

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

PRINTED: 08/18/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185174</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/18/2015</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>FLORENCE PARK CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6975 BURLINGTON PIKE FLORENCE, KY 41042</b>
--	---

(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				
	An offsite revisit was conducted and based on the acceptable Plan of Correction, the facility was deemed to be in compliance as alleged on 08/03/15.				

{F 000}

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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.

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/09/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042
---	---

(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  An Abbreviated Survey investigating KY#00023392 and KY#00023425 was initiated on 07/02/15 and concluded on 07/09/15. KY#00023392 and KY#00023425 were substantiated with deficiencies cited with the highest scope and severity cited at an "E".	F 000	This Plan of Correction for the survey completed at Florence Park Care Center on 7/9/2015 constitutes our written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update	F 157	F157  Address what corrective action will be implemented for those residents found to have been affected by the deficient practice:  The family of resident #2 was notified of the resident's weight loss on 6/9/15 by the Dietician. Further discussion with the family regarding the weight loss and interventions was also held with the family on 6/15/15 with the Unit Manager (UM). Documented evidence was found to be in the chart on 6/9/15 and 6/15/15. The facility spoke with family and corrections in place prior to survey. The medical record of Resident #2	08/03/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Patricia S. Lehnert RN</i>	TITLE <i>Director of Nursing</i>	(X8) DATE <i>8-13-2015</i>
--	-------------------------------------	-------------------------------

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.

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/09/2015
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042		
(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 157	<p>Continued From page 1 the address and phone number of the resident's legal representative or interested family member.</p> <p>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 notify one (1) out of seven (7) sampled residents' Responsible Party/Power of Attorney (POA) when the resident experienced a change in status. There was no documented evidence provided to show Resident #2's Responsible Party/POA was notified when the resident experienced a weight loss of more than five (5) percent (%) in one (1) month.</p> <p>The findings include: Review of the facility's policy, titled, "Procedure for Weight Loss/Gain Monitoring", undated, revealed the resident weights were maintained routinely to ensure proper nutrition. The Procedure was for all residents to be weighed by nursing staff upon admission and at least monthly by the 10th of the month (unless contraindicated or otherwise noted in the care plan). The percentage of weight change was calculated for one (1) month, three (3) months and six (6) months. Additionally, weight changes were monitored by the nursing and the dietician or diet technician. Continued review revealed residents with significant weight loss (5% or more in 1 month; 7.5% or more in three (3) months; and 10% or more in six (6) months) were evaluated to determine if a significant change Minimum Data Set (MDS) assessment was necessary. The resident, the resident's physician and the resident's sponsor/responsible party were notified</p>	F 157	<p>was reviewed by the Director of Nursing (DON) on 7/13/15 and notification of all other changes and physician's orders to responsible party/POA were noted to be in place within the resident's record. No further status changes were noted where Power OF Attorney had not been notified.</p> <p><i>Address how the facility will identify other residents having the potential to be affected by the same practice.</i></p> <p>The DON and/or UM's will review all records for residents identified as having a significant weight loss during the past 3 months to ensure that family/responsible party/POA notification has taken place. This review will be completed by August 3, 2015.</p> <p><i>Address what measures will be put into place or systemic changes made to ensure that the practice will not recur:</i></p>	

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/09/2015
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6675 BURLINGTON PIKE FLORENCE, KY 41042		
(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 157	<p>Continued From page 2</p> <p>of significant weight change. The dietician or dietetic technician would evaluate the weight change, enter a chart note, and make appropriate recommendations for unplanned weight changes.</p> <p>Review of Resident #2's medical record revealed the resident was admitted by the facility on 05/11/15 with diagnosis which included Altered Mental Status, Anxiety, Depressive Disorder, Muscle Weakness, Urinary Tract Infection, and Cardiac Pacemaker. Review of the resident's Quarterly Minimum Data Set (MDS), dated 06/06/15, revealed the resident was assessed to be moderately impaired in cognition. Continued review of the MDS revealed, under section K, the resident experienced a loss of 5% or more in the last month or 10% or more in the last six (6) months that was not physician-prescribed weight-loss regimen. Review of the residents monthly weights revealed the resident was admitted with a weight of one-hundred and fifty-six (156) pounds on 05/11/15 and was weighted again on 06/03/15 and weighted one-hundred and forty-four point six (144.6) pounds.</p> <p>Review of Nursing Notes, dated 06/03/15 at 7:37 PM, written by Licensed Practical Nurse (LPN) #4, revealed a new order from the Dietician for Boost VHC one (1) time a day regarding weight loss this month. There was no documented evidence related to LPN #4 notifying the resident's Power of Attorney.</p> <p>Review of the Dietitian note, dated 06/05/15 at 10:03 AM, revealed the resident had a "weight warning", he/she weighed 144.6, which was a 7.3% loss in over a month. The Dietitian noted the resident lost 11.4 pounds and was now on</p>	F 157	<p>All nurses will be educated on family notification of changes in resident status including weight loss and communication of subsequent Dietician and Interdisciplinary Team (IDT) recommendations by August 3, 2015. This inservice will be conducted by the DON and/or (UM's) (See inservice outline attached-Exhibit A).</p> <p><i>Address how the facility will identify other residents having the potential to be affected by the same practice:</i></p> <p>To ensure ongoing compliance, the UM's will conduct a monthly audit of each resident's record who has been identified as having a significant weight loss for family notification. (See audit form attached -Exhibit B). The results of those audits will be forwarded to the Quality Assurance Committee (QA Committee) in 3 months to determine if there is any need for changes to facility</p>		

