

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

PRINTED: 12/16/2014
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 12/05/2014
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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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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 12/02/14 and concluded on 12/05/14. The facility was found not meeting the minimum requirements for recertification and deficiencies were cited at the highest scope and severity of an "E". An Abbreviated Survey was conducted in conjunction with the Recertification Survey to investigate KY 22535. The Division of Health Care unsubstantiated the allegation with unrelated deficiencies cited.	F 000	LIFE CARE CENTER OF BARDSTOWN ACKNOWLEDGES RECEIPT OF THE STATEMENT OF DEFICIENCIES AND PROPOSES THIS PLAN OF CORRECTION TO THE EXTENT THAT THE SUMMARY OF FINDINGS IS FACTUALLY CORRECT AND IN ORDER TO MAINTAIN COMPLIANCE WITH APPLICABLE RULES AND PROVISION OF QUALITY CARE OF RESIDENTS THE PLAN OF CORRECTION IS SUBMITTED AS A WRITTEN ALLEGATION OF COMPLIANCE LIFE CARE CENTER OF BARDSTOWN'S RESPONSE TO THIS STATEMENT OF DEFICIENCIES DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY DEFICIENCY IS ACCURATE. FURTHER, DANVILLE CENTRE RESERVES THE RIGHT TO REFUTE ANY OF THE DEFICIENCIES ON THE STATEMENT OF DEFICIENCIES THROUGH INFORMAL DISPUTE RESOLUTION, FORMAL APPEAL PROCEDURES AND/OR ANY OTHER ADMINISTRATIVE OR LEGAL PROCEEDING.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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.	F 280	Life Care Center of Bardstown will continue to protect our residents by providing resident assessments and care planning. 1. Resident # 5 has been successfully discharged from the center to home. All residents have the potential to be affected. The Medical Director was made aware of this finding on 12/19/2014 by the Director of Nursing (D.O.N.) with no new orders. 2. All care plans will be reviewed by the IDT (DON/ADON/SDC, Therapy, Social Services and/or Activities) to identify if all care plans reflect the residents' current needs, problems, goals, care, treatment and services and to ensure all have been updated at least quarterly. This will be completed by 12/31/2014.	01/09/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Executive Director* (X6) DATE: 12/23/14

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 30 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.

DEC 29 2014

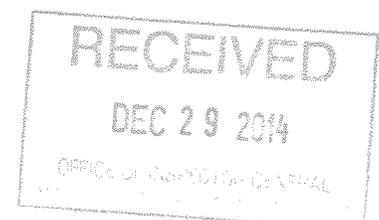
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: XOG311 Facility ID: 100489 If continuation sheet Page 1 of 24

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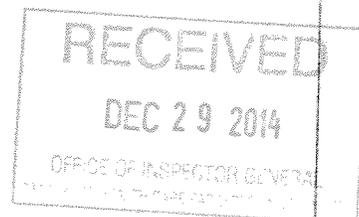
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F 280	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to revise a resident's comprehensive care plan regarding constipation, risk for fluid deficit, and infection for one (1) of seventeen (17) sampled residents. Resident #5. The facility failed to revise Resident #5's care plan to address new diagnoses of Fecal Impaction, Dehydration and Acute Urinary Retention after return from the emergency department. The findings include: Review of the facility's policy and procedure titled Resident Care Plan, revised December 2008, revealed care plans were reviewed at least quarterly and as needed to reflect the resident's current needs, problems, goals, care, treatment and services. Review of Resident #5's medical record revealed the facility admitted the resident on 11/07/14 and was sent to the hospital on 11/26/14 for an increased potassium level, Dehydration and Urinary Tract Infection. Further review of medical record revealed, six days later, on 12/02/14, the resident experienced constipation and requested to be sent to the emergency room to have his/her kidneys checked. The emergency room physician diagnosed the resident with Abdominal Pain, Fecal Impaction and Urinary Retention. A urinary catheter was placed and an enema was administered in the emergency room. The emergency room physician ordered a fleets enema to be given that night and as needed for constipation.	F 280	Any issue identified will be immediately corrected. DON/ADON/UM and /or SDC will complete a 30 day look back audit (11/25/2014-12/25/2014) on all residents who have been sent to the hospital to identify any change in condition or need for care plan revision to ensure all residents' current problems, goals and care reflect their individual needs. This will be completed by 12/31/2014. Any issue identified will be immediately corrected. 3. SDC/DON/ADON to reeducate licensed nurses and care plan team (nursing, therapy, social services, activities and MDS department), including Unit Managers, regarding care plan policy, to include, care plan updates, changes to care plan after hospital visit, change in condition care plan revision, how to update care plan and ensuring all care plans are individualized to meet resident needs. This education will be both verbal and in writing to ensure understanding and will be completed by 1/2/2015. DON/ADON/UM to review all records within 3 days of hospital visit to ensure care plan updated timely, effectively, reflect current needs, goals and is individualized. This will begin 12/20/2014 and be ongoing.		



