

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

PRINTED: 02/17/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R 02/17/2016
NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516		
(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 Off-site Revisits was conducted on 02/17/16. Based on the facility's acceptable Plan of Correction (POC), received on 02/16/16, the facility was deemed to be in compliance on 001/06/16 as alleged.	{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.

*Acceptable  
POC  
alleged date  
01/06/16*

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

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CMB NO. 0938-0  
(X3) DATE SURVEY  
COMPLETED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185322	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  12/17/2015
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NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516
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F 000 INITIAL COMMENTS

A Recertification Survey was initiated on 12/15/15 and concluded on 12/17/15 with deficient practice cited at the highest scope and severity of an "F"

F 000

F 155 483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES

F 155

The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.

**Immediate Corrective Action:**

Physicians orders were obtained on 12-15-15 by the DON for all residents who were noted as DNR. The NP instructed the QA Director on 12-16-15 to list all residents who did not have a code status listed and that she would come to facility within the week and notify family members to write orders for Full Code or DNR. All residents had orders in place by 12-18-15. A mandatory meeting for all nurses (RM/LPN) as well as all was held on 12-21-15 by the DON and Asst. Adm. to inform staff of the requirement to reflect DNR or Full Code Status by a Physicians order and that policy updates would be presented at a later date ( see addendum ). All facility staff were instructed on awareness of resident code status on 12-21-15 to assure understanding that if no red dot were present then resident was a full code (see addendum).

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review, and review of facility's policies, it was determined the facility failed to ensure the resident's desired code status and Advance Directives was reflected in the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Marcus Snyder</i>	TITLE <i>Assistant Administrator</i>	(X6) DATE <i>2-16-2016</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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F 155 Continued From page 1

Physician's Orders for nine (9) of ten (10) sampled residents (Resident #1, #2, #3, #4, #5, #7 #8 #9 and #10).

Record review revealed, six (6) sampled residents (Residents #1, #3, #4, #5, #7, and #10), had a signed and witnessed "Emergency Medical Services" (EMS), "Do Not Resuscitate" (DNR) Form. However, there was no documented evidence these (6) residents had a Physician's Order reflecting their DNR Code Status.

Further record review revealed, three (3) sampled residents (Residents #2, #8, and #9) had signed a "Resident Self Determination Directives" Form which according to staff interview would indicate if the resident's were a full code status; however, the Form did not include code status. Further review revealed there was no documented evidence these three (3) residents had a Physician's Order reflecting their Full Code Status.

The findings include:

Review of the facility's "DNR Policy and Procedure", effective 02/24/2013, revealed all residents would be offered an opportunity to make an informed decision regarding their code status upon admission to the facility. Further review of the Policy, revealed information regarding Cardio Pulmonary Resuscitation (CPR) versus DNR status will be provided as part of the admission process.

Review of the facility's "Resident Self Determination Act" Form, undated, revealed, upon admission to the facility, residents would be notified of their right to accept or refuse medical

F 155

**Other Residents Potentially Affected:**  
All residents have the potential for negative outcomes when policies and procedures to formulate orders for advance directives and resident's desired code status are not maintained.

**Systemic Changes:** A revision of facility policy and procedure for Code Status was implemented by the QA Director on 01-05-16 as well as revisions of the "Resident Self Determination Directives" to reflect code status per resident wishes. It is now required that code status must be specified at time of admission by physicians order and care planned accordingly by the RN/LPN staff. Policy updates were added to the facility Policy and Procedure Manual for review and awareness of all new hires. Updates were also added to the Nursing Communication Book for staff and agency (RN/LPN) awareness.

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NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516
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F 155 Continued From page 2  
or surgical treatment and formulate an Advance Directive.

1. Review of Resident #1's clinical record revealed the facility admitted the resident on 12/07/15 with diagnoses which included Parkinson's Disease, Depression, and Anxiety. Resident #1 was a new admission and his/her Minimum Data Set (MDS) was not due at the time of this review.

Continued review of Resident #1's clinical record revealed he/she had a signed and witnessed EMS DNR Form, dated 11/19/15. Further review of the clinical record revealed the resident had an Advance Directive as DNR; however, there was no documented evidence of a Physician's Order for DNR.

Further review of Resident #1's clinical record revealed the resident had a signed Resident Self Determination Directives Form dated 12/07/15, which included instructions to not administer antibiotics, intravenous infusions, and tubes for any reason; however, the Form did not include the resident's code status.

2. Review of Resident #3's medical record revealed the facility admitted the resident on 08/10/15 with diagnoses which included Urinary Retention, Depression, Dementia and Diabetes. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 11/11/15, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) of a ninety-nine (99), indicating the resident could not complete the interview, revealing Resident #3 to be severely cognitively impaired.

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**Monitoring:** Will be maintained by the QA Director and the SS Director as Specified by the policy and procedure (see addendum). Review of monthly MD order forms by the QA will assure code status is specified for all residents as noted per Advance Directive form. SS Director will provide a list of all resident's code status (see addendum) and post for staff awareness. A summary will be provided to DON, Asst. Adm., Dietary Sup., Pharmacist, and MD (when present) at the monthly QA meeting.