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/09/2015
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042		
(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 157	<p>Continued From page 3</p> <p>eight (8) ounces (oz) of Boost VHC one (1) time a day to increase calories in intake. Further review revealed she would continue to monitor the resident.</p> <p>Interview with Power of Attorney (POA) #1, on 07/04/15 at 3:22 PM, revealed she was not notified when Resident #2 began losing weight. She reported she voiced her concern with the Dietitian and was upset that she was not notified.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 07/08/15 at 9:20 AM, revealed Resident #2 was briefly on her unit. She reported the resident was losing weight, but not the brief period she had him on her unit. She reported Resident #2's Power of Attorney never expressed to her concerns she had about not being told about the resident's weight loss. LPN #4 stated she documented the Dietitian wanted to prescribe Boost to Resident #2 due to weight loss. LPN #4 reported the facility's process for notifying the physician and the resident's responsible party would be to send messages to the physician and to contact the family. LPN #4 reported she tried to contact the resident's POA; however, no one answered the phone when she called, so she did not leave a message due to Health Insurance Portability and Accountability Act (HIPPA) and reported she did not document the telephone call. Continued interview with LPN #4 revealed she believed she talked to the resident's POA #2 because he was in to see the resident that day.</p> <p>Interview with Resident #2's Responsible Party (POA) #2, on 07/09/15 at 12:00 PM, revealed he was not informed of Resident #2's continuous weight loss and reported he was upset about not being told.</p>	F 157	<p>policy/procedure and to determine a plan for ongoing monitoring. QA Committee consists of Director of Nursing, Medical Director, Administrator, MDS Coordinator, Unit Managers, Social Worker, and Dietician.</p>		

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/09/2015
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042		
(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 157	Continued From page 4  Interview with Registered Nurse (RN) #1/Unit Manger, on 07/08/15 at 2:59 PM, revealed Resident #2 was on the skilled unit for a month before he/she moved to the Memory Care Unit (MCU). RN #1 reported he was not informed the resident's Responsible Party/POA was upset about not being notified of the resident's change in weight. Continued interview with RN #1 revealed the process for notifying the resident's responsible party/POA regarding a change in his/her weight was that the Dietitian would often review the resident's plan of care and review the resident's weights. He reported the Dietitian would then make a recommendation and the nursing staff would contact the resident's physician to ensure the Dietitians recommendation was approved and the family would then be notified which would show up on the physician telephone order. RN #1 reported he would check to see if LPN #4 notified the family using the physician order dated for 06/03/15; however, RN #1 never reported back with the documentation.  Interview with the Dietitian, on 07/08/15 at 5:06 PM, revealed the POA reported to her she was upset about not being notified of Resident #2's weight change and his/her recent recommendation, adding the Boost, to increase his/her weight. The Dietitian reported that when she made recommendations she would indicate the reasoning for placing residents on supplements. She reported a fax sheet would be sent to the resident's physician and nursing staff would notify the resident's responsible party. The Dietitian reported she spoke to the resident's responsible party/POA about the resident's weight loss and discussed the POA's concern with the	F 157			

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/09/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042
---	---

(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 157	Continued From page 5 Unit Manager, RN #1. The Dietitian reported she thought the nurse involved was in-serviced after that, but did not know the outcome of what happened from that.  Interview with the Director of Nursing (DON) on 07/09/15 at 4:02 PM, revealed she did not speak to the POA regarding Resident #2, but was aware the POA was upset about not being notified of Resident #2's 5% or greater weight loss. Continued interview with the DON revealed the Dietitian indicated the POA spoke with her and the unit manager about the resident's weight loss and reported the responsible party/POA was upset about not being notified about the resident's weight loss. She reported LPN #4 was talked to about notifying residents responsible party about any change of status. Continued interview with the DON revealed that staff could leave messages to residents responsible party without violating HIPPA. She reported staff could say, "please call the facility back so they could provide an update regarding the residents status". Further interview with the DON revealed it would be her expectation that staff would notify the residents family member/responsible party immediately when there was a change in the resident's status.  Interview with the Director of Clinical Operations, on 07/09/15 at 5:10 PM, revealed it would be his expectation that staff would follow the rules and regulations and that there would be a good clinical outcome.	F 157		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a	F 241	F241  Address what corrective action will be implemented for those residents found to have been affected by the deficient practice:	08/03/15