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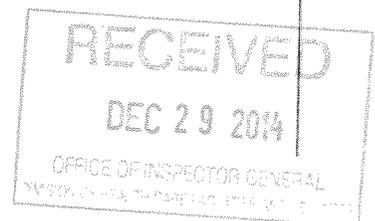
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F 280	Continued From page 2 Continued review of medical record revealed a nursing order, dated 12/03/14, that stated to measure and record intake and output every shift; however, this information was not added to the nurse aide care directive sheet (reviewed on 12/04/14) or to Resident #5's care plan. Review of Resident #5's care plan for Risk for Deficient Fluid Volume and Constipation, dated 11/07/14, revealed no additional nursing interventions were added after the resident's change in condition and emergency room visits. Review of Resident #5's care plan for Infection of Urine, dated 12/01/14, revealed no new interventions for the new diagnosis of Acute Urinary Retention. Interview with RN #4, on 12/04/14 at 2:45 PM, revealed Resident #5 complained of constipation on the night of 12/02/14 and an order for medication to relieve constipation was obtained; however, it was not effective. RN #4 stated the resident requested to be sent to the emergency room and was transferred. RN #4 stated she received report from the Emergency Department regarding Resident #5's diagnoses of a Fecal Impaction and Urinary Retention. She stated the emergency room physician ordered a Fleets enema to be sent back with the resident and another one was to be given later that evening. She stated she was responsible for updating the resident's care plan when there was a change in condition and/or new orders were received. RN #4 stated it was very busy the night of 12/02/14 and she forgot to update Resident #5's care plan. Interview with East Unit Manager, on 12/04/14 at 1:40 PM, revealed Resident #5's care plan	F 280	DON/ADON and/or UM to review 10 care plans weekly x 6 weeks beginning week of 1/5/2015, then 5 care plans weekly x 4 weeks to ensure all care is individualized and meets resident needs. DON/ADON/Staff Development Coordinator (SDC) and /or Unit Manager (UM) to review 10 C.N.A. care plans weekly x 6 weeks beginning week of 1/5/2015, then 5 C.N.A care plans weekly x 4 weeks to ensure all are individualized, updated and meet resident needs. New physician orders will be reviewed by the DON/ADON and /or UM to ensure any change in condition that requires care plan revision is completed and care plan reflects this change. This will begin 12/22/2014 and be ongoing 3 x week. 4. QA Team consisting of Executive Director, DON/ADON, MDS Nurse, Social Services and or Activities Department to meet monthly x 3 months beginning month of January 2015, then at least quarterly, to review all audit findings and review/revise plan and make recommendations. 5. Date of Compliance Jan. 9, 2015	



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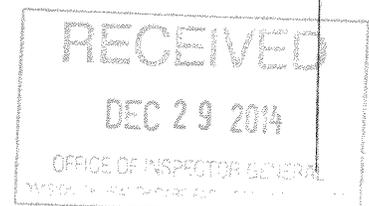
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F 280	Continued From page 3 should have been updated after the resident's change in condition and after each return from the hospital. She stated the Director Of Nursing and Assistant Director Of Nursing conducted the weekly care plan meetings and revised care plans when indicated. She stated she did not participate in the weekly care plan meetings, but was given tasks after the meetings from the DON regarding care plan updates. The East Unit Manager stated she had not received any updates or direction to revise Resident #5's care plan. Interview with Resident #5, on 12/04/14 at 10:55 AM, revealed the resident had requested to go to the hospital and once there received an enema for constipation with minimal results and a urinary catheter. The resident stated the facility gave Milk of Magnesia for constipation; however, Miralax worked better for the resident. Continued interview with Resident #5 revealed the constipation was not resolved and the resident was experiencing pressure and felt the need to have a bowel movement, but could not. Interview with Director of Nursing (DON), on 12/04/14 at 4:45 PM, revealed she was aware of Resident #5's change in condition and hospital visits. However, she was not aware Resident #5's care plan had not been updated to include additional nursing interventions for hydration and constipation. The DON stated the care plan revisions somehow must have been missed.	F 280			
F 327 SS=E	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration	F 327			



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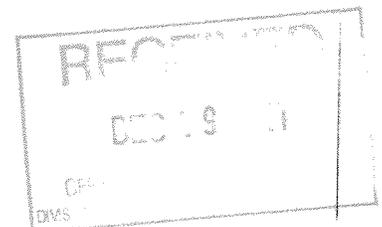
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F 327	Continued From page 4 and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to ensure each resident received adequate fluids to prevent dehydration for two (2) of seventeen (17) sampled residents, (Resident's #1, #4, #5 and #12) and ten (10) of twelve (12) unsampled residents (Unsampled Residents B, D, E, F, G, H, I, J, K, and L). The findings include: Review of the facility's policy and procedure for Hydration & Nutrition, dated October 2008, revealed the nutrition and hydration status of each resident was maintained as close to optimal level as possible. Fluid was available to residents at all times. An ongoing assessment of ability to consume and assimilate food and fluid by the resident was conducted by the nursing personnel. Assessments included positioning needs, nutritional balance and imbalance of intake, weight loss or gain and signs and symptoms of dehydration. Review of the facility's BM Protocol revealed the purpose of the protocol was for the facility to provide appropriate interventions for signs and symptoms of constipation. The protocol interventions stated if constipation was a chronic problem: ensure adequate fluid intake; offer high fiber diet unless contraindicated or request Registered Dietitian (RD) consult; prune juice with meals; request physician order for bulk laxative if	F 327	F327 1. Resident #4 and Resident #5 have been successfully discharged from the center. Medical Director was made aware of this finding by the DON on 12/5/2014 no new orders noted. Unsampled Residents # B, D, E, G, H, J and L have had no change in hydration status. Each respective resident's physician was notified by the ADON on 12/23/2014 and No new orders were noted. All residents have the potential to be affected. 2. A onetime hydration assessment was completed on every resident residing in the center to identify any change in hydration status. This was completed on 12/23/2014 by DON/ADON/UM/SDC. This included mucus membrane assessment and skin turgor. No issues were identified.	01/09/2015	