Completion Date 01/06/16

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IDENTIFICATION NUMBER:

185322

(X2) MULTIPLE CONSTRUCTION  
A. BUILDING

B. WING

(X3) DATE SURVEY  
COMPLETED

12/17/2016

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ROSE MANOR HEALTH CARE

STREET ADDRESS, CITY, STATE, ZIP CODE  
3057 NORTH CLEVELAND ROAD  
LEXINGTON, KY 40516

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(X5)  
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Continued review of Resident #3's medical record revealed a signed and witnessed EMS DNR Form, dated 09/13/15. Continued review revealed the resident had an Advance Directive as DNR; however, there was no documented evidence of a Physician's Order for DNR.

Interview, on 12/17/15 at 2:35 PM, with Resident #3's son, revealed the family discussed with the Advanced Practice Registered Nurse (APRN) the families wishes to have no aggressive treatment for the resident as they desired Palliative care.

3. Review of Resident #4's clinical record revealed the facility admitted the resident on 08/18/14 with diagnoses including Dementia with Behavior Disturbance, Diabetes Mellitus, Chronic Anemia, Hypertension, Congestive Heart Failure, and Chronic Kidney Disease. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 11/17/15, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of zero (0) out of fifteen (15), indicating the resident was severely cognitively impaired.

Further review of Resident #4's clinical record revealed a signed and witnessed EMS DNR Form, dated 08/18/14. Continued review revealed the resident had an Advance Directive as DNR; however there was no documented evidence of a Physician's Order for DNR.

4. Review of Resident #5's clinical record revealed Resident #5 was admitted to the facility on 01/01/78 with diagnoses which included Status Post Head Injury with Secondary Epilepsy, Cerebral Palsy, and Spastic Quadripareisis. Further review of the clinical record revealed a

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(X3) DATE SURVEY  
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185322

B. WING

12/17/2015

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DEFICIENCY)

(X5)  
COMPLETE  
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F 155 Continued From page 4  
EMS/DNR Form signed and dated 05/29/08;  
however, there was no documented evidence of a  
Physician's Order for DNR.

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5. Review of Resident #7's clinical record  
revealed the facility admitted the resident on  
06/03/14 with diagnoses which included  
Hyperlipidaemia, Memory Loss, and Recurrent  
Urinary Tract Infection. Review of the Quarterly  
MDS Assessment dated 12/03/15, revealed the  
facility assessed the resident to have a Brief  
Interview for Mental Status (BIMS) of a one (1)  
revealing Resident #7 to be severely cognitively  
impaired.

Continued review of Resident #7's clinical record  
revealed a signed and witnessed EMS DNR  
Form, dated 06/03/14. Further review of the  
clinical record revealed the resident had an  
Advance Directive as DNR; however, there was  
no documented evidence of a Physician's Order  
for DNR.

Review of the signed Resident Self Determination  
Directives Form dated 06/03/14, included  
instructions for antibiotics, intravenous infusions,  
nutrition by artificial means for short-term use and  
hospitalization; however, the Form did not include  
the resident's code status

5. Review of Resident #10's closed clinical  
revealed the resident was admitted on 01/05/15  
with diagnoses to include Dementia,  
Hypertension, Depression, Anxiety, Osteoarthritis,  
Atrial-Fibrillation, Chronic Pain, and Debility.  
Further review revealed the resident expired on  
11/29/15.

Continued review of Resident #10's closed

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clinical record revealed a signed and witnessed EMS/DNR Form dated 11/27/15; however, there was no documented evidence of a Physician's Order for a DNR

7. Review of Resident #2's clinical record revealed the facility admitted the resident on 06/05/15 with diagnoses that included Advanced Alzheimer's Disease with Behavior Disturbance, Depression, Iron Deficiency Anemia, and Hypertension.

Review of the Quarterly Minimum Data Set (MDS) Assessment dated 10/06/15 revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of zero (0) out of fifteen (15), indicating the resident was severely cognitively impaired.

Further review of Resident #2's clinical record revealed the resident had a signed Resident Self Determination Directives Form dated 12/08/14; however, the Form did not include the code status. Further review revealed the resident had an Advance Directive as Full Code; however, there was no documented evidence of a Physician's Order for code status.

8. Review of Resident #8's clinical record revealed the facility admitted the resident on 01/14/14 with diagnoses including Multiple Sclerosis.

Review of the Quarterly Minimum Data Set (MDS) Assessment dated 10/01/15, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of one (1) out of fifteen (15), indicating the resident was severely cognitively impaired.

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Further review of Resident #8's clinical record revealed the resident had a signed Resident Self Determination Directives Form dated 01/14/14; however, the Form did not include the resident's code status. Review of the residents Advance Directive revealed the resident's status was Full Code; however, there was no documented evidence of a Physician's Order for code status.

9 Review of Resident #9's clinical record revealed the facility admitted Resident #9 to the facility on 09/07/14 with diagnoses which included Dementia, Hypertension, and Rheumatoid Arthritis. Further review of the clinical record revealed a Resident Self-Determination Directives Form, dated 10/09/14; however, the Form did not include information related to code status. There was no documented evidence of a Physician's Order for code status.