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/09/2015
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042		
(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 241	<p>Continued From page 6</p> <p>manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interviews and review of the facility's policy, it was determined the facility failed to create an environment that would maintain or enhance the resident's dignity and respect. During meal observations, Resident #2 as well as Unsampled Resident's A, B, F, I, J and L were observed to wait long periods of time for their meal while observing other residents at their table consume their meal.</p> <p>Additionally, Unsampled Residents G and K were observed to have staff standing while feeding them.</p> <p>The findings include,</p> <p>Review of the facility's policy, titled "Resident's Bill of Rights", undated, revealed resident's had the right to be free from physical, verbal, and mental and emotional abuse and to be treated at all times with courtesy, respect and full recognition of dignity and individuality.</p> <p>Observation, on 07/06/15 at 5:30 PM till 5:49 PM, revealed Unsampled Resident's A and B were observed sitting at a dining table for over fifteen (15) minutes watching two (2) other resident's eating their meal before they received their tray. Unsampled Resident A stated, "I had to wait for over thirty-five minutes (35) minutes for his/her tray". Unsampled Resident A reported this upset him/her.</p>	F 241	<p>1) Residents A and B: Residents A and B had independently sat at dining room table where residents were eating which was the first meal seating. Residents A and B usually ate the second seating. Residents A and B were interviewed by the UM on July 23, 2015 to determine their preference for eating time and place and the residents chose to eat in the main dining room. In the main dining room all residents are served in one meal seating and Residents A and B are enjoying their meals in the main dining room.</p> <p>2) Resident K: Activities assistant was educated by the DON on 7/9/15 regarding not standing while feeding the resident. Resident K has no noted negative effects from the Activities Assistant standing during the meal. The DON and UM have observed Resident K during 5 separate meals to ensure that she is being assisted by staff who are sitting and not standing. No</p>		

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

PRINTED: 07/29/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/09/2015
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042		
(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 241	<p>Continued From page 7</p> <p>Observation, on 07/06/15 at 5:46 PM, revealed the Activities Assistant was observed standing while assisting Unsampld Resident K with his/her meal.</p> <p>Interview with the Activities Assistant, on 07/09/15 at 9:30 AM, revealed she would normally sit with the residents while they ate, but did not have a chair to sit in while assisting Unsampld Resident K.</p> <p>Observation on 07/07/15 at 8:15 AM, revealed Unsampld Resident J was observed sitting with other residents during breakfast, but was moved from the table by an unidentified staff member who explained to the resident, "Your tray was not on the cart". Unsampld Resident J was moved outside of the small dining room into the main dining room where he/she was able to view other resident's eating their breakfast. Unsampld Resident J was observed receiving his/her meal at approximately 8:50 AM, thirty-five (35) minutes after the time the resident was placed at the table within the main dining room to eat. Unsampld Resident J was assisted by staff.</p> <p>Observation, on 07/07/15 at 8:16 AM, revealed Resident #2 was observed seated in the back of the dining room for breakfast and joined a table with other residents being assisted with their meal for breakfast. Resident #2 received his/her breakfast on the second cart which came at 8:34 AM.</p> <p>Observation, on 07/07/15 at 8:30 AM, revealed Unsampld Resident F was observed sitting with other resident's during breakfast as they ate. He/she was observed gazing at the residents as they ate. Unsampld Resident F's tray was given</p>	F 241	<p>observations of employees standing have been noted.</p> <p>3) Resident J: The DON and UM have observed Resident J during 5 separate meals to ensure that her tray has arrived on the meal cart. Each observation revealed that Resident J's tray was on the cart.</p> <p>4) Resident #2: Resident #2 has discharged and no further corrective action can be implemented at this time for Resident #2.</p> <p>5) Resident F: Resident F eats on the second meal seating. Resident F will be engaged in an activity during the first meal seating. A list has been provided to staff to ensure that anyone working on the unit will know which meal seating the resident prefers so that they will not be inadvertently assisted to a table that is being used for a different meal seating.</p> <p>6) Residents I and L: The DON and the UM have observed Residents I and L on 5 separate</p>		