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F 327	<p>Continued From page 5</p> <p>stools are too soft; or request physician order for stool softener if stools are too hard; and, update care plan as indicated.</p> <p>1. Review of Resident #5's medical record revealed the facility admitted the resident on 11/07/14. Physician orders dated for 11/12/14 and 11/13/14 stated to encourage oral fluids. A Brief Interview for Mental Status (BIMS) exam was conducted on 12/04/14 and the resident scored a nine (9) out of fifteen (15) indicating cognitively intact.</p> <p>Interview with Resident #5's Physician, on 12/05/14 at 12:00 PM, revealed his expectation regarding the orders, to encourage fluids, written on 11/12/14 and 11/13/14, was for staff to ensure the resident received more than the calculated daily amount of fluids. The Physician stated Resident #5's base line laboratory values for Blood Urea Nitrogen (BUN) were normally in the thirties (normal range was BUN 7-25 mg/dL) and the Creatinine range was 1.2 to 2.4. mg/dL (normal 0.6-1.3 mg/dL). He stated he was monitoring the resident's lab values closely and once they were elevated significantly he made the decision to send the resident to the hospital for an evaluation and treatment on 11/26/14.</p> <p>Continued review of Resident #5's medical record revealed the resident's potassium level on 11/13/14 was 5.1 mEq/L (normal range 3.5-5.3 mEq/L) and BUN was 48 mg/dL (normal 7-25 mg/dL). Laboratory values on 11/26/14 for Potassium was 6.5 mEq/L, BUN was 71 mg/dL and the Creatinine was 1.9 mg/dL.</p> <p>Review of the physician orders, dated 11/26/14, revealed to send the resident to the emergency</p>	F 327	<p>Dietary Manager to review preferred fluids for each resident to identify if every resident is receiving their preferred fluids to increase intake. This was completed on 12/6/2014.</p> <p>Any issue will be immediately noted and tray card updated.</p> <p>Dietary Manager to include total cc's on tray card beside preferred drink completed on 12/6/2014 to identify amount taken in, to ease intake evaluation and to identify if resident is not drinking served fluids.</p> <p>Nursing staff is documenting on the tray card if resident's preferences change during meal service and turning that into the kitchen to update.</p> <p>Nurse Managers and/or Department Heads assigned to meal service to monitor tray pass in the dining room and in room services 3 x by 12/30/2014 (this will include all 3 meals) to identify if residents' are receiving their preferred drinks per tray card and any drinks spilled to be replaced.</p> <p>Any issue will be immediately corrected.</p>		



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F 327	<p>Continued From page 6</p> <p>room for an increased Potassium and BUN levels. The Hospital Discharge Summary, dated 11/28/14, revealed the final diagnoses were Urinary Tract Infection, Acute Renal Failure and Dehydration. The Physician noted the Acute Renal Failure and Dehydration was resolved prior to discharge as evidence by laboratory values for BUN of 38 mEq/L and a Creatinine of 1.1 mg/dL.</p> <p>Further review of the medical record revealed, six days later, on 12/02/14, the resident experienced constipation and requested to be sent to the emergency room. The emergency room physician diagnosed the resident with abdominal pain, fecal impaction and urinary retention. A urinary catheter was placed and an enema was given in the emergency room. Review of the Emergency Department physician's orders revealed a Fleets enema to be given that night and as needed for constipation. However, review of the medical record revealed no documented evidence that a follow-up enema was administered.</p> <p>Review of Hospital Radiology Report, dated 12/03/14, revealed increased gas and stool throughout the colon. There was left-sided constipation with rectal fecal impaction. The rectum was dilated with stool up to 8.5 centimeters.</p> <p>Interview with RN #4, on 12/04/14 at 2:45 PM, revealed Resident #5 complained of constipation on the night of 12/02/14 and an order for medication to relieve constipation was obtained, however it was not effective. RN #4 stated the resident requested to be sent to the emergency room and was transferred. RN #4 stated she received report from the Emergency Department regarding Resident #5's diagnoses of a Fecal</p>	F 327	<p>DON/ADON or UM to complete a one-time audit to review dietician log by 12/29/2014 to identify if any resident with high risk condition for hydration change and/or is at risk for hydration change is recorded on that log for dietician to review.</p> <p>Any issue identified will be immediately corrected.</p> <p>ADON to review BM record for each resident by 12/24/2014 to identify any resident that has not had BM in 3 days or more and to identify if they are on intake monitoring.</p> <p>Any issue identified will be immediately corrected.</p> <p>3. SDC/DON/ADON and /or UM to reeducate nursing staff regarding hydration policy, what are high risk conditions/changes that may affect hydration, what is on the tray card (preferred fluid and amount of fluid), monitoring BM, hydration assessment, reporting decreased intake notifying physician of hydration change, replacing spilled fluids, offering fluid alternatives, recording information on the dietician log and hydration change risk after hospital stay.</p>		

