185446		07/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

(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 056	Continued From page 5 Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056	determine if any other areas require sprinklers according to regulation. • The maintenance director or the maintenance assistant will audit the sprinklers monthly times 6 months and then quarterly for position and function and report any identified concerns to the Administrator for plan of action/correction. **Monitoring Changes to Assure Continuing Compliance** • The results of the assessment and the maintenance prevention program monitoring will be brought to the Quality Assessment monthly meeting and to the Safety Committee for further review, analysis, and recommendations as needed. • Date of Completion: 08/15/13	

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