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/09/2015
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042		
(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 241	<p>Continued From page 8</p> <p>to him/her at 8:45 AM, he/she was observed eating independently.</p> <p>Observation, on 07/07/15 at 8:35 AM, revealed Unsampld Residents I and L were sitting at the table with Resident #3 and Unsampld Resident D and watched as Resident #3 and Unsampld Resident D ate their breakfast. The Unit Manager/LPN #5 was observed to sit down and assist Unsampld Resident I with his/her meal at 8:45 AM and the Activities Assistant sat down to assist Unsampld Resident L at 8:46 AM.</p> <p>Observation, on 07/07/15 at 8:50 AM, revealed Unsampld Resident G was observed assisted by staff with his/her meal while CNA #7 stood over him/her.</p> <p>Interview with Certified Nursing Assistant (CNA) # 7, on 07/07/15 at 3:45 PM, revealed staff should sit while assisting the residents with their meal. She reported this was important so that staff would not jab the fork into the resident's mouth and so that staff could see what the residents were eating. Continued interview revealed she should have been sitting while assisting Unsampld Resident G with his/her meal.</p> <p>Interview with CNA #3, on 07/07/16 at approximately 1:30 PM, revealed staff should not stand over the residents while assisting them with their meal. Additionally, CNA #3 reported staff should not place a tray in front of another resident while their peers were eating in front of them. She stated this kept anger down and stated "I would be mad and I try to put myself in their shoes and would not want to be sitting for ten (10) minutes while someone else was eating". Continued interview with CNA #3 revealed staff</p>	F 241	<p>meals and no further episodes of waiting for their tray and assistance with their meal has been observed. The Medical Records for Residents I and L have been reviewed and no negative effects have been noted.</p> <p>7) Resident G: Resident G has no noted negative effects from staff standing during the meal. The DON and UM have observed Resident G during 5 separate meals to ensure that she is being assisted by employees who are sitting and not standing. No observations of employees standing have been noted during meals.</p> <p><i>Address how the facility will identify other residents having the potential to be affected by the same practice:</i></p> <p>The DON and UM observed meals on 5 separate occasions to monitor for employees standing while assisting residents with eating. No occurrences of other residents being affected were noted.</p>		

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/09/2015
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042		
(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 241	<p>Continued From page 9</p> <p>should maintain eye contact with the residents while assisting them with their meal and not standing on top of them. CNA #3 reported this could be a dignity issue. Continued interview with CNA #3 revealed Unsampld Resident's I and L should not have been waiting long periods of time without their tray while others at their table were eating.</p> <p>Interview with CNA #5, on 07/07/15 at 2:15 PM, revealed staff usually sat the residents in a general area waiting for when the trays came up to the Memory Care Unit (MCU). She reported a resident should not watch another resident eat, and added it was not fair to the resident.</p> <p>Interview with CNA #4, on 07/07/15 at 2:48 PM, revealed staff knew what trays came up on which carts; therefore, staff try to seat the residents whose meals arrive to the unit on the different carts, together. Continued interview with CNA #4 revealed it was rude for residents to wait for their tray while other residents were eating. She reported, "that's just rude". CNA #4 reported it could be a form of dignity because no one wants to watch while others eat.</p> <p>Interview with Unit Manager/Registered Nurse (RN) #1, on 07/08/15 at 2:59 PM, revealed he was assisting staff on the MCU with meal service. He reported that while assisting the residents with their meal on 07/07/15 supper, two (2) residents complained to him about how long they had to wait for their meal. He reported these residents were ambulatory and oriented to self and time. Continued interview revealed the two (2) residents were sitting at a table were two (2) other residents were observed eating their food for over fifteen (15) minutes. Further interview with RN #1</p>	F 241	<p>During the DON and UM observations, no occurrences of residents watching other residents eating were noted as all residents were seated for their chosen meal seating time and there were no occurrences of residents waiting for their meals an excessive amount of time as residents who were at the same table were served together. Additionally, those residents not eating were engaged in an activity in a separate area.</p> <p>The UM interviewed residents who are interviewable to determine if they were pleased with their meal time and seating. The facility did identify one more resident who wanted to go to the main dining room for her meals and her tray was moved to that dining room and she is leaving the unit for each meal to eat in the other dining room.</p> <p><i>Address what measures will be put into place or systemic</i></p>		

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/09/2015
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042		
(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 241	<p>Continued From page 10</p> <p>revealed Unsampld Residents A and B complained to him and reported how upset they were about waiting for their meal. RN #1 reported he thought it could have been a dignity concern if the resident's felt as though they were forgotten about.</p> <p>Interview with LPN #5/Unit Manager, on 07/09/15 at 10:26 AM, on the MCU. LPN #5 reported she noticed there was a concern related to the residents waiting to receive their meal based upon the spaced out times between the meals that came up on cart one (1), two (2), and three (3). She reported she has worked on changing the times the carts come up to the unit for the residents who were more mobile and changing the time for those who needed assistance with their meals. Additionally, LPN #5 reported staff should not be standing over the residents while assisting them with their meal. She stated these concerns could be a dignity issue and would have to re-educate staff.</p> <p>Interview with the Dietary Supervisor, on 07/08/15 at 5:11 PM, revealed he could not recall who stated the carts needed to be changed on the MCU, but reported the change would be made to have some of the residents food carts changed.</p> <p>Interview with the Social Service Director, on 07/09/15 at 12:28 PM, revealed the goal of the facility was for every resident who were at a table would eat at the same time. She further stated the goal of the facility was that staff would sit while assisting residents with their meals. The Social Service Director reported this could be a dignity concern.</p> <p>Interview with the Director of Nursing (DON), on</p>	F 241	<p><i>changes made to ensure that the practice will not recur:</i></p> <p>All activities staff, dietary staff, and nursing staff will be educated on procedures that ensure residents are not watching other residents eat and that all staff sit when feeding/assisting residents with eating. This inservice will be conducted by the DON and/or UM by August 3, 2015. (See inservice outline attached -- Exhibit C).</p> <p><i>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained:</i></p> <p>An audit of meal service will be conducted by the DON and/or UM. This audit will be completed two times per week for each meal (i.e., breakfast meal 2x per week; lunch meal 2x per week, supper meal 2x per week) for the next four weeks to ensure all staff are sitting when feeding/assisting residents, residents at same</p>		