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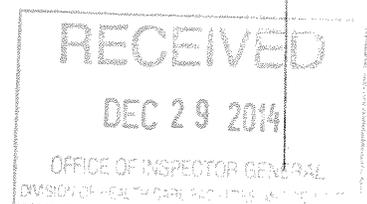
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F 327	<p>Continued From page 7</p> <p>Impaction and Urinary Retention. She stated the emergency room physician ordered a Fleets enema to be sent back with the resident and was to be given later that evening.</p> <p>Interview with Resident #5's Spouse, on 12/04/14 at 1:05 PM, revealed he was notified of Resident #5's transfer to the hospital. He stated he went to the hospital and the Emergency Room physician told him the resident was full of stool and the stool was pushing on the resident's bladder causing the urinary retention.</p> <p>Interview with Resident #5, on 12/04/14 at 10:55 AM, revealed the resident requested to go to the hospital and once there received an enema for constipation with minimal results and a urinary catheter. The resident stated the facility gave her Milk of Magnesia for constipation; however, Miralax worked better for the resident. Resident #5 stated the constipation was not resolved and the resident was experiencing pressure and felt the need to have a bowel movement, but could not. The resident stated discharge from the facility was planned for today and he/she was going home to take Miralax so he/she could have a bowel movement.</p> <p>Interview with the Emergency Room Director, on 12/05/14 at 11:59 AM, revealed the physician ordered a Fleets enema to go and to give one that night meant for the hospital to administer a Fleets enema prior to sending the resident back to the facility and then for the nursing facility to continue care for constipation by following up with another enema later that evening.</p> <p>Interview with Regional Clinical Nurse Consultant, on 12/05/14 at 10:30 AM, revealed the facility's</p>	F 327	<p>This will be completed by 1/4/2015. This education will include both verbal and written test to assess competency. A score of 85 % will be considered competency. This education will be included in orientation for all new hires by the SDC/ADON beginning 1/4/2015.</p> <p>Dietary Manager to reeducate dietary staff on providing proper fluids according to tray card and observing any spilled fluids and replacing them.</p> <p>Charge nurse to total fluid intake daily, assess hydration status of each resident and notify the physician to place resident on intake and output. (Example infections, diet change, dialysis, nausea or vomiting).</p> <p>Nurse Managers as part of the IDT process reviews total intake of all residents to ensure proper hydration Monday through Friday.</p>		



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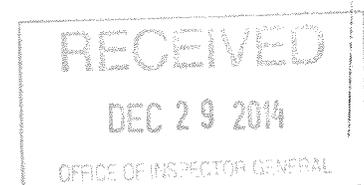
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F 327	<p>Continued From page 8</p> <p>interpretation of the emergency room physician's documentation was that the enema was given to the resident prior to leaving the hospital and not for the nursing home facility to follow up with another once the resident was readmitted.</p> <p>Review of Resident #5's dietary order revealed the resident received a mechanical soft diet with double portions of protein. Review of documented weight history revealed a weight of 104 pounds on 11/14/14, 105 pounds on 11/18/14 and 106 pounds on 11/26/14. However, Resident #5's weight obtained on 12/05/14, at surveyor's request, revealed the resident's weight was 124.9 pounds, an 18.9 pound discrepancy. The facility was unable to provide a reason or determine the cause of the 18.9 pound discrepancy.</p> <p>Continued review of Resident #5's medical record revealed no documented evidence the facility was measuring fluid intake prior to the nursing order dated 12/03/14 which stated to measure and record intake and output every shift.</p> <p>Review of Resident #5's Nurse Aide Care Directive sheet, on 12/04/14, revealed it did not provide direction to the aides to encourage and monitor fluid intake.</p> <p>Review of nursing documentation revealed Resident #5's hydration assessments were not completed daily from 11/21/14 until discharge on 12/04/14.</p> <p>Review of the Monthly Flow Report for Dietary Intake for Resident #5 revealed the resident's average daily intake of food from 11/09/14 to 12/04/14 was forty nine (49) percent.</p>	F 327	<p>Dietary Manager/SDC to review 20 tray cards each week x 4 weeks beginning week of 1/4/2015 then 10 tray cards x 4 weeks to ensure preferred fluids are on tray cards and amounts are on tray cards.</p> <p>Department Managers to review all 3 meals daily 4 x weekly beginning the week of 12/30/2014 x 8 weeks then 1 meal daily 3 x weekly to ensure preferred drinks are served, the correct amount is served, that any spilled drink is replaced, alternate fluids are offered and any decreased intake is reported to charge nurse.</p> <p>ADON/UM to review BM output for all residents at least 2 x weekly x 6 weeks beginning week of 1/1/2015 then at least 1 x weekly to ensure BMs are occurring at least every 3 days.</p>		



