

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

PRINTED: 10/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2013
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004
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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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F 000	INITIAL COMMENTS A standard health survey was initiated on 09/24/13 and concluded on 09/26/13 with deficiencies cited at the highest scope and severity of an "E". A Life Safety Code Survey was conducted on 09/24/13 with deficiency cited at the highest scope and severity of an "F" with the facility having the opportunity to correct deficiencies before remedies would be recommended for imposition.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the	F 225	F225 1. R# 8's family reported missing ring and facility had already replaced. R#8 was assessed and no negative outcomes were noted. 2. All residents have the potential to be affected by the alleged deficient practice. All interviewable residents will be interviewed by the Social Services Director by 10/30/2013 to ensure they don't have any allegations of abuse including misappropriation or missing items. Any allegations of abuse will be reported according to the guideline and an investigation completed.	

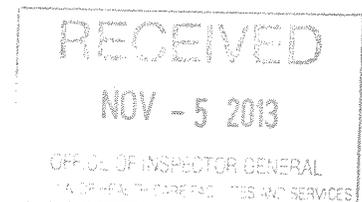
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Executive Dir* (X6) DATE *11/8/2013*

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

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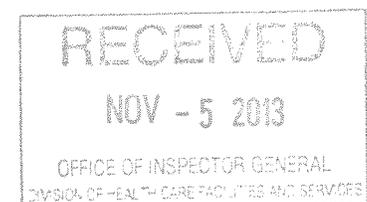
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F 225	<p>Continued From page 1 investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to report an allegation of misappropriation of property for one (1) of sixteen (16) sampled residents, Resident #8.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Protection of Residents: Reducing the Threat of Abuse and Neglect, dated 02/2009, revealed the staff were to report incidents of allegations of abuse to outside authorities such as the Health Department, Police, or Ombudsman (the Executive Director, Director of Nursing, or designee reports all incidents of alleged abuse to the required agencies).</p> <p>Record Review of Resident #8's clinical record, revealed the facility admitted the resident on 02/24/11, with a diagnosis of Senile Dementia with Depression. Review of Resident #8's Quarterly assessment, dated 07/16/13, revealed Resident #8 had a BIM score of three (3) which meant the resident was not interviewable.</p>	F 225	<p>3. Staff were reeducated on the Abuse Policy including proper reporting guidelines by the Director of Nursing and Assistant Director of Nursing on 09/27/13. Any staff that did not attend the initial inservice were reeducated by their individual department manager by 10/09/2013. The Assistant Director of Nursing educated the Nursing staff; The Dietary Manager educated the Dietary staff; The Housekeeping Director educated the Housekeeping Staff; The Director of Rehab educated the Therapy Department. The Regional Vice President educated the Executive Director on the Abuse Policy including proper reporting guidelines.</p> <p>The Executive Director will ensure any allegation of abuse is reported according to the guidelines. Any allegation of abuse will be reported to the Regional Vice President and/or Regional Nurse by the Executive Director, Director of Nursing or Social Services Director <i>within</i></p>		



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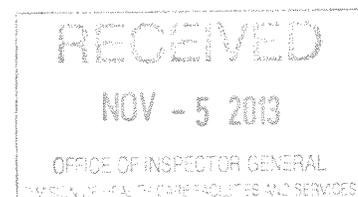
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F 225	<p>Continued From page 2</p> <p>Observation of Resident #8, on 09/24/13 at 3:50 PM, revealed Resident #8 was sitting in his/her wheelchair outside of his/her room playing with a ring located on the ring finger of his/her left hand.</p> <p>Interview with Resident #8's family, on 09/26/13 at 2:07 PM, revealed Resident #8 had a plain gold band that became missing about six (6) months ago. The family member stated he/she was aware of the gold band and that the gold band was replaced by the facility. The family member stated the Social Services Department assisted Resident #8 with this concern.</p> <p>Review of the Concern and Comment Form, dated 08/26/13, revealed the family member reported the ring missing. The investigation revealed the room was searched. All departments were notified of the missing gold ring. The form indicated the staff were to try to locate the ring, the ring was possibly swept away and often found on floor. Record review of the action taken, revealed the ring was replaced.</p> <p>Interview with Social Services, on, 09/26/13 at 2:27 PM, revealed she was not aware of Resident #8 having a ring. Resident #8 did report to her that his/her ring was missing. Social Services stated she called the family to confirm there was a ring. Social Services then stated she reported to the Administrator and started the process of investigating. She stated she also reported the item missing in the morning meeting. They then determined if the missing item was reportable and they kept a log of the items that came up missing. The ring was the only thing that had come up missing. Social Services stated she, the Administrator and Director of Nursing felt it was</p>	F 225	<p>one (1) hour of receiving the allegation. All reportable allegations will be thoroughly investigated by the Social Service Director, Director of Nursing and/or Executive Director. The Regional Vice President and/or Regional Nurse will review all grievances, including any allegations of abuse monthly for six months. The Regional Vice President and/or Regional Nurse will ensure that any Allegations of Abuse, including Misappropriation of Property have been properly reported according to guidelines.</p> <p>4. All grievances and allegations of abuse will be presented to the Performance Improvement Committee on-going monthly by the Executive Director or Social Services Director. The PI Committee consists of the Executive Director, Director of Nursing, Medical Director, MDS Coordinator 1, MDS Coordinator 2, Social Service Director, Business Office</p>	