Interview, on 12/17/15 at 10:00 AM, with State Registered Nurse Aide (SRNA) #4, revealed residents who were a DNR had a red dot on the outside of their door. Further interview revealed no dot on the door meant the resident was a Full Code.

Interview, on 12/17/15 at 1:23 PM, with SRNA # 5, revealed residents who were a DNR had a red dot on the outside of their door. Further interview revealed she did not know what mechanism was in place for residents who were a Full Code.

Interview, on 12/15/15 at 8:50 AM, with Licensed Practical Nurse (LPN) # 1, revealed the facility did not have a Physician's Order for code status for residents with a DNR status because the facility's DNR policy stated the EMS/DNR Form was the order for DNR. Further interview with

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LPN #1, revealed the EMS/DNR Form was not sent to the physician by the facility for signature, and the Form did not have a designated section for physician signature. LPN # 1 revealed all residents electing a Full Code status would complete the facility's "Resident Self Determination Directives" Form on admission and the form was then placed in the residents clinical record. However, further interview with LPN # 1, revealed she was not aware the Form did not cover code status.

Interview with the Director of Nursing on 12/17/15 at 2:30 PM revealed a red dot was placed on resident doors and charts to indicate residents were DNR code status. She further stated, upon admission, facility process was to review Advance Directives with residents and families and complete a EMS/DNR and/or a Self-Determination Directives Form if they so desired. The DON revealed she was not aware of the requirement for signed Physician's Orders for Advance Directives.

Interview, on 12/17/15 at 2:57 PM, with the Assistant Administrator (AA), revealed residents who were DNR status had a red dot on their doors and charts. She stated, their process was to educate residents and families on Advance Directives upon admission and to complete a EMS/DNR Form and/or a Self-Determination Directives Form. She stated, the facility used the EMS/DNR Form for all residents who had elected a DNR Advance Directive, and she was unaware the Form was not a Physician's Order. Continued interview with the AA revealed she was unaware the facility's Self Determination Directives Form did not address code status for residents electing a Full Code status.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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<p>F 280 483.20(a)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility's policies, it was determined the facility failed to ensure the resident's Comprehensive Plan of Care was revised to include the resident's desired code status for six (6) of ten (10) sampled residents (Resident #2, #3, #4, #7, #8, and #10)</p> <p>Record review revealed, four (4) sampled residents (Residents #3, #4, #7, and #10), had signed and witnessed "Emergency Medical Services" (EMS), "Do Not Resuscitate" (DNR) Forms. However, there was no documented</p>	<p>F 280 F280</p> <p><b>Immediate Corrective Action:</b></p> <p>A review of all resident care plans was completed by the QA Director on 12/17/20 and began on 12-17-15 to reflect code status per physician's order. Plan of care for residents #3, #4, #7, #10 were updated by the QA Director on 12-17-15 to reflect their DNR Code Status as noted by physician's order. Plan of care for resident #2 was updated as DNR code status by the QA Director on 12-18-15 by the order written by the NP on the same date. Resident #10 had order written by the NP on 12-18-15 for Full Code and the POC was updated by the QA Director on 12-18-15 to reflect code status as ordered.</p>
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evidence these (4) residents Care Plans were revised to reflect their DNR Code Status.

Further record review revealed, two (2) sampled residents (Residents #2, and #8) had Advance Directives indicating the resident's code status was Full Code; however, there was no documented evidence these two (2) resident's Care Plans were revised to reflect their Full Code Status.

The findings include:

Review of the facility policy titled " Care Plan Update Policy and Procedure " effective 12/15/14, revealed all charge staff including Registered Nurses (RN) and Licensed Practical Nurses (LPN) should ensure consistent efforts to review and update resident Care Plans. Further review revealed each Plan of Care would have a Care Plan Update Form placed with it, and changes were be entered as they occurred. Per Policy, this process was mandated as part of the daily duties and was to be completed when entering Weekly Notes and Skin Reviews. The Policy stated, reviews would continue Quarterly, Annually and with Significant Change Assessments.

1. Review of Resident #3's medical record revealed the facility admitted the resident on 08/10/15 with diagnoses which included Urinary Retention, Depression, Dementia and Diabetes. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 11/11/15, revealed the facility assessed Resident #3 to have a Brief Interview for Mental Status (BIMS) of a ninety-nine (99), indicating the resident could not complete the interview, revealing Resident #3 to

F 280 **Other Residents Potentially Affected:**

All residents have the potential for Negative outcomes when the Comprehensive Care Plan is not revised and updated to reflect The residents desired code status.