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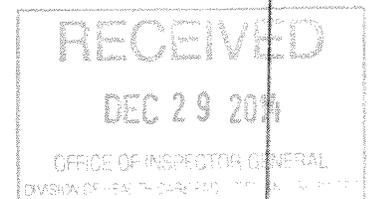
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F 327	<p>Continued From page 9</p> <p>Interview with the Registered Dietitian, on 12/04/14 at 4:00 PM, revealed she was unaware of Resident #5's weight discrepancy of 18.9 pounds and the recent hospitalizations for dehydration and fecal impaction. She stated if she had known she would have re-evaluated the resident's dietary needs for adequate hydration. She stated the weight discrepancy would have increased the amount of fluid intake the resident required by 148 milliliters per day.</p> <p>Observation, on 12/03/14 at 8:05 AM, revealed Resident #5 was sitting on the bed, eyes closed with a breakfast meal tray in front of the resident. The food on the tray appeared to be untouched by the resident. Review of the December's Monthly Flow Report for documented food intake revealed the resident ate zero percent of breakfast meal on 12/03/14. There was no documentation of fluid intake.</p> <p>Observation of Resident #5, on 12/03/14 at 12:00 PM, revealed the resident was sitting up on the bed, eyes closed, with the lunch meal tray in front of the resident. Continued observation at 3:15 PM, revealed the lunch tray was on the counter near the sink with food that appeared untouched. The resident was sitting on the bed with eyes closed and untouched servings of cottage cheese and pimento cheese and one slice of bread was in front of resident.</p> <p>Observation of Resident #5, on 12/03/14 at 5:20 PM, revealed the resident was again sitting up on the bed with eyes closed, and a dinner meal tray in front of the resident with food that appeared untouched. The Surveyor tried to arouse the resident to conduct an interview concerning appetite and meal consumption. Resident #5</p>	F 327	<p>DON/ADON/Dietary Manager to review dietician log weekly beginning the week of 12/30/2014 to ensure any resident that has a risk for hydration change, has constipation, significant weight changes or re hospitalized have their names on the log for dietician review. This will be on going.</p> <p>4. QA Team consisting of Executive Director, DON/ADON, MDS Nurse, Social Services and or Activities Department to meet monthly x 3 months beginning month of January 2015, then at least quarterly, to review all audit findings and review/revise plan and make recommendations.</p> <p>5. Date of compliance Jan. 9, 2015.</p>		



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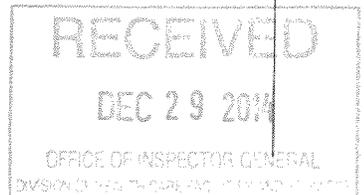
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F 327	<p>Continued From page 10</p> <p>attempted to open his/her eyes and mumbled incoherently. Review of the December's Monthly Flow Report for documented food intake revealed Resident #5 consumed less than twenty five percent of the lunch meal and twenty five percent of the dinner meal.</p> <p>Observation on 12/04/14 at 10:55 AM, revealed Resident #5's cup of fluid was on the bedside table and not within reach of the resident. The Surveyor requested Resident #5 to reach for the cup and observation revealed the resident was unable to reach the cup.</p> <p>Review of Resident #5's care plans for Risk for Deficient Fluid Volume and Constipation, dated 11/07/14, revealed no additional nursing interventions were added after the resident's change in condition and hospital visits. Review of Resident #5's care plan for Infection of Urine, dated 12/01/14, revealed it was not updated to reflect interventions for new diagnoses of Acute Urinary Retention and catheter placement.</p> <p>Interview with the East Unit Manager, on 12/04/14 at 1:40 PM, revealed Resident #5's care plans should have been updated and was not sure why they were not. She stated nursing would encourage fluids at medication pass by giving small cup of water with the pills.</p> <p>Interview with the Director of Nursing (DON), on 12/04/14 at 4:45 PM, revealed she was aware Resident #5's change in condition and hospital visits; however, was not aware the resident's care plan for constipation and fluid volume deficit had not been updated; that fluids were not in reach at</p>	F 327			