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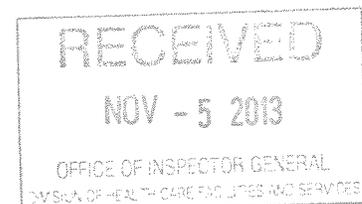
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F 225	Continued From page 3 not reportable because no one would steal, they know the staff and they were not like that. Social Services stated she was not sure though of what happened to the ring. Interview with the Director of Nursing (DON), on 09/26/13 at 3:17 PM, revealed she was aware of Resident #8's ring missing. Social Services Department completed all of the investigations. The DON stated the staff do come together to determine if the missing item was reportable. The DON stated she did not feel like it was an issue and did not think it was a concern of theft. The DON stated she had twenty-four hours to report an allegation of misappropriation of an item and agreed that the item should have been reported. Interview with the Administrator, on 09/26/13 at 2:50 PM, revealed he was familiar with Resident #8's missing ring. The Administrator stated the missing ring was not reported because he thought there was a chance that the ring was in laundry or that Resident #8 could have lost the ring. The Administrator stated he waited about three (3) weeks for the ring to turn up and then replaced the ring. The Administrator stated he did not think about the ring being a theft situation. The Administrator stated he had twenty-four hours to report things like abuse, mental abuse, physical abuse, unusual events like fire, power outage and misappropriation of property. The Administrator stated though he was not sure if the ring was stolen, he probably should have reported the allegation.	F 225	Manager, Maintenance Director, Housekeeping/Laundry Director, Health Information Manager, Admission Coordinator, Business Development Director, Activity Director, Director of Rehab and Assistant Director of Nursing to ensure allegations were reported timely and investigated. 5. Completion Date:	10/31/13	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a	F 241	F241: 1. R#4 was assessed and no negative outcomes noted. LPN#1 and LPN#2 were reeducated on 09/26/2013 regarding dignity and in particular on explanation of care while providing care by the Director of Nursing and Assistant Director of Nursing.		



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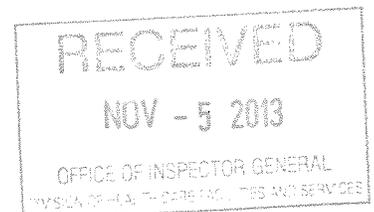
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F 241	<p>Continued From page 4</p> <p>manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to provide care in a manner to maintain dignity for one (1) of sixteen (16) sampled residents. Resident #4 received care and procedures without explanation of the procedures.</p> <p>The findings include:</p> <p>Review of the facility's policy of the Preservation of Residents' Rights, revised 06/17/08, revealed all associates are responsible for the preservation of residents' rights.</p> <p>Observation of Resident #4 during a skin assessment, on 09/25/13 at 9:25 AM, revealed Licensed Practical Nurse (LPN) #1 and LPN #2 provided a complete skin assessment, peri-care and a G-tube replacement without explaining each procedure prior to or during each procedure.</p> <p>Review of Resident #4's clinical record, revealed the facility readmitted the resident on 08/06/13, with diagnosis of Paralysis Agitans, Lack of Coordination, Lewy Body Dementia and Esophageal Reflux secondary to Parkinsonism. The Quarterly Minimum Data Set (MDS), dated 08/27/13, revealed the facility staff completed the assessment for mental status and determined the resident was severely impaired.</p>	F 241	<p>2. All residents have the potential to be affected by the alleged deficient practice. All other interviewable residents will be interviewed by the Social Services Director by 10/30/2013 to see if any other dignity and respect of individuality issues exist. Any issues noted will be immediately investigated, addressed and corrected by the Director of Nursing or Executive Director. The Resident Council Committee will be asked by the Social Services Director or Activity Director if any dignity and respect of individuality issues exist by 10/30/2013.</p> <p>3. All Nursing staff were reeducated by the DON and ADON on 10/09/2013 and 10/10/2013 regarding dignity and in particular explaining care while providing care. The DON and/or ADON will randomly monitor five instances of care being provided weekly. The monitoring will be conducted during care to ensure that staff</p>	



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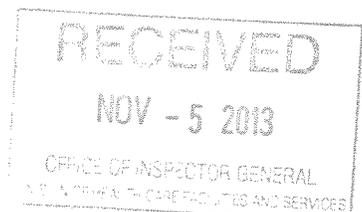
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F 241	Continued From page 5 Review of the incontinence care plan for Resident #4, dated 06/03/13, revealed his/her dignity would be maintained by reassurance during incontinent episodes. Review of the inservice, One Step Beyond, Customer Service, dated 08/2013, revealed LPN #2 signed the attendance record; however, LPN #1 was not signed in for attendance. Interview with Licensed Practical Nurse (LPN) #1 and LPN #2, upon completion of the skin assessment, peri-care and G-tube replacement, on 09/25/13 at 10:41 AM, revealed any procedures provided to the residents were to be explained before the procedure or care was provided. LPN #1 and LPN #2 stated they were trained on resident rights and dignity and Resident #4 should have received an explanation of each care and procedure provided before it was done. Interview with the Director of Nurses (DON) and the Assistant Director of Nurse (ADON), on 09/26/13 at 2:45 PM, revealed the residents were to be treated with respect, staff were to be polite and courteous. These areas were included in the resident rights along with treating the resident with dignity. The residents are to be put first. The ADON reported there was training provided to the staff in One Step Beyond, Customer Service that pertained to dignity and resident rights.	F 241	are explaining care prior to providing the actual care. On-Going education will continue including the Ombudsman. 4. All audits or issues will be presented to the Performance Improvement Committee monthly for six months for recommendations and compliance. 5. Completion Date:	10/31/13
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a	F 253	F253: 1. There weren't any individual residents identified in the Statement of Deficiencies. The Pepsi Cola Vending Machine,	