**Systemic Changes:** All nursing staff (RN/LPN) were instructed of the requirement to add the resident code status to all resident care plans by the DON and Asst. Adm. at a mandatory meeting on 12-21-15 (see addendum). Facility Policy and Procedure for Code Status was revised to reflect the requirement for the nursing staff (RN/LPN) to assure that code status was included in the plan of care. All nursing staff were required to review and acknowledge understanding of this requirement when P&P was revised and updated on 01-05-16. The policy was added to the facility P&P Manual as well as the nursing Communication Book for review and awareness of requirement by all Nursing and Agency staff.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/17/2015
NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516	
(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 280	<p>Continued From page 10 be severely cognitively impaired.</p> <p>Continued review of Resident #3's medical record revealed a signed and witnessed EMS DNR Form, dated 09/13/15. In addition, there was a Advance Directive as DNR; however, there was no documented evidence of a Care Plan related to the resident's DNR code status.</p> <p>2. Review of Resident #4's medical record revealed the facility admitted the resident on 08/18/14 with diagnoses including Dementia with Behavior Disturbance, Diabetes Mellitus, Chronic Anemia, Hypertension, Congestive Heart Failure, and Chronic Kidney Disease. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 11/17/15, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of zero (0) out of fifteen (15), indicating severe cognitive impairment.</p> <p>Further review of Resident #4's medical record revealed a signed and witnessed EMS DNR Form, dated 08/18/14. Continued review revealed the resident had an Advance Directive as DNR; however there was no documented evidence of a Care Plan related to the residents DNR code status.</p> <p>3. Review of Resident #7's medical record revealed the facility admitted the resident on 06/03/14 with diagnoses which included Hyperlipidemia, Memory Loss, and Recurrent Urinary Tract Infection. Review of the Quarterly MDS Assessment dated 12/03/15, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) of a one (1) revealing the resident was severely cognitively impaired.</p>	F 280	<p><b>Monitoring:</b> Will be maintained By the Don and Weekly review of all residents care plans. The "Comprehensive Care Plan" review form has been updated (see addendum) to specify review of code status. Results of review will be submitted at QA meetings monthly by the DON to the disciplinary team.</p> <p><b>'Completion Date' 01-06-16</b></p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/17/2015
NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516	

(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)
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F 280 Continued From page 11 F 280

Continued review of Resident #7's medical record revealed a signed and witnessed EMS DNR Form, dated 06/03/14. Further review of the clinical record revealed the resident had an Advance Directive as DNR; however, there was no documented evidence of Care Plan related to the resident's DNR code status.

4. Review of Resident #10's closed medical record revealed the facility admitted the resident on 01/05/15 with diagnoses to include Dementia, Hypertension, Depression, Anxiety, Osteoarthritis, Chronic Pain, and Deolity. Further review revealed the resident expired on 11/29/15.

Continued review of Resident #10's closed medical record revealed the resident had a signed and witnessed EMS/DNR Form dated 11/27/15; however, there was no documented evidence of a Care Plan related to the resident's DNR status.

5. Review of Resident #2's medical record revealed the facility admitted the resident on 06/05/15 with diagnoses including Advanced Alzheimer's Disease with Behavior Disturbance, Depression, Iron Deficiency Anemia, and Hypertension. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 10/06/15 revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of zero (0) out of fifteen (15), indicating severe cognitive impairment.

Further review of Resident #2's clinical record revealed the resident had a an Advance Directive as Full Code; however, there was no documented evidence of a Care Plan related to code status.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/17/2015
NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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F 280 Continued From page 12

F 280

6. Review of Resident #8's medical record revealed the facility admitted the resident on 01/14/14 with diagnoses including Multiple Sclerosis.

Review of the Quarterly Minimum Data Set (MDS) Assessment dated 10/01/15, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of one (1) out of fifteen (15), indicating severe cognitive impairment.

Further review of Resident #8's medical record revealed the resident had a Advance Directive revealing the resident's code status was Full Code; however, there was no documented evidence of a Care Plan related to code status.

Interview with the Director of Nursing on 12/17/15 at 2:30 PM revealed she was unaware code status needed to be care planned and agreed the resident's care plans needed to be revised to include code status.

Interview, on 12/17/15 at 2:57 PM, with the Assistant Administrator (AA), revealed the facility was unaware code status needed to be care planned; however, stated all resident care plans should include information related to the resident's Advance Directive.

F 282 483.20(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.

F 282

**Immediate Corrective Action:** Resident #3 was weighed by the DON and QA Director on 12-16-15 with a weight of 78.7 noted which was a 2.7 lb increase from the previous week. A mandatory meeting for all nursing staff (RN, LPN, SRNA) was held on 12-21-15 and instruction given on weekly wt requirements and pending policy updates to specify staff efforts and reporting requirements (see addendum).

F 282

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/17/2015
NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516	