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/09/2015
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8975 BURLINGTON PIKE FLORENCE, KY 41042		
(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 241	Continued From page 11 07/09/15 at 4:02 PM, revealed it would be her expectation that staff would not stand over the residents during meal service and that residents were served their meals at the same time. Continued interview with the DON revealed this could be difficult on the memory care unit. The DON reported she knew dining services was a problem and had worked on changing the times the residents received their meals. The DON reported she asked Dietary to bring the trays for the residents who were more alert on the first cart to avoid residents from waiting a long period of time. The DON reported this could be a dignity issue.  Interview with the, Director of Clinical Operations, on 07/09/15 at 5:10 PM, revealed it would be his expectation that the rules and regulations would be followed related the Resident's Rights.	F 241	table are served together, residents not eating are engaged in alternate activity, residents who need assistance with feeding are identified/ assisted per their plan of care and the meal cards match the meal served on tray correctly. The results of audits will be forwarded to the QA Committee to determine a schedule for ongoing monitoring and to determine that interventions have been effective. (See audit form attached – Exhibit D).		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of the facility's policy, it was determined the facility failed to follow one (1) out of seven (7) sampled residents Comprehensive Care Plans. Resident #2 was observed on two (2) separate meals eating alone when his/her care plan indicated he/she would have assistance with meals.	F 282	F282  <i>Address what corrective action will be implemented for those residents found to have been affected by the deficient practice:</i>  The Medical Record for Resident #2 was reviewed and the Plan of Care was updated to show that the resident's abilities fluctuate during eating and that assistance can vary day to day.	08/03/15	

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/09/2015
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042		
(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 282	Continued From page 12  The findings include:  Review of the facility's policy, titled "Policy and Procedure Care Planning", undated, revealed the facility would develop a comprehensive care plan for each resident which included measurable objectives to meet the resident's medical, nursing, and mental psychosocial needs. Further review of the care plan policy revealed the procedure of the policy was the plan of care would be developed to utilize the RAI process as a foundation and would address problems, potential needs, strengths, and preferences. Additionally, the plan of care would be reviewed and updated by the interdisciplinary team and the resident and/or resident's sponsor a minimum of quarterly.  Review of Resident #2's medical record revealed the resident was admitted by the facility on 05/11/15 with diagnoses which included Altered Mental Status, Anxiety, Depressive Disorder, Muscle Weakness, Urinary Tract Infection, and Cardiac Pacemaker. Review of the resident's Quarterly Minimum Data Set (MDS), dated 06/06/15, revealed the resident was assessed to be Moderately Impaired. Review of Resident #2's care plan revealed the resident was assessed on 05/11/15 to have a goal date of 09/07/15 for the resident to maintain current level of function in eating which required the resident to be extensive; assist of one (1) person with eating.  Observation, on 07/07/15 at 8:30 AM and 5:30 PM, revealed Resident #2 was seated in the back of the dining room and was served his/her breakfast. Staff assisted the resident with set-up only. Resident #2 was observed eating his/her	F 282	Address how the facility will identify other residents having the potential to be affected by the same practice:  The care plan for any resident identified on the MDS as requiring limited or extensive assistance with eating will be reviewed to ensure that the care plan matches the assistance being provided. This review will be conducted by the MDS Coordinator and/or Unit Manager and will be completed by August 3, 2015.  Address what measures will be put into place or systemic changes made to ensure that the practice will not recur:  Inservice education was provided to the MDS staff regarding documentation on care plans to match the resident's abilities keeping in mind that the MDS is coded at the highest level of assistance and not always at the resident's consistent level.		