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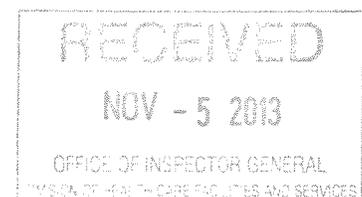
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F 253	Continued From page 6 sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy Environmental Services, it was determined the facility failed to maintain a sanitary environment in one (1) of one (1) facility dining rooms. The findings include: Review of the facility's policy Environmental Services, not dated, revealed Environmental Services ensured overall cleanliness of the facility and maintained order and safety for residents, families and staff. Observation of the dining room, on 09/24/13 at 12:27 PM, revealed four (4) of the four (4) windowsills in the restorative dining area with cobwebs containing insects and a thick buildup of a black and brown debris. The baseboard was ripped away from the wall under the air conditioning unit revealing a thick black substance and debris. Two (2) of the two (2) air vents and two (2) of the two (2) return vents were caked with brown fuzzy particles and debris. A Pepsi Cola vending machine with signage reading out of order was parked against the dining room wall with a thick layer of brown fuzzy particles and debris on top. A bug light on the wall had cobwebs extending all the way to the vending machine and contained multiple captured insects. Interview with Housekeeper #9, on 09/26/13 at 12:45 PM, revealed the dining room was swept and mopped three times a day after each meal.	F 253	<p>window seals, baseboards, air vents, return vents, and bug lights in the dining room were immediately cleaned on 9/24/2013 by Housekeeping Staff.</p> <p>2. All residents have the potential to be affected by the alleged deficient practice. All other resident areas were checked and any items of concern were addressed and appropriately cleaned by the Housekeeping Staff and/or Director of Environmental Services.</p> <p>3. The Director of Environmental Services met with the Housekeeping staff on 10/08/2013 and has provided them with check lists to adhere to during daily assignments. The Director of Environmental Services will review the checklists and randomly audit on a weekly basis. The Housekeeping staff were reeducated on 10/08/2013 regarding cleaning schedules by the Director of Environmental Services and importance of addressing cleaning needs.</p>		



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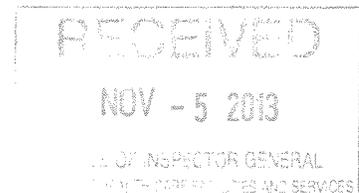
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F 253	Continued From page 7 The Housekeeper revealed windowsills and light dusting was completed once a month. Interview with the Director of Maintenance, on 09/26/13 at 1:50 PM, revealed the Pepsi vending machine was placed in the dining room while the staff lounge was being remodeled. However, the Director of Maintenance revealed the vending machine was no longer going to be used and had been sitting in the dining room for a month. Interview with the Director of Environmental Services, on 09/26/13 at 1:50 PM, revealed the Pepsi Machine was dirty and should be included with routine cleaning due to the potential for dust and cobwebs to blow debris in food. The Director of Environmental Services revealed the vents were dirty, but did not know if they could be removed for cleaning and were only being lightly dusted to remove debris. The Director of Environmental Services revealed windowsill were dirty and should be cleaned routinely. The Director of Environmental Services revealed she did round routinely to ensure cleanliness, but admits some area were overlooked.	F 253	The department managers have room assignments to check on a daily basis. The Department Managers were reeducated on 09/27/2013 to ensuring cleanliness and sanitary environment are monitored during daily rounds. All cleaning concerns will be discussed in the daily morning meetings, documented on the daily meeting minutes and immediately addressed. 4. Any issues will be presented to The Performance Improvement Committee and will provide recommendations and adherence to compliance. The Performance Improvement Committee will review monthly for six months. 5. Completion Date:	10/30/13	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	F309: 1. R#A had no negative affect from the noted deficient practice from not following proper technique. R#4 had no negative affect or outcome from the noted deficient practice from not following proper technique. R#10 was immediately offered		



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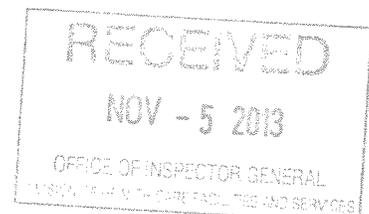
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F 309	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of the facility's policies Medication Administration, Shower, and Gastrostomy and Jejunostomy Tubes, it was determined the facility failed to provide the necessary care and services to maintain the highest practicable physical, mental, and psychosocial well-being for two (2) of the sixteen (16) sampled and one (1) of the one (1) unsampled residents (Resident # 4, 10, and unsampled A) LPN #1 failed to take Unsampled Resident A's apical pulse prior to administration of the medication Digoxin. LPN #1 administered a dose of Digoxin crushed and mixed with four (4) other medications to Unsampled Resident A. LPN #1 used improper technique reinserting a gastrostomy feeding tube on Resident #4. The staff failed to provide Resident #10 their scheduled shower for a week, despite requesting the shower from staff.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility's policy Shower, not dated, revealed the purpose of a shower was to provide cleanliness and comfort to the resident, prevent body odors, and allow the opportunity to observe the resident's skin condition. Resident #10, revealed the facility admitted the resident on 09/27/10, with diagnosis of a Seizure Disorder, Bipolar Disease, and Degenerative Disc Disease. The facility assessed the resident utilizing the Minimum Data Set (MDS), on 07/30/13, as having a Brief Interview for Mental Status (BIMS) of 14 indicating the resident was cognitively intact and required limited assistance of a one-person assist with bathing, hygiene, and dressing. Review of the resident's 	F 309	<p>and given a shower on 9/26/2013.</p> <ol style="list-style-type: none"> 2. All residents have the potential to be affected by the alleged deficient practice. 3. The Pharmacy Consultant will be scheduled to follow LPN#1 on Med Pass by 11/07/2013 to ensure proper compliance. <p>The Unit Managers and/or Assistant Director of Nursing will observe four med passes weekly for one month; three med passes the second month and two med pass weekly the third month.</p> <p>All new Nurse hires will be followed two times during their 90 day initial review period.</p> <p>All nursing staff were reeducated on proper pulse check and proper checking of g-tube placement by the Director of Nursing and Assistant Director of Nursing on 10/09/2013.</p>		