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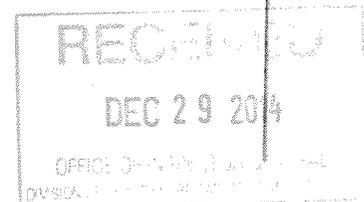
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F 327	<p>Continued From page 11 all times; and the resident daily average food consumption was less than fifty percent.</p> <p>Interview with Regional Clinical Nurse Consultant, on 12/05/14 at 11:40 AM, revealed the facility did not record fluid intake on residents. She stated the only way the facility could monitor fluid intake was to record the residents' intake to ensure adequate hydration. She also stated they do not record hydration pass or medication pass fluid consumption. She stated getting the fluid to the residents was one piece and getting them to drink was another. She stated the corporate office changed the protocol from documenting intake and output for residents to completing a hydration assessment instead.</p> <p>2. Review of Resident #1's clinical record revealed the facility admitted the resident on 06/11/14 with diagnoses of Dementia, History of Falls, Blindness, Arthritis, and Hemiplegia. Review of the admission Minimum Data Set (MDS), dated 06/18/14, revealed the facility assessed the resident to have a severe cognition impairment and was dependent on staff for all Activities of Daily Living (ADL) including eating. The clinical record revealed the resident had three inpatient stays at a Psych Hospital for behavioral modification and medication adjustment. The last hospital stay was from October 19 through November 5, 2014.</p> <p>Continued review of the clinical record revealed the resident was admitted to a local acute hospital on 11/11/14 with Respiratory Distress,</p>	F 327			



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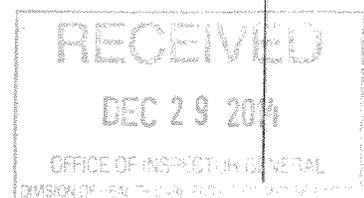
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F 327	<p>Continued From page 12</p> <p>Pneumonia, Urinary Tract Infection, and Dehydration. The record revealed the Registered Dietitian (RD) assessed Resident #1's daily fluid needs to be 2455 milliliters (ml) on 06/26/14; however, there was no documented record of the resident's fluid intake at meals or at bedside.</p> <p>Review of the comprehensive care plan for nutrition, dated 06/25/14, revealed the resident was on thin liquids with no interventions to monitor fluid intake.</p> <p>Review of the lab work completed in the Emergency Room of the acute hospital, on 11/11/14, revealed Resident #1's renal function was within normal range and the sodium level was slightly elevated to 150 (normal range 136-146).</p> <p>Interview with the RD, on 12/04/14 at 10:14 AM, revealed this Dietitian was not the person who completed the Nutritional Assessment on 06/26/14. The RD stated the facility does not record fluid intake from meals or at bedside; therefore, she does not have any measurable fluid intake for residents. She stated she would review the nurses' notes for documentation of signs and symptoms of dehydration and speak with the nurses and nurse aides regarding the resident's fluid intake. She indicated she would monitor any labs obtained. She said if a resident was experiencing a Urinary Tract Infection (UTI), she would recommend increased fluids. However, she revealed she did not have measurable fluid amounts to review to determine if the resident was drinking the recommended fluid intake. She revealed she had no knowledge of Resident #1 not drinking enough fluids and the diagnosis of Dehydration was present upon</p>	F 327			



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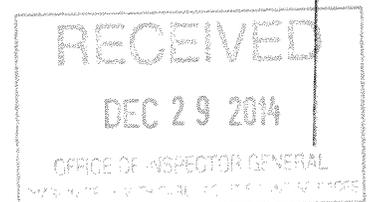
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F 327	<p>Continued From page 13 admission to the acute hospital.</p> <p>Review of the comprehensive care plan for nutrition, dated 06/25/14, revealed the resident was on thin liquids with no interventions to monitor fluid intake.</p> <p>Review of the lab work completed in the Emergency Room of the acute hospital, on 11/11/14, revealed Resident #1's renal function was within normal range and the sodium level was slightly elevated to 150 (normal range 136-146).</p> <p>3. Observation of the lunch service in the main dining room, on 12/02/14 at 12:00 PM, revealed staff served residents fluids after serving food. The staff served Unsampld Resident G iced tea with the meal. Review of the resident's meal ticket revealed the resident was to also receive eight (8) ounces of coffee and eight (8) ounces of milk.</p> <p>The staff served Unsampld Resident E coffee as the only drink with the meal. Review of the meal ticket revealed eight (8) ounces of chocolate milk and eight (8) ounces of tea was to be provided.</p> <p>Observation of the evening dinning service, on 12/02/14 at 4:45 PM, revealed nursing staff served beverages to residents with the food. The staff served Resident #12 coffee with the meal. Review of the meal ticket for Resident #12 revealed the resident was to receive eight (8) ounces of tea and four (4) ounces of prune juice.</p> <p>The staff served Resident #4 one carton of chocolate milk (half-pint) with the meal. Review</p>	F 327			