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/09/2015
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042	
(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 282	<p>Continued From page 13</p> <p>meal by himself/herself, without the assistance of staff. Resident did not complete his/her meal. A different observation during supper revealed the resident was seated at the table with other residents. Staff assisted the resident with set-up only and the resident was observed eating his/her meal without the assistance of staff.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 07/07/16 at approximately 1:30 PM revealed she had worked with Resident #2. She reported the resident was good at feeding himself/herself and did not require assistance with feeding.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 07/09/15 at 9:42 AM, revealed Resident #2 required assistance with eating for his/her meals. She reported staff would encourage him/her to finish his/her meal. Continued interview with LPN #3 revealed she was not certain of the resident's care plan, thus needed to review it. LPN #3 reviewed the resident's care plan and reported that if the resident was an assist of one (1), he/she needed a nurse or CNA to sit down and eat with him. Continued interview revealed the resident should have had staff to sit to assist him/her with his/her meal. LPN #3 further revealed the care plan should have been followed regarding the resident's activity of daily living (ADLs) in regards to eating.</p> <p>Interview with Minimum Data Set Coordinator (MDS) #1, on 07/09/15 at 11:48 AM, revealed the purpose of the care plan was to ensure the residents get their proper care. She reported it helped staff to know the resident's participation and how much staff was needed for the resident's care. MDS Coordinator #1 reported she was not</p>	F 282	<p>Inservice education also provided to nursing staff, certified nursing assistants, and assistant nurse aides re-educating they follow residents' Care Plan interventions to ensure they are providing the appropriate assistance as stated on Care Plan. Both Inservice provided on 7/28/2015 by the Director of Nursing. (See inservice outline attached – Exhibit E &amp; I).</p> <p><i>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained:</i></p> <p>To ensure ongoing compliance and effectiveness of interventions, a 25% sample of care plans of residents requiring extensive assistance with eating will be audited by the Director of Nursing monthly to ensure that the care plan matches the residents' abilities. Meal audits will also be completed to observe and to ensure staff</p>	

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/09/2015
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042		
(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 282	<p>Continued From page 14</p> <p>familiar with Resident #2's plan of care and referred it MDS #2.</p> <p>Interview with MDS Coordinator #2, on 07/09/15 at 12:25 PM, revealed Resident #2 was assessed to be supervision with eating, but was charted a couple of days as being an extensive assist. In reviewing the MDS, MDS Coordinator #2 reported Resident #2 typically could be supervision of set-up only; however, he/she would fluctuate. She reported the resident was care planned to have a one (1) assist because the resident was losing weight and wanted staff to assist him/her with his/her meals. MDS #2 reported it would be her expectation that the care plan would be followed because it determined the care the resident needed. Additionally, she reported staff should have assisted the resident with his/her meals.</p> <p>Interview with the Director of Nursing (DON), on 07/09/15 at 4:02 PM, revealed it was important for the care plan to be followed. She reported it would be her expectation that the care plans would be followed. Continued interview with the DON revealed "Extensive" meant staff should have remained with the resident during his/her meals. She reported staff should encourage the resident to eat on his/her own; however, staff should have been sitting with Resident #2.</p> <p>Interview with the Director of Clinical Operations, on 07/09/15 at 5:10 PM, revealed it was his expectation that staff would follow the care plan because the facility design a plan that was unique to each resident for their highest practical well being.</p>	F 282	are providing appropriate required assistance as stated on residents' Care Plan. (See audit form attached – Exhibit D & F). The results of the audits will be referred to the QA Committee in 3 months to determine a schedule for ongoing monitoring and if any changes to plan of action are needed.		
F 364	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR,	F 364			

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/09/2015
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042	
(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 364 SS=D	Continued From page 15 PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  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 provide one (1) out of seven (7) sampled residents their meal preference. Resident #2 was observed on two (2) separate meals to have been served without his/her chocolate pudding as suggested by the resident's Power of Attorney (POA) and Dietitian.  The findings include:  Review of the facility's policy, titled "Procedure for Food Likes and Dislikes", revised 12/31/97, revealed the purpose was to ensure residents individual preferences were obtained and followed at each meal. This would ensure resident optimal nutritional intake. The Procedure was for the Dietary Representative to conduct an interview in order to obtain the residents likes and dislikes upon admission, significant weight loss, refusal to eat, or other nutritional concerns. Family members would participate. Continued review of the facility's policy revealed that after the process of interviewing was complete, the Dietary Representative would enter the new resident into the dietary computer system. This was necessary to guarantee that the resident was added to the tray line process, as soon as	F 364	F364  <i>Address what corrective action will be implemented for those residents found to have been affected by the deficient practice:</i>  Resident #2 was provided pudding when tray was noted without pudding. Resident was discharged from the facility and there is no further corrective action to be implemented for Resident #2.  <i>Address how the facility will identify other residents having the potential to be affected by the same practice:</i>  To identify other residents the Dietary Director and Dietary Supervisor have been monitoring resident trays prior to leaving the kitchen to ensure that dietary preferences are on the tray. All residents' trays will be audited at least 1 time by August 3, 2015.	08/03/15