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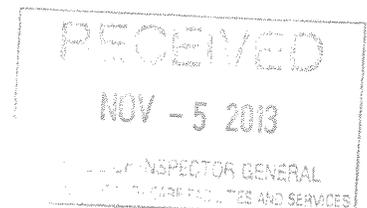
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2013
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004		
(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 309	<p>Continued From page 9</p> <p>comprehensive plan of care revealed the resident required assistance with hygiene and would have assist of 1 person to help groom and bath as needed.</p> <p>Observation of Resident #10, on 09/25/13 at 4:05 PM, revealed the resident had long facial and chin hairs. Concurrent interview revealed the resident has had problems receiving showers and baths. The resident stated he/she should receive a shower twice a week, but usually only gets one (1) shower a week. The resident revealed he/she did not receive their scheduled shower on 09/24/13 and had it been a whole week since the last bath.</p> <p>Interview with Resident #10, on 09/26/13 at 10:30 AM, revealed the resident requested a shower after dinner on 09/25/13, but was told it was not his/her scheduled time and they had just received one a few days prior. The resident revealed despite informing staff the resident did not get their scheduled shower the resident was still not bathed.</p> <p>Review of the West Unit Shower Schedule revealed the resident was scheduled to receive showers on Tuesdays and Fridays during the day shift. The shower schedule revealed every resident was to go to the shower room for their shower and bed baths were not to be done unless directed by the charge nurse. All showers would have a pink shower slip completed with all skin issues marked, linen change marked, the resident's name, the Certified Nursing Assistance (CNA) name, date and signed off by the charge nurse. Review of the shower list for 09/24/13 revealed only two (2) of the six (6) resident's scheduled received their shower. Review of the</p>	F 309	<p>A schedule is implemented for resident showers. The Unit Manager and /or ADON will review shower schedules daily and shower slips will be turned into the unit managers daily and/or Assistant Director of Nursing to compare ensure residents are receiving assigned showers according to schedule.</p> <p>All nursing staff were reeducated by the Director of Nursing and Assistant Director of Nursing on 10/09/2013 and 10/10/2013 covering adhering to shower schedule and proper documentation upon giving showers.</p> <p>4. Information will be presented to the Performance Improvement Committee monthly for six months. The Performance Improvement Committee will make recommendations and review oversight of compliance.</p> <p>5. Completion Date:</p>	11/08/13	



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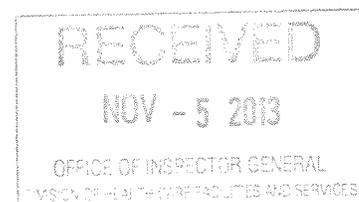
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F 309	<p>Continued From page 10</p> <p>charting for baths revealed Resident #10 had only received three (3) showers during the entire month of September.</p> <p>Interview with CNA #8, on 09/26/13 at 10:50 AM, revealed the CNA's document their baths/showers in the computer system and then the nurses go into the system at the end of the shift to sign off their charting, verifying that everything was done.</p> <p>Interview with CNA #5, on 09/26/13 at 1:35 PM, revealed she was Resident #10's assigned CNA on 09/24/13 and she did not give the resident their scheduled shower because time just got away from her. The CNA revealed she was supposed to fill out the communication form stating the resident did not receive their shower so the next shift could complete the assigned shower. The CNA revealed she did not fill out the communication form, but should have to ensure the next shift knew to add the resident to their list.</p> <p>Interview with Licensed Practical Nurse #1 (LPN), on 09/26/13 at 1:40 PM, revealed she was Resident #10's assigned nurse on 09/24/13. The LPN revealed the CNA's are supposed to document on the shower list communication form why a shower was not done and then the nurse signs off that form. The nurse revealed she did not remember if there was a form for that day. LPN #1 revealed she was not aware the resident had not received a shower for a week. However, LPN #1 revealed she did remember the resident telling her during his/her dressing change that it was not yet done, and she did not follow up and ensure the resident received their shower.</p> <p>Interview with the Director of Nursing (DON), on</p>	F 309			



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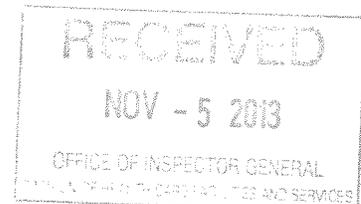
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F 309	<p>Continued From page 11</p> <p>09/26/13 at 3:15 PM, revealed she noticed showers were not being completed while reviewing the computer charting. The DON revealed the shower sheets were developed to help with communication to ensure the resident were being bathed and if not, why. However, the DON revealed getting showers completed was apparently an ongoing problem.</p> <p>2. Observation of Licensed Practical Nurse (LPN) #1, on 09/25/13 at 8:15 AM, revealed LPN #1 crushed Metoprolol (blood pressure) medication and placed in a separate medicine cup. Oxytab (pain medication), Donepazil, Prilosec (antacid medication), Lasix (water pill) and Digoxin (heart medication) were all placed together in another cup. LPN #1 was then observed to mix the medication with applesauce.</p> <p>Observation of LPN #1 administering the crushed medication to unsampled Resident #A, on 09/25/13 at 8:15 AM, revealed she obtained un-sampled Resident #A's vitals (which were within normal limits) and then administered the medication.</p> <p>Interview with LPN #1, on 09/26/13 at 10:22 AM, revealed she should not mixed the digoxin with the other medications because if the residents pulse was low she would have to discard all of the crushed medication. LPN #1 stated she should have taken the pulse first to ensure the pulse was appropriate before mixing with the other medications. LPN #1 stated she separated the metoprolol pill but thought since the resident's pulse was always appropriate she felt that it would be ok mixing the digoxin with the other medication. LPN #1 stated she knew things could change for residents and should have taken the pulse first before mixing the medication.</p>	F 309			