(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) COMPLETE DATE
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F 282	<p>Continued From page 13</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 ensure interventions on Comprehensive Care Plans were implemented related to weight loss, for one (1) of ten (10) sampled residents (Resident #3).</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Topic Weight Loss Program" undated, revealed there was at times events that contributed to weight loss (illness, fluid retention, loss of family member) and staff may need to repeat the weight after two (two) weeks observation. Further review revealed if weight loss was unexpected, weight loss monitoring was required.</p> <p>Review of the facility's policy titled "Resident Care Plan" undated, revealed the licensed nurse must review the resident care plan each time an order was received from a physician to determine if an entry was needed.</p> <p>Review of Resident #3's medical record revealed the facility admitted the resident on 08/10/15 with diagnoses which included Urinary Retention, Depression, Dementia and Diabetes.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 11/11/15, revealed the resident's Brief Interview for Mental Status (BIMS) was a ninety-nine (99) indicating the resident was unable to complete the interview and was severely cognitively impaired.</p>	F 282	<p><b>Other Residents Potentially Affected:</b></p> <p>A review of all care plans was completed by the QA Director and DON from 12-16-15 thru 12-21-14 to assure weight as specified by the care plan All residents have the potential for negative outcomes when efforts for quality care are not implemented as specified per the Comprehensive Care Plan.</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/17/2015
NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516	
(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)  DATE OF COMPLETION
F 282	<p>Continued From page 14</p> <p>Review of the Physician Progress Note dated 08/23/15, revealed Resident #3 was under palliative care. Continued review of the Note dated 10/02/15, revealed Resident #3 had abnormal weight loss, was a Do Not Resuscitate (DNR) code status, and was under palliative care.</p> <p>Review of the Physician/Prescriber Telephone Orders dated 09/22/15, revealed an order for a weight every two (2) weeks.</p> <p>Review of the Comprehensive Care Plan dated 08/19/15, revealed Resident #3 had a nutritional deficit due to poor intake and was presently under weight. The goal stated the resident would receive adequate by mouth intake as evidenced by no weight loss. The approaches included a diet change from regular to pureed diet with staff to feed the resident, and House Supplement Shakes with all meals with all medication pass. Continued review of the Care Plan revealed on 09/22/15, there were new approaches added which included weights every two (2) weeks and Remeron (antidepressant medication used to increase appetite) fifteen (15) milligrams (mg's) per mouth at night.</p> <p>Review of the Record of Vital Signs and Weight Log revealed a weight dated 10/01/15, reflecting a weight of eight one (81) pounds.</p> <p>Review of the Weekly Weight Sheet revealed the next recorded weight was dated 10/28/15, over three (3) weeks later, reflecting a weight of 75.6 pounds which was a weight loss of 5.4 pounds.</p> <p>Telephone interview, on 12/17/15 at 11:10 AM, with Advanced Practice Registered Nurse (APRN), revealed she spoke with the family</p>	F 282	<p><b>Systemic Changes:</b> Education of staff for weekly weight requirements were provided by the DON on 12/21/15. A complete revision of "Weight Loss Prevention and Monitoring" policy and procedure was implemented (see addendum) on 01-05-16 by the QA Director and posted on the staff bulletin board for review by all direct care (SRNA) staff. Charge Staff (RN/LPN) were educated on following the care plan by the DON at the mandatory nurses meeting on 12/21/15 (see addendum) The policy was signed to acknowledge awareness by charge staff (RN/LPN) on 01/05/16 (see addendum).</p>

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NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516
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F 282 Continued From page 15  
regarding Resident #3's care and she was informed by the family they wanted Palliative care for their family member. Continued interview with APRN, revealed the family requested no tube feeding, labs or other invasive procedures. Further interview revealed the family, however, was in agreement with weight monitoring.

Interview, on 12/17/15 at 2:35 PM, with Resident #3's son revealed, the family discussed with the APRN, they did not want any aggressive treatment for the resident, and especially did not want a tube for feeding. Continued interview revealed the family was supportive of Resident #3 to be weighed as ordered by the APRN/Physician. Further interview revealed they wanted to see if the current interventions that were already in place was effective to prevent further weight loss.

Interview, on 12/17/15 at 2:50 PM, with Licensed Practical Nurse (LPN) #1, revealed the SRNA's were responsible for obtaining the weekly and every two (2) week weights and reported abnormal weights to the Director of Nurses (DON). Continued interview, revealed Resident #3 had a significant weight loss and by not having the weights obtained every two (2) weeks as ordered could have interfered with his/her plan of care.

Interview, on 12/17/15 at 2:58 PM, with the Director of Nursing (DON), revealed it was her expectation for staff to obtain the resident's weights as per Physician's Orders and as per Care Plan. Further interview revealed she was not sure why the weights were missed. Continued interview revealed, by not following the Care Plan, the facility could have missed a significant weight loss.

F 282

**Monitoring:** Will be maintained by the DON weekly who will note results for those on weekly weights in the residents record. Review of all care plans weekly will assure compliance with weights per MD orders. A report of review will be submitted at QA meetings monthly.

**'Completion Date'** 01-06-16

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/17/2015
NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

F 431

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced

F 431

**Immediate Corrective Action:**

The Licensed Practical Nurse (LPN) responsible for leaving the med cart unlocked and unattended was given disciplinary counseling by the DON and Asst. Adm. on 12-17-15. A mandatory meeting was held 12-21-15 for all charge staff (RN/LPN) by the DON and Asst. Adm. staff were given review of "Medication Storage" and safety requirements and informed failure to comply would result in disciplinary action and/or termination as deemed appropriate by the Asst. Adm. (see addendum).