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/09/2015
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042	
(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 364	<p>Continued From page 16</p> <p>humanly possible. After the resident was entered into the tray line database a tray line card would be produced at every meal for the individual. The interview information was communicated to the Dietitian and/or Dietetic Technician and the Interdisciplinary Team was appropriate. Dietary maintains on going communication with the inter-disciplinary team and resident (when appropriate).</p> <p>Review of Resident #2's medical record revealed the resident was admitted by the facility on 05/11/15 with diagnosis which included Altered Mental Status, Anxiety, Depressive Disorder, Muscle Weakness, Urinary Tract Infection, and Cardiac Pacemaker. Review of the resident's Quarterly Minimum Data Set (MDS), dated 06/06/15, revealed the resident was assessed to be moderately impaired in cognition. Continued review of the MDS revealed, under section K, the resident experienced a loss of 5% or more in the last month or 10% or more in the last six (6) months that was not physician-prescribed weight-loss regimen. Review of the residents monthly weights revealed the resident was admitted with a weight of one-hundred and fifty-six (156) pounds on 05/11/15 and was weighted again on 06/03/15 and weighted one-hundred and forty-four point six (144.6) pounds.</p> <p>Review of Dietary Note, dated 06/09/15 at 9:52 AM, revealed the POA provided the Dietary Manager with updated food preference list which would be addressed on the resident's diet card.</p> <p>Review of "Weight Change Note", dated 06/09/15 at 10:25 AM, revealed the resident would receive chocolate pudding to be added to lunch and</p>	F 364	<p><i>Address what measures will be put into place or systemic changes made to ensure that the practice will not recur:</i></p> <p>Dietary staff will be educated by the Dietary Director by August 3, 2015 on meal tray preparation with food preferences. (See Inservice outline attached – Exhibit C).</p> <p>All staff will be educated by Director of Nursing on checking tray card after setting up the tray to ensure that the resident's tray matches the meal card by August 3, 2015. (See inservice outline attached – Exhibit C).</p> <p><i>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained:</i></p> <p>To ensure ongoing compliance, the Dietary Director and/or designee will audit one full cart of each meal (i.e., one cart consisting of 20 trays from breakfast, one cart of 20 trays from lunch, and one cart of 20</p>	

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/09/2015
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042	
(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 364	<p>Continued From page 17 dinner trays.</p> <p>Review of Resident #2's Meal Card revealed the standing order was for the resident to receive one-half (1/2) cup of Chocolate Pudding.</p> <p>Observation of Resident #2, on 07/06/15 at 6:15 PM, revealed Resident #2 received his/her meal in his/her room. There was no chocolate pudding on the resident's tray. The resident's POA asked for chocolate pudding from staff on the resident's behalf. Additionally, on 07/07/15 at 5:30 PM, Resident #2 was observed, sitting during dining with his/her supper tray. The resident's tray did not have chocolate pudding on it.</p> <p>Interview with Certified Nursing Assistant (CNA) #7, on 07/07/15 at 3:45 PM, revealed she did not work with Resident #2 very often. She reported she did not know the resident had lost weight. Further interview with CNA #7 revealed she was assigned to work with the resident on 07/06/15. She reported she did not realize the resident had a standing order for one-half (1/2) cup of chocolate pudding. Continued interview with CNA #7 revealed that if the resident liked chocolate pudding, he/she should have received the pudding on his/her tray, adding it was important to honor the resident's preferences so that they would eat what they liked. She reported she would not want to eat anything she did not like and stated she should have gotten Resident #2 pudding from him/her.</p> <p>Interview with Licensed Practical Nurse (LPN) # 3, on 07/09/15 at 9:42 AM, revealed Resident #2 should have gotten the chocolate pudding with his/her meals. She reported it was important to have something he/she wanted to eat, because</p>	F 364	<p>trays from dinner service) each week x 4 weeks. (See audit form attached – Exhibit G).</p> <p>The results of those audits will be forwarded to the QA Committee to determine a schedule for ongoing monitoring and to evaluate the effectiveness of interventions.</p> <p>The Unit Manager will audit trays at the point of service to ensure that residents are receiving foods identified on their tray card. This audit will be conducted three times per week for each meal (i.e., breakfast meal 2x per week; lunch meal 2x per week, supper meal 2x per week) for the next four weeks. (See audit form attached – See Exhibit D). The results of the audits will be forwarded to the QA Committee to determine a schedule for ongoing monitoring and to determine that interventions have been effective.</p>	

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/09/2015
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042		
(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 364	Continued From page 18 he/she was more likely to eat it.  Interview with the Dietary Supervisor, on 07/07/15 at 5:32 PM, revealed Resident #2 should have received chocolate pudding on his/her meal tray. He reported it must have been missed, adding the kitchen staff should have placed the pudding on the resident's tray. He stated that if it was missed with the kitchen staff, then the person setting up the resident's tray should alert the kitchen staff so that the resident could receive his/her pudding.  Interview with the Corporate Registered Dietitian, on 07/08/15 at 5:06 PM, revealed she talked to Resident #2's POA regarding the chocolate pudding. She reported it was added to the resident's meal ticket as a preference to see if that would work in assisting the resident with gaining weight. The Dietitian reported the chocolate pudding should have been on the resident's tray. Continued interview with the Corporate Registered Dietitian reported the CNA should have offered the resident the chocolate pudding. Further interview with the Corporate Registered Dietitian revealed it was important the resident received the foods he/she liked because the goal was to increase the resident's intakes.  Interview with the Director of Nursing, on 07/09/15 at 4:02 PM, revealed it would have been her expectation that Resident #2 would have been given chocolate pudding on his/her tray because it was his/her preference and the resident was experiencing weight loss, stating "the resident needed that if it would help".  Interview with the Director of Clinical Operations, on 07/09/15 at 5:10 PM, revealed it would be his	F 364			