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F 309	Continued From page 12 Interview with LPN #2, on 09/26/13 at 10:29 AM, revealed if she was administering the digoxin medication she would want to take the pulse first before crushing the medication. If you crush the medication together and then took the vitals you would have to discard all the medication and this was not good practice. Interview with the Nurse Manager of the West Unit, on 09/26/13 at 10:32 AM, revealed staff should obtain vitals before giving medication. The Unit Manager stated if the nurse crushed the medication, mixed the drugs and found the pulse to be low, the nurse would have to discard all the medication and this would not be a good practice. The Unit Manager stated she monitors the medication pass every three (3) months and had not found any concerns with the medication pass. Interview with the Director of Nursing (DON), on 09/26/13 at 3:17 PM, revealed it was not a good idea to mix blood pressure medication and digoxin with other medications because if the pulse was low the nurse would have to discard all the medication. The DON stated she provides periodic training and pharmacy comes to the facility to do periodic medication checks. The DON stated she had not identified any concerns. 3. Review of the Medication Administration Policy, revised 10/04, revealed the apical pulse (obtained over the heart) was taken thirty (30) seconds (unless irregular) before administration of digoxin and are approximately written in the MAR. a. If apical pulse is irregular, take for 60 seconds. b. If apical pulse is less than fifty (50), notify physician. C. If apical pulse is less than sixty (60), digoxin is held unless specified by physician.	F 309			



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F 309	<p>Continued From page 13</p> <p>Observation of LPN #1, on 09/25/13 at 8:15 AM, revealed when she administered the digoxin medication to un-sampled Resident #A, she obtained a radial pulse (wrist pulse).</p> <p>Interview with LPN #1, on 09/26/13 at 10:22 AM, revealed she was nervous and new she was to take the apical pulse because the apical pulse was more accurate.</p> <p>Interview with the West Unit Manager, on 09/26/13 at 10:32 AM, revealed when administering digoxin you should always obtain an apical pulse because this ensures the accuracy of the pulse. If the pulse is too low you would not want to give the medication.</p> <p>Interview with the DON, on 09/26/13 at 3:17 PM, revealed when you administer digoxin you should obtain an apical pulse because if the pulse was low you do not want to give the medication. The apical pulse was more accurate then the radial pulse.</p> <p>4. Review of the facility's policy for Gastrostomy (G) and Jejunostomy (J) Tubes, revised 02/2011, revealed the G-Tube was used to supply nutrition and hydration to residents unable to take liquids or food by normal means. The procedure was to check for patency by inflating the balloon with ten (10) cc of sterile water prior to placement. After insertion, the five (5) cc G-tube balloon was to be inflated with three (3) cc sterile water, then pulled back gently until resistance was felt, then taped to the abdomen.</p> <p>Clinical record review of Resident #4, revealed</p>	F 309		

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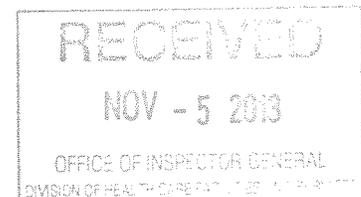
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DEPT. OF INSPECTOR GENERAL
HEALTH CARE FACILITIES AND SERVICES

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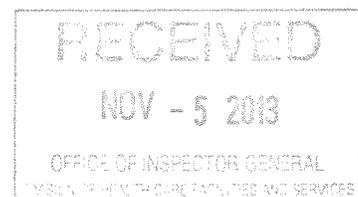
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F 309	Continued From page 14 he/she was admitted, on 3/1/07, with the diagnosis of Paralysis Agitans, Lack of Coordination, Lewy Body Dementia and Esophageal Reflux secondary to Parkinsonism. He/She was assessed for weight loss. The resident was identified with an unavoidable weight loss. Nutritional feedings were ordered by the physician for administration via the G-tube every eight (8) hours. Observation of Resident #4 and interview with Licensed Practical Nurse (LPN) #1 and LPN #2 during skin assessment with G-tube replacement, on 09/26/13 at 9:25 AM, revealed LPN #2 removed his/her shirt and the G-tube was not taped to the abdomen. LPN #1 and LPN #2 proceeded with the skin assessment and peri-care when LPN #1 stated, "look his/her G-tube is out." LPN #1 reported he/she was suppose to be wearing an abdominal binder to support the G-tube and maintain placement. LPN #1 stated this was an 18 French G-tube with a twenty (20) cc balloon. She continued with the insertion of the G-tube. She did not check for patency of the balloon prior to insertion. Observed LPN #1 insert twenty (20) cc of normal saline into the balloon followed by an abdominal binder placed. Interview with the Director of Nurses and the Assistant Director of Nurse, on 09/26/13 at 2:45 PM, stated the nurses should check for patency of the G-tube balloon prior to insertion to ensure proper functioning and security of the G-tube.	F 309			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441	F441: 1. R4 was assessed and no negative outcomes noted.		