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/17/2016
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NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516
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F 431	<p>Continued From page 17</p> <p>by: Based on observation, interview, record review and a review of the facility's policy, it was determined the facility failed to ensure proper storage of drugs and biologicals.</p> <p>The Medication cart for the long hall was observed to be unlocked and unattended by staff with medication on top of the cart on 12/15/15 for a period of four (4) minutes. This had the potential to affect two (2) of ten (10) sampled residents (Resident #4 and #7) and nine (9) unsampled residents (Unsampled Residents B,C,D,E,F,G,H, and I).</p> <p>The findings include:</p> <p>Review of the facility's policy "Medication Storage in the Facility" undated, revealed Medication rooms, carts and medication supplies were to be locked or attended by staff with authorized access.</p> <p>Review of the Daily Verification of Wander Guard Alarm Placement List, undated, revealed Resident #4, #7, and Unsampled Residents B, C, D, E, F, G, H and I were on the list for having a Wander Guard.</p> <p>Observation on 12/15/15 at 5:07 AM on the Long Hall, revealed a medication cart was unlocked and unattended. Continued observation revealed a medication cup containing one (1) pill and four (4) vials of Insulin in a tray were on top of the medication cart. Further observation revealed Licensed Practical Nurse (LPN) #2 was observed in the front of the building at the nurse's station, and did not return to the Long Hall until 5:11 AM, four (4) minutes later.</p>	F 431	<p><b>Other Residents Potentially Affected:</b> All residents have the potential for negative outcomes when staff do not assure that they follow required procedures for medication storage.</p> <p><b>Systemic Changes:</b> A monitoring tool was developed (see addendum) to reflect review by all disciplinary members (DON, Asst. Adm., QA Coord., SS, FSS) of the status of the med cart and assure that charge staff (RN/LPN) are maintaining proper storage protocol. This "Medication Storage" procedure remains as a required review by all new hires and agency staff and is posted in the Nursing Communication Book.</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/17/2015
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NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516
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F 431	<p>Continued From page 18</p> <p>Interview, on 12/15/15 at 5:55 AM, with LPN #2, revealed she had gone to the front of the building to answer the door and make a call at the nurse's station and had left the medication cart unlocked and unattended and left medication on top of the cart. Further interview revealed she should have ensured all medication was locked inside the cart before leaving the cart to go to the front of the building. LPN #2 revealed by not ensuring the medication cart was locked when unattended, she placed the residents at risk for possibly obtaining medication without staffs knowledge.</p> <p>Interview, on 12/17/15 at 1:50 PM, with LPN #1/Unit Manager/Quality Assurance Nurse, revealed Residents #4, #7, and Unsampled Residents B, D, E, F, G, and H, were cognitively impaired and moved throughout the facility independently with a rolling walker or in their wheel chairs. Further interview revealed Resident #4, Resident #7, Unsampled D, and Unsampled Resident H were residents on the Long hall where the medication cart was left unlocked and unattended. Continued interview revealed the facility had orientation that covered the medication cart and she expected nurses to follow policy and procedure pertaining to medication proper storage of medication. Further interview, revealed nurses were never to leave the Medication cart unlock and leave any type of medication on top of the cart, stating the facility had wandering residents.</p> <p>Interview, on 12/17/15 at 2:50 PM, with the Director of Nurses (DON), revealed she expected all nurses to follow policy and they were never to leave their medication cart unlocked or leave medication on top of the cart.. Continued</p>	F 431	<p><b>Monitoring:</b> The QA Director will</p> <p>Continue to check the med room weekly</p> <p>For dates on multi dose meds/vials and Pharmacy station reviews are done monthly to check for proper dates and expiration dates as well as proper storage . Monitoring will also</p> <p>Will be maintained</p> <p>by the QA team and review of the observation reports at monthly QA meetings which will continue for an indefinite time period until compliance is assured and maintained.</p> <p>Completion Date 01/06/16</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/17/2015
NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 431	Continued From page 19 interview, revealed the facility had wandering residents and this placed the residents at risk.	F 431	
F 441 SS=0	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	<b>Immediate Corrective Action:</b> Disciplinary counseling was given to Licensed Practical Nurse (LPN) on 12-17-15 by the DON and Asst. Adm. A mandatory meeting was held on 12-21-15 (see addendum) for all charge staff (RN/LPN) by the Don and Asst. Adm. to instruct of mandated infection control efforts in regards to cleaning and disinfecting glucometer between residents. Staff were informed that non-compliance would result in immediate disciplinary action.  <b>Other Residents Potentially Affected:</b> All residents are at risk for negative outcomes when the facility does not assure that staff observe/maintain procedures set forth to prevent the spread of infection.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/17/2015
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NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516
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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)
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F 441	<p>Continued From page 20 infection.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to maintain an effective Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for one (1) of ten (10) sampled residents (Resident #4) and one (1) Unsampled Resident (Unsampled Resident A).</p> <p>Observation during medication pass, revealed a staff member obtained a fingerstick blood sugar on Resident #4, then without cleaning and disinfecting the glucometer proceeded to obtain a fingerstick blood sugar on Unsampled Resident A.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Infection Control Requirements for Blood Glucose Monitoring" dated 12/02/09, revealed blood glucose meters needed to be cleaned and disinfected after each use for individual resident care.</p> <p>Observation during medication pass, on 12/15/15 at 5:12 AM, revealed Licensed Practical Nurse (LPN) #2 was observed to use the glucometer to obtain a fingerstick blood sugar on Resident #4, and then place the glucometer on top of the</p>	F 441	<p><b>Systemic Changes:</b> The QA Director Updated the facility P&amp;P for blood glucose monitoring on 01-05-16 (see addendum) the revision specifies the required process to prevent the potential spread of bloodborne pathogens. All charge staff (RN/LPN) were required to sign a copy of the revision on 01-05-16 (see addendum). Education for disinfecting the glucometer was provided at the mandatory meeting on 12-21-15. The policy was added to the P&amp;P Manuel as well as the Nursing Comm. Book for review by all new hires and agency staff.</p>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2015  
FORM APPROX  
OMB NO. 0938-C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/17/2015
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NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516
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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) COMPLETE DATE
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F 441 Continued From page 21  
medication cart. LPN #2 then picked up the glucometer and proceeded to Unsampled A's room and obtained a fingerstick blood sugar for Unsampled Resident A. LPN #2 failed to clean and disinfect the glucometer after obtaining the fingerstick blood sugar on Resident #4, and before obtaining the fingerstick blood sugar on Unsampled Resident A.