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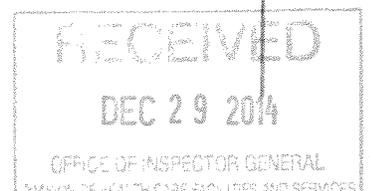
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F 327	<p>Continued From page 14</p> <p>of the meal ticket for Resident #4 revealed the resident was to receive eight (8) ounces of whole milk and eight (8) ounces of tea in addition to the chocolate milk.</p> <p>The staff served Unsampld Resident B coffee with the meal. Review of the meal ticket for Unsampld Resident B revealed the resident was to receive eight (8) ounces of tea with the coffee.</p> <p>The staff served Unsampld Resident D a cup of coffee with the meal. Review of the meal ticket for Unsampld Resident D revealed the resident was to receive eight (8) ounces of 2% milk and eight (8) ounces of tea.</p> <p>The staff served Unsampld Resident E a cup of coffee with the meal. Review of the meal ticket for Unsampld Resident E revealed eight (8) ounces of chocolate milk and eight (8) ounces of tea was to be provided with the coffee.</p> <p>The staff served Unsampld Resident F a cup of coffee with the meal. Review of the meal ticket for Unsampld Resident F revealed eight (8) ounces of chocolate milk and eight (8) ounces of whole milk was to be provided with the coffee.</p> <p>The staff served Unsampld Resident G a cup of coffee with the meal. Review of the meal ticket for Unsampld Resident G revealed the resident was to receive eight (8) ounces of chocolate milk in addition to the coffee.</p> <p>The staff served Unsampld Resident H eight (8) ounces of tea with the meal. Review of the meal ticket for Unsampld Resident H revealed the resident was to receive eight (8) ounces of whole milk and eight (8) ounces of chocolate milk.</p>	F 327			



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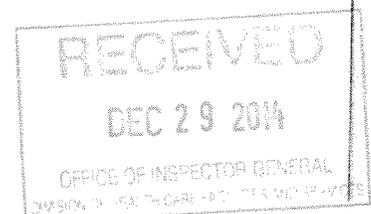
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F 327	Continued From page 15 The staff served Unsampld Resident I eight (8) ounces of tea with the meal. Review of the meal ticket for Unsampld Resident I revealed eight (8) ounces of whole milk and eight (8) ounces of tea were to be provided. The staff served Unsampld Resident J eight (8) ounces of tea with the meal. Review of the meal ticket for Unsampld Resident J revealed eight (8) ounces of whole milk in addition to eight (8) ounces of tea was to be provided. The staff served Unsampld Resident K eight (8) of nectar thick juice with the meal. Review of the meal ticket revealed Unsampld Resident K was to be provided eight (8) ounces of nectar thick coffee in addition to the juice. The staff served Unsampld Resident L eight (8) ounces of tea with the meal. Review of the meal ticket for Unsampld Resident L revealed eight (8) ounces of whole milk was to be provided with the tea. Interview with Certified Nursing Assistant #1 (CNA), on 12/02/14 at 5:42 PM, revealed the residents should get the fluids listed on the meal ticket. She stated the dietary department did not provide the fluids on the meal tray, instead nursing was to obtain the fluids from the dispenser in the dining room and milk from the ice bowl provided by the dietary staff. She stated nursing management was assisting with passing the food trays during this meal service and did not follow the meal ticket. Another interview with CNA #1, on 12/4/14 at 10:20 AM, revealed the CNA looked at the	F 327			



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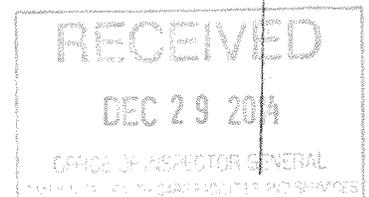
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F 327	Continued From page 16 resident's meal ticket to ensure the diet was correct and appropriate adaptive equipment was provided. The CNA stated the nursing staff provided fluids during the meal based on the resident's preference more than based on what was on the meal ticket. Interview with Licensed Practical Nurse (LPN) #4, on 12/4/14 at 10:35 AM, revealed nurses on the night shift complete a daily hydration assessment for each resident on the computer. Fluids from meals are not recorded. Interview with the Dietary Manager, on 12/02/14 at 5:23 PM during the evening meal, revealed the residents should receive the fluids listed on the resident's meal ticket. She stated those fluids listed on the meal ticket are calculated by the RD for the resident's daily estimated fluid needs and should be provided. She stated the residents could still receive any beverage of choice in addition to the fluids listed on the meal ticket.	F 327			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	F441 Life Care Center of Bardstown will continue to protect our residents by ensuring infection control protocol is being followed. 1. Resident # 2 physician was notified of dressing change procedure and identified issues by the Charge Nurse. No new orders noted. Medical Director was notified by DON on 12/19/2014 of issues with Resident # 3 linen handling, touching personal items and hand washing. No new orders noted. All residents have the potential to be affected.	01/09/2015	



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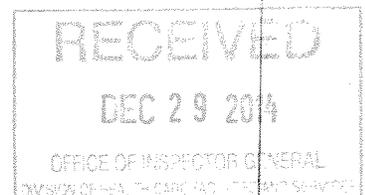
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F 441	<p>Continued From page 17</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to 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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to prevent the development and transmission of disease and infection for two (2) of seventeen (17) sampled residents. Resident #2 and #3. LPN #5 failed to implement the wound care policy regarding proper glove change to prevent transmission of disease and infection during wound care. In addition, CNA #9 and #10 failed to ensure they did not contaminate resident belongings and/or remove a bag of infectious soiled linen bare handed from a resident's room who was in isolation.</p>	F 441	<p>2. DON/ADON/UM/SDC/Treatment Nurse to complete wound care competencies to identify if all licensed staff follow infection control policy , which includes hand washing , handling linens and disposing of soiled items.. This will be completed by 1/5/2015. Any licensed nurse that has not completed competency by 1/5/2015 will complete it prior to returning to work.</p> <p>Any issue identified will require immediate reeducation both in writing and verbally and will be corrected immediately.</p> <p>SDC/UM to conduct care competencies for at least 15 C.N.A.'s to identify if C.N.A follows infection control policy during care, which includes hand washing, handling linens and disposing of soiled items. This will be completed by 1/5/2015.</p> <p>Any issues identified will be immediately corrected. Infection Control Nurse to conduct a onetime assessment of at least 3 nurses providing wound care to three different residents to identify any issue with dressing change technique and to ensure infection control practices are observed. This will be completed by 1/6/2015.</p> <p>Any issue identified will be immediately corrected.</p>		