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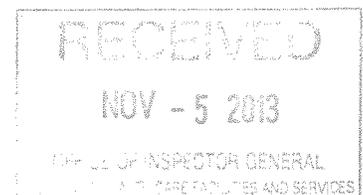
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F 441	Continued From page 15 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish 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 infection. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review,	F 441	2. All residents have the potential to be affected by the alleged deficient practice. 3. All nursing department staff were reeducated by the ADON and DON on 10/09/2013 and 10/10/2013 covering hand hygiene and peri-care procedures including proper hygiene after removing gloves. The Unit Managers and/or ADON will conduct six random audits weekly for twelve weeks to ensure that proper hand hygiene and peri-care is occurring. This will include all three nursing shifts. <i>Proper hand hygiene and peri-care procedures including proper hygiene after removing gloves education will be covered in each new employee orientation session.</i> <i>Continued observation of at least three (3) staff per week will continue on-going to ensure proper hand hygiene and peri-care is occurring. Observations will be conducted</i>		



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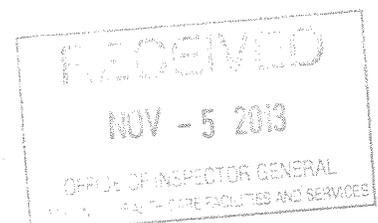
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F 441	<p>Continued From page 16</p> <p>interview and the facility's policy review, it was determined the facility failed to follow their infection control program for one (1) of sixteen (16) sampled resident and one (1) unsampled residents. Resident #4 received peri-care in a dirty to clean method and staff failed to practice hand hygiene upon removal of gloves.</p> <p>The findings include:</p> <p>Review of the Peri-Care Inservice, undated, revealed hands were to be washed before and after all glove changes. The inservice instructed staff not to cross contaminate. PeriCare procedure for the male patient was to clean in the front, pull back the foreskin and clean around the penis opening. Also, wipe the top of the penis down and front to back with a clean wipe for each area of the wipe for each swipe.</p> <p>Review of the Certified Nurse Aid/Nurse Orientation Infection Control, undated, revealed tips for peri-care was to never go back with the soiled cloth, always wipe front to back only, use the amount of wipes or cloths to maintain good technique.</p> <p>Observation of peri-care for Resident #4, on 09/25/13 at 9:25 AM, revealed Licensed Practical Nurse #1 obtained a container of water with wash cloths and proceeded to provide peri-care. She started by wetting the wash cloth and applied a wash creme. She began washing the left groin and left side of the scrotal sac and then continued to the right groin and the right side of the scrotal sac. She continued to wash the scrotal sac with the same wash cloth, proceeded to the penial shaft, then the meatus (opening) of the penis. She then obtained a second wash cloth, soaked</p>	F 441	<p><i>by the ADON and/or Unit Managers.</i></p> <p><i>Proper hand hygiene and peri-care procedures including proper hygiene after removing gloves will be discussed quarterly or every three (3) months in the mandatory monthly Nurses and C.N.A. meetings.</i></p> <p>4. All audits will be presented to the Performance Improvement Committee monthly for review and recommendations.</p> <p>5. Completion Date:</p>	10/30/13	



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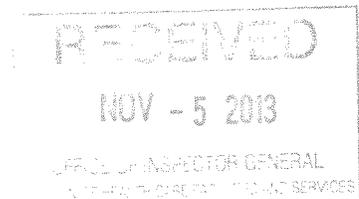
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F 441	<p>Continued From page 17</p> <p>the cloth in clear water, wiped the left side of the groin and scrotal sac, then proceeded to wipe the right side of the groin and scrotal sac. LPN #1 continued to rinse the scrotal sac, the penial shaft and the meatus of the penis. LPN #2 picked up a dry wash cloth and patted dry the left groin and scrotal sac, then patted dry the right groin and scrotal sac. She continued to dry the scrotum, the penial shaft and the meatus, using the same wash cloth as she moved from dirty to clean areas of the body.</p> <p>Observation of LPN #2 during peri care and skin assessment, on 09/25/13 at 9:25 AM through 10:41 AM, LPN #2 changed her gloves three times without hand hygiene prior to donning the next set of gloves.</p> <p>Record review of Resident #4, revealed the facility readmitted the resident on 08/06/13, with the diagnosis of Paralysis Agitans, Lack of Coordination, Lewy Body Dementia and Esophageal Reflux secondary to Parkinsonism. The quarterly Minimum Data Set (MDS), Version 3.0, dated 08/27/13, revealed the facility staff completed the assessment for mental status determined the resident was severely impaired.</p> <p>Review of the incontinence care plan for Resident #4, dated 06/03/13, revealed his/her was to provide prompt pericare as needed for incontinent episodes.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 and LPN #2, upon completion of the peri-care, on 09/25/13 at 10:41 AM, stated the procedure for peri-care was to clean from each side of the groin, the scrotal sac and then the penis. LPN #1 and LPN #2 stated they had been to the training</p>	F 441			



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F 441	<p>Continued From page 18</p> <p>for peri-care. LPN #1 and LPN #2 stated that is the method they use when peri-care was provided. Each stated they had observed the Certified Nurse Aides (CNA) complete the same process during peri-care. LPN #1 and LPN #2 stated they should have cleaned from the opening of the penis first and continued to the scrotal sac, as that would be clean to dirty. Each LPN stated, the technique used was cross contamination and was a concern for potential urinary tract infections. LPN #2 stated she should have washed her hands after removal of her gloves each time and that was a concern for bacteria growth.</p> <p>Interview with the Director of Nurses (DON) and the Assistant Director of Nurse (ADON), on 09/26/13 at 2:45 PM, stated the practice of the staff was to wash their hands between glove changes or use a hand gel, which depended on the care provided. Each stated cross contamination was a concern when hand hygiene was not practiced.</p>	F 441		