Interview with LPN #2, on 12/15/15 at 5:55 AM, revealed she had to clean the glucometer at her other job, but she had not cleaned the glucometers at this facility. Continued interview with LPN#2, revealed she should have cleaned the glucometer to prevent passing germs from resident to resident.

Interview with LPN #1/Unit Manager on 12/17/15 at 1:50 PM, revealed, every nurse was expected to clean and disinfect the glucometer between residents and this information was reviewed during orientation. Continued interview with LPN #1, revealed this clearly was an infection control issue.

Interview with the Director of Nursing (DON), on 12/17/15 at 2:50 PM, revealed nurses were never to go from resident to resident using the glucometer without cleaning and disinfecting the glucometer between each resident. Continued interview with the DON, revealed she expected staff to follow the facility's policy with cleaning the meter using the Super Sani-Cloth Germicidal Disposable Wipes. Further interview revealed this was an infection control problem.

F 441 **Monitoring:** Will be maintained by the DON and QA Director during rounds daily with observation of staff routine. This observation will be for all shifts and be maintained indefinitely with disciplinary action required for failure to comply with infection control requirements. Report will be given to the QA team at meetings monthly.

**'Completion Date' 01-06-16**

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

PRINTED: 02/17/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185322</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>02/01/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ROSE MANOR HEALTH CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516</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	
{K 000}	INITIAL COMMENTS  Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 01/28/16 as alleged.	{K 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: 01/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185322	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING	(X3) DATE SURVEY COMPLETED  12/15/2015
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NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516
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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
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K 000	INITIAL COMMENTS  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One Story, Type III (211)  SMOKE COMPARTMENTS: Three  COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM originally installed.  FULLY SPRINKLERED, SUPERVISED (Dry SYSTEM) original  EMERGENCY POWER: Type II Diesel original  A life safety code survey was initiated and concluded on 12/15/15. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for thirty-four (34) beds and the census was thirty-three (33) on the day of the survey.  Deficiencies were cited with the highest deficiency identified at "E" level.	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD.  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Melissa Hester</i>	TITLE <i>Asst Administrator</i>	(X6) DATE <i>1-21-2016</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 01/06/2016  
FORM APPROVED  
OMB NO. 0938-0392

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185322	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING	(X3) DATE SURVEY COMPLETED  12/15/2015
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NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516
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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
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- K 018	<p>Continued From page 1</p> <p>minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of resident room doors located in the corridor. The deficiency had the potential to affect one (1) of three (3) smoke compartments, sixteen (16) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation on 12/15/17 at 3:43 PM, with the Maintenance Director, revealed a privacy curtain impeded the closing of the door for resident room #5 and a recliner was blocking the door from resident room #6 from closing. Interview, with the Maintenance Director, revealed he checked the doors monthly and had not noticed any problems with the doors closing before the survey.</p>	K 018	<p>K018</p> <p>The corrective action accomplished on 12-16-15 for residents in #5 was to ensure the privacy curtain was put in the bracket provided, to prevent the privacy curtain from impeding the door to close, in room #6 the chair was moved so it would not impede the door from closing.</p> <p>All residents have the potential to be affected when curtains and chairs block doors from closing.</p> <p>The systemic changes put into place was to instruct all staff on 12-21-16 to ensure all privacy curtains are placed correctly in provided brackets to hold them away from the door and make sure all furniture is placed in a position so that the door will close properly before they leave a residents room.</p> <p>Monitoring will be maintained by the Asst. Administrator and the Housekeeping Supervisor to ensure there are no impediments to the closing of resident doors. Findings will be reported weekly to Asst. Administrator and at monthly QA meetings.</p> <p>Completion Date 12-22-2015</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/06/2015  
FORM APPROVAL  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185322	(X2) MULTIPLE CONSTRUCTION: A. BUILDING 01 - MAIN BUILDING 01  B. WING	(X3) DATE SURVEY COMPLETED  12/15/2015
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NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516
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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
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K 018	<p>Continued From page 2</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 3/4-in (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than twenty (20) minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding one (1) inch (2.5 centimeters) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of five (5) lb (2.2 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in</p>	K 018		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/06/2016  
FORM APPROVED  
OMB NO. 0936-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185322	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  12/15/2015
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NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516
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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 DEFICENCY)	(X5) COMPLETION DATE
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K 018	Continued From page 3 buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2.  Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.  Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lb (22 N) shall be permitted to be kept in service.  19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted	K 018		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4 6.12, NFPA 13, NFPA 25, 9 7.5  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the automatic sprinkler system was maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, eighteen (18) residents, staff and visitors.  The findings include:	K 052	K 062 The corrective action was to contact Loorsen Fire & Safety to schedule a date to replace the corroded sprinkler heads. (Koorsen ordered the wrong sprinkler heads and had to reorder. They will be installed by 1-28-2016.)  All residents, visitors and staff have the potential to be affected if the sprinkler system is not maintained properly.  They systemic changes put into place is to instruct the Maintenance Supervisor and Dietary Manager to inspect the sprinkler heads monthly in the Dietary Department. Report all findings to the Asst. Administrator. The Asst. Administrator will notify Koorsen Fire & Security to replace any faulty sprinkler heads. The Maintenance Supervisor will inspect all other sprinkler heads in the facility monthly and report any faulty sprinkler heads to the Asst. Administrator.  Monitoring will be maintained by the Maintenance Supervisor and the Asst. Administrator. Both will inspect all sprinkler heads monthly and report at monthly QA meetings.  Completion Date 1-28-2016	