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/09/2015
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042		
(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)	(X3) COMPLETION DATE	
F 364	Continued From page 19 expectation that staff would follow the rules and regulations regarding residents meal preferences.	F 364			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	F441  <i>Address what corrective action will be implemented for those residents found to have been affected by the deficient practice:</i>  A specific resident was not identified in the Statement of Deficiencies.  <i>Address how the facility will identify other residents having the potential to be affected by the same practice:</i>  To identify any other residents, the Director of Nursing and Unit Manager observed 5 separate meals to identify any further occurrences of meal trays being placed on the wrong cart. Staff placed dirty trays on the dirty tray cart and did not mix clean with dirty.  <i>Address what measures will be put into place or systemic</i>	08/03/15	

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/09/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042
---	---

(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 20 infection.  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 provide a safe and sanitary environment for the residents on the Memory Care Unit (MCU). During meal observations, a resident's dirty tray was placed back into a cart with residents' trays that had not been served. Additionally, the meal cart was left opened as staff severed the residents.  The findings include,  Review of the facility's policy, titled "Policy and Procedure General Infection Control", undated, revealed the facility would provide care and services to prevent the spread of illness. The procedure was for staff to follow proper infection control measures to prevent the spread of infection. Continued review revealed the dietary precautions was to 5(c) Service food properly. Staff were to keep foods covered until served. (d) Additionally, staff were to clean up thoroughly. They were to keep work surfaces, cutting boards and utensils properly cleaned after each use. Items were to be washed thoroughly and dirty items should be kept away from food and clean items.  Observation, on 07/06/15 at approximately 5:45 PM, revealed the Activity Director was observed assisting with supper trays on the MCU. The	F 441	<i>changes made to ensure that the practice will not recur:</i>  All dietary staff, nursing staff and activities staff will be educated on preventing cross-contamination by placing only dirty trays with dirty and clean trays with clean. Same staff will be educated on reporting to maintenance any issues with door latches on food carts. This inservice will be completed by August 3, 2015. The Dietary Director will educate dietary staff and the Director of Nursing and/or Unit Manager will educate all other staff. (See inservice outline attached – Exhibit C).  <i>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained:</i>  An audit of meal service will be conducted by the Director of Nursing and/or Unit Manager. This audit will be completed two times per week for each meal (i.e., breakfast meal 2x	
-------	---	-------	--	--

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/09/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042
---	---

(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

Activity Director was observed taking a resident's dirty tray and placing it in cart two (2), which contained resident's trays that had not yet been severed to the residents. Realizing her mistake, the Activity Director then removed the dirty tray from cart two (2), paused for a second, then placed the dirty tray into cart one (1), which was empty. Additionally, during the same meal observation, cart two (2) cart was observed to remain opened during periods of the meal service while staff distributed trays to the residents.

Interview with the Director of Activities, on 07/08/15 at 4:08 PM, revealed she would only assist on the MCU when asked to assist with dining. She reported she could not recall placing the dirty tray in with the clean tray because there was so much going on that day. She reported she remembered two (2) carts being there and just trying to get trays out to the residents. Continued interview with the Director of Activities revealed she could have placed the dirty tray in with the clean, but knew that was a "no, no", because "you got good food and finished food".

Interview with the Dietary Supervisor, on 07/08/15 at 5:11 PM, revealed the second (2nd) cart's latch was still intact; however, it was a little loose which caused the cart to come open. The Dietary Supervisor reported the cart should have remained closed for cross contamination concerns. Continued interview with the Dietary Supervisor revealed staff should never mix the dirty trays in with the clean trays for cross contamination concerns.

Interview with the Corporate Registered Dietitian, on 07/08/15 at 5:06 PM, revealed staff should not have placed the dirty tray in with the clean trays.

F 441 per week; lunch meal 2x per week, supper meal 2x per week) for the next four weeks. (See inservice outline attached – Exhibit D). The results of the audits will be forwarded to the QA Committee to determine a schedule for ongoing monitoring and to determine that interventions have been effective.

The Dietary Director will audit latching of all food carts weekly x 4 weeks. (See audit form attached – Exhibit H). The results of the audits will be forwarded to the QA Committee to determine a schedule for ongoing monitoring and to ensure that staff education has been effective.

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

PRINTED: 07/23/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/09/2015
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042		
(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 22 She reported this was not normal procedure.  Interview with the Director of Nursing (DON), on 07/09/15 at 4:02 PM, revealed staff should never mix dirty and clean. She reported it would be her expectation that to protect the residents from infection control problems, she would have sent the cart back and would have had new trays sent up, adding it was contaminated at that point. Continued interview revealed the facility would want the carts to be latched properly and reported it was an infection control concern. Continued interview revealed she contacted maintenance for the latch to be repaired on the cart.  Interview with the Director of Clinical Operations, on 07/09/15 at 5:10 PM, revealed it was his expectation that all the rules and regulations would be followed concerning infection control concerns.	F 441			