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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1978 Original building, and 2013 Building Addition. SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type V (000) SMOKE COMPARTMENTS: Ten (10) smoke compartments. FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic, dry sprinkler system. GENERATORS: One (1) Type II generator, 30 KW, fuel source is propane gas. One (1) Type II, 350 KW generator, fuel source is diesel, installed on 2013. A standard Life Safety Code survey was conducted on 09/24/13. Life Care Center of Bardstown was found not in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate	K 000	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

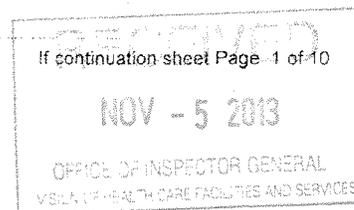
TITLE

(X6) DATE

[Handwritten Signature]

X Executive Director 10/1/2013

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



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K 000 Continued From page 1
noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)

K 000

Deficiencies were cited with the highest deficiency identified at F level.

K 029 NFFPA 101 LIFE SAFETY CODE STANDARD
SS=D
One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

K 029

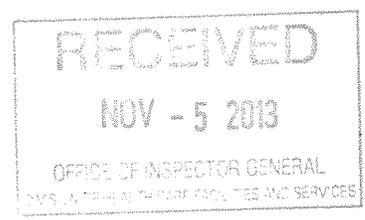
K29:

1. There weren't any individual residents identified in the alleged deficient practice.
2. All residents have the potential to be affected by the alleged deficient practice. The door closer was installed on the closet in the Therapy Gym on 9/27/2013 by The Construction Company that originally hung the door. All other closets containing storage items were checked by the Maintenance Director and/or Maintenance Assistant on 09/27/2013 to ensure proper closers were installed. There weren't any other doors identified as needing closers.

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of ten (10) smoke compartments, approximately twenty-five (25) residents, staff and visitors. The facility has one-hundred (100) certified beds and the census was sixty-seven (67) on the day of the survey.

The findings include:

Observation, on 09/24/13 at 1:48 PM, with the



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K 029 Continued From page 2
Maintenance Director revealed the door to the Storage Room located in the Rehab Gym building addition, did not have a self-closing device installed on the door.

Interview, on 09/24/13 at 1:48 PM, with the Maintenance Director revealed he was not aware of the door to the Storage Room located in the Rehab Gym not being equipped with a self-closing device.

Reference:
NFPA 101 (2000 Edition)

19.3.2 Protection from Hazards.
19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:
(1) Boiler and fuel-fired heater rooms
(2) Central/bulk laundries larger than 100 ft² (9.3 m²)
(3) Paint shops
(4) Repair shops
(5) Soiled linen rooms
(6) Trash collection rooms
(7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of

K 029 3. The Maintenance Director, Maintenance Assistant and Housekeeping Director were educated by the Executive Director on 10/16/2013 covering rooms/closets containing storage items or hazardous materials must have a door closer on the door. The Maintenance Director will conduct weekly audits for three months on all rooms containing hazardous materials or storage items to ensure door closers are present and working properly. **After three months, the Maintenance Director and/or Maintenance Assistant will conduct monthly on-going audits on all rooms containing hazardous materials or storage items to ensure door closers are present and working properly.**



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K 038 Continued From page 4
Maintenance Director revealed the two (2) doors accessing the enclosed exterior courtyard located in the Rehab Gym building addition, could be confused as exits in the event of an emergency. The doors were not identified as "NO EXIT".

Interview, on 09/24/13 at 1:55 PM, with the Maintenance Director revealed he was unaware of proper signage being required at any door leading to the enclosed, exterior courtyard of the building.

Reference: NFPA 101 (2000 edition)

7.10.1.4* Exit Access.

Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs.

Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements.

7.10.8.1* No Exit.

Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows:

NO
EXIT

Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high,

K 038

An audit was conducted by the Maintenance Director of the building and no other doors required this type of signage.

- The Maintenance Director and Maintenance Assistant were educated by the Executive Director on 10/16/2013 regarding doors that aren't designated exits need signage stating "This Is Not An Exit".

The Maintenance Director and/or Maintenance Assistant will check all the doors weekly that have signage stating "This Is Not An Exit". These audits will be conducted during door checks and will ensure proper signage remains in place.

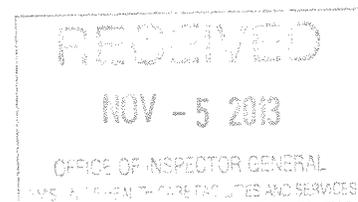
- Results from the audits will be presented to the Performance Improvement Committee monthly for review and recommendations by the***



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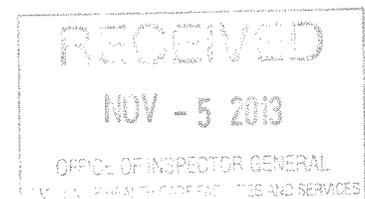
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K 038	Continued From page 5 with the word EXIT below the word NO. Exception: This requirement shall not apply to approve existing signs.	K 038	Maintenance Director and/or Maintenance Assistant monthly to ensure continued compliance.	
K 051 SS=F	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building fire alarm system was installed in	K 051	5. Completion Date: K-51: 1. There weren't any individual residents identified in the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. All identified pull stations that are above 4'1/2" will be lowered to the proper height of not less than 3'1/2" and not more that 4'1/2". The Construction Contractor will complete the work. Contract completed for items to be corrected. All other pull stations were audited by the Maintenance Director and/or Maintenance Assistant for proper height on 09/27/2013. All other pull stations met the requirement.	10/30/13