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

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OMB NO. 0938-036

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

185322

(X2) MULTIPLE CONSTRUCTION  
A. BUILDING 01 - MAIN BUILDING 01

B. WING

(X3) DATE SURVEY  
COMPLETED

12/15/2015

NAME OF PROVIDER OR SUPPLIER

ROSE MANOR HEALTH CARE

STREET ADDRESS, CITY, STATE, ZIP CODE

3057 NORTH CLEVELAND ROAD  
LEXINGTON, KY 40516

(X4) D  
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 062

Continued From page 4  
Observation on 12/15/15 at 3:29 PM, with the  
Maintenance Director, revealed four (4) corroded  
automatic sprinkler heads in the kitchen area.  
Interview, with the Maintenance Director, revealed  
an outside contractor had told the facility the  
corroded automatic sprinkler heads did not have  
to be changed.

K 062

The findings were acknowledged by the  
Administrator during the exit conference.

Reference: NFPA 25 ( 1998 Edition)

2-2.1.1\* Sprinklers shall be inspected from the  
floor level annually. Sprinklers shall be free of  
corrosion, foreign materials, paint, and physical  
damage and shall be installed in the proper  
orientation (e.g., upright, pendant, or sidewall).  
Any sprinkler shall be replaced that is painted,  
corroded, damaged, loaded, or in the improper  
orientation.

Exception No. 1\* Sprinklers installed in  
concealed spaces such as above suspended  
ceilings shall not require inspection.

Exception No. 2: Sprinklers installed in areas that  
are inaccessible for safety considerations due to  
process operations shall be inspected during  
each scheduled shutdown.

K 068  
SS=D

NFPA 101 LIFE SAFETY CODE STANDARD

K 068

Combustion and ventilation air for boiler,  
incinerator and heater rooms is taken from and  
discharged to the outside air. 19.5.2.2

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

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OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185322	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING	(X3) DATE SURVEY COMPLETED  12/15/2015
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NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516
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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
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K 068	<p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure fuel-fired heating devices were installed according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect all staff using the basement storage area.</p> <p>The findings include:</p> <p>Observation on 12/15/16 at 3:18 PM, with the Maintenance Director, revealed the fuel-fired water heater in the basement storage area did not take air for combustion directly from the outside. Interview, with the Maintenance Director, reveled it had always been this way and he did not see a need for it to be changed.</p> <p>NFPA 101 (2000 Edition)</p> <p>19.5.2.2* Any heating device, other than a central heating plant, shall be designed and installed so that combustible material cannot be ignited by the device or its appurtenances, and the following requirements also shall apply:</p> <p>(1) If fuel-fired, such heating devices shall comply with the following:</p> <p>(a) They shall be chimney connected or vent connected.</p> <p>(b) They shall take air for combustion directly from the outside.</p> <p>(c) They shall be designed and installed to provide for complete separation of the combustion system from the atmosphere of the</p>	K 068	<p>K 068</p> <p>The corrective action taken was to contact Plumbers on 12-18-2016 to obtain advice on how to solve the fresh air intake for the water heater.</p> <p>Staff working in the area near the water heater have the potential to be affected.</p> <p>The systemic changes was to install a fresh air intake vent to allow fresh air intake into the room where the water heater is located at all times.</p> <p>Monitoring of the fresh air vent will be maintained by the Maintenance Supervisor and reported at monthly QA Meetings.</p> <p>Completion 1-19-2016</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/06/2015  
FORM APPROVED  
OMB NO. 0938-0399

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185322	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  12/15/2015
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NAME OF PROVIDER OR SUPPLIER  ROSE MANOR HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3057 NORTH CLEVELAND ROAD LEXINGTON, KY 40516
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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
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K 068	Continued From page 6 occupied area.  (2) Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure.	K 068		
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