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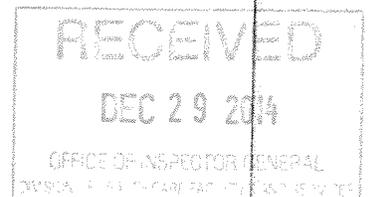
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F 441	Continued From page 18 The findings include: Review of the facility's Wound Dressing Policy, revised 10/07/10, revealed proper dressing procedure included: cleansing the wound; removing gloves; following hand hygiene protocol; and, donning new gloves. Review of the facility's Infection Control Plan, revised 02/06/08, revealed strategies to achieve goals for infection prevention and control activities may include the following: Appropriate storage; cleaning; disinfection; sterilization; and/or, disposal of supplies and equipment. In addition to the appropriate use of personal protective equipment. Review of the Centers for Disease Control (CDC) guidelines, revealed gloves should be changed; when gloves are soiled; or when going from dirty task/area to clean task/area. The CDC defined a dirty area as an area where there was a potential for contamination with blood or body fluids and an area where contaminated or used supplies or equipment are stored or handled. The CDC defined a clean area as an area with uncontaminated or unused material. The CDC also indicates hand hygiene was also necessary before and after glove use because hands could become contaminated through small defects in gloves and from the outer surface of the gloves during removal. 1. Observation of a skin assessment and wound care treatment, on 12/02/14 at 3:35 PM, with Licensed Practical Nurse (LPN) #5, revealed while she performed a dressing change to three (3) ulcers on the buttocks, glove change and hand hygiene was not performed after cleansing	F 441	3. SDC/UM/Treatment Nurse to reeducate licensed nurses regarding wound care policy, infection control policy, hand washing and when to change gloves by 1/5/2015. This education will be provided both in writing and verbally to enhance competency and understanding. SDC/UM to reeducate C.N.A staff regarding infection control policy, concentrating on hand washing, when to change gloves, not to touch personal items and discarding trash. This will be completed by 1/5/2015 and will be completed both in writing and verbally to enhance understanding. DON/Treatment Nurse /UM to monitor care being provided during dressing change to 3 residents weekly x 6 weeks beginning week of 1/5/2015, then 1 resident weekly x 4 weeks to ensure dressing change technique and infection control policy is followed. SDC to monitor at 7 C.N.A.s providing resident care weekly (on various shifts) x 6 weeks starting week of 1/5/2015, then 3 C.N.A.s providing care weekly x 4 weeks to ensure infection control practices are followed. This observation will include hand washing, linen handling and disposing of trash.		



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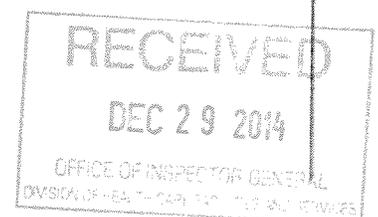
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F 441	<p>Continued From page 19</p> <p>the wounds and before applying new dressings to two (2) of the three (3) wounds.</p> <p>Interview with LPN #5, on 12/02/14 at 5:00 PM, revealed she should have changed gloves between wounds and washed her hands with a glove change. She also stated she had received wound care training, but was unsure of when.</p> <p>Review of LPN #5's Competency/Skills Checklist, dated 03/12/14, revealed no evidence of training on Infection Control or Wound Care.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 12/04/14 at 12:56 PM, revealed infection control issues were discussed in orientation and as needed. The ADON further stated proper wound care procedures were to wash hands between glove change. She stated gloves should be changed after cleansing of a wound.</p> <p>Interview with Staff Development Coordinator, on 12/04/14 at 1:10 PM, revealed she was responsible for all education and training. She stated education and training were done as needed, but an in-service was done at least monthly. She further revealed she was responsible for wound care audits, but had not performed those audits due to her being new to the position. She indicated possible negative outcomes if proper wound care procedures were not followed could include; cross contamination; wounds not healing; and, increased infections.</p> <p>2. Review of Resident #3's medical record revealed a diagnosis of extended spectrum beta lactamase Citrobacter Urinary Tract Infection. Review of the nursing care plan for infection,</p>	F 441	<p>Beginning 12/20/2014 all new hires will be oriented to infection control practices/policy and all new hire licensed nurses will have a wound care competency observed during orientation. This will be completed by the SDC/ADON or UM and be ongoing</p> <p>4. QA Team consisting of Executive