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K 051	Continued From page 6 accordance with NFPA standards. The deficiency had the potential to affect eight (8) of ten (10) smoke compartments, all residents, staff and visitors. The facility has one-hundred (100) certified beds and the census was sixty-seven (67) on the day of the survey. The findings include: Observations, on 09/24/13 between 11:30 AM and 2:17 PM with the Maintenance Director, revealed the manual fire alarm pull stations located at six (6) of the exits from the original building, were mounted over 4-1/2 feet above the finished floor. Interviews, on 09/24/13 between 11:30 AM and 2:17 PM with the Maintenance Director, revealed he was unaware of the required mounting heights of the manual pull stations for the fire alarm system and acknowledged they were installed above the maximum allowable mounting height. Reference: NFPA 72 (1999 Edition). 2-8.1 Mounting. Each manual fire alarm box shall be securely mounted. The operable part of each manual fire alarm box shall be not less than 31/2 feet (1.1 m) and not more than 41/2 feet (1.37 m) above floor level.	K 051	3. The Maintenance Director and Assistant Maintenance Director were educated by the Executive Director on 10/16/2013 covering proper pull station height. Any pull stations that are installed in the future will be measured and documented for proper height by the Maintenance Director and/or Maintenance Assistant. <i>The Maintenance Director and/or Maintenance Assistant will audit all pull stations monthly. The audits will include that pull stations appear in working order and are proper height.</i> 4. <i>Audits</i> or any issues or updates will be presented to the Performance Improvement Committee <i>monthly by the Maintenance Director or Maintenance Assistant</i> for compliance and recommendations. 5. <i>Completion Date:</i> 11/09/13
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.	K 062	



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K 062	<p>Continued From page 7 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect each of the eight (8) smoke compartments, all residents, staff and visitors. The facility has one-hundred (100) certified beds and the census was sixty-seven (67) on the day of the survey. The facility failed to ensure items were not stored within eighteen (18) inches from any sprinkler heads and sprinkler head spray patterns were not obstructed.</p> <p>The findings Include:</p> <ol style="list-style-type: none"> Observations, on 09/24/13 between 9:30 AM and 2:02 PM, with the Maintenance Director revealed the sprinkler heads located in the East Hall Private Dining Room, the Oxygen Transfer Room, the Director of Nursing (DON) Office and the Administration Office had its spray patterns obstructed by surface mounted fluorescent light fixtures. The light fixtures were positioned less than four (4) inches from the sprinkler heads and extended further down from the ceiling than the sprinkler head diffusers did. <p>Interviews, on 09/24/13 between 9:30 AM and 2:02 PM, with the Maintenance Director revealed he was unaware the positioning of the surface mounted light fixtures would obstructed the spray patterns of the sprinkler heads upon activation of the automatic sprinkler system.</p>	K 062	<p>K-62:</p> <ol style="list-style-type: none"> There weren't any individual residents listed in the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. The areas identified in the Statement of Deficiencies will be repaired and lights will be reinstalled by our Construction Contractors to ensure the proper distance from the sprinkler. Construction contract completed for items to be repaired. The Maintenance Director conducted a complete building audit to identify any other areas that may have lights that are lower than the sprinkler and not having proper distance between the two. All other identified areas of concern will be corrected to allow the proper distance.



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K 062 Continued From page 8

2. Observation, on 09/24/13 at 2:02 PM, with the Maintenance Director revealed a wall cabinet recently installed at the entrance to the new Rehab Gym was within eighteen (18) inches of the sprinkler head above.

Interview, on 09/24/13 at 2:02 PM, with the Maintenance Director revealed he was aware top of the of the wall cabinet being within eighteen (18) inches of the sprinkler head and was scheduled to be relocated by the sprinkler contractor.

Reference:
NFPA 13 (1999 Edition)

5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development

5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing Shall comply with 5-5.5.2.

Table 5-6.5.1.2. Positioning of sprinklers to avoid obstructions to discharge requires at least one foot clearance between sprinkler heads and obstructions to spray patterns that are level with or taller than the sprinkler head.

NFPA 25 (1998 Edition)

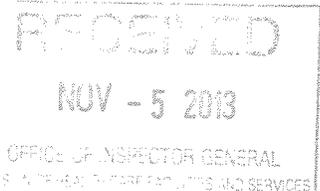
2-2.1.1. Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall).

K 062 3. The Maintenance Director and Maintenance Assistant were educated by the Executive Director on 10/16/2013 regarding proper distance between a light fixture and sprinkler head when the fixture is lower.

If any light fixtures or sprinkler heads are installed in the future, the Maintenance Director and/or Maintenance Assistant will measure and document that proper distance is correct.

The Maintenance Director and/or Maintenance Assistant will audit all lights monthly to ensure proper distance exists from the sprinkler head. Any issues will be documented on the audit form.

4. Any identified areas that are non-compliant ***from the audits*** will be presented to the Performance



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K 062	Continued From page 9 Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. 2-2.1.2*. Unacceptable obstructions to spray patterns shall be corrected. NFPA 101 (2000 Edition) 4.6.12.1. Every required sprinkler system shall be continuously maintained in proper operating condition.	K 062	Improvement Committee <i>by the Maintenance Director or Maintenance Assistant</i> that consists of the Executive Director, Director of Nursing, Medical Director, MDS Coordinator 1, MDS Coordinator 2, Social Service Director, Dietary Manager, Business Office Manager, Maintenance Director, Housekeeping/Laundry Supervisor, Medical Records Director, Admission Coordinator, Business Development Director, Activity Director and Director of Rehab for review and recommendations. 5. Completion Date: 11/09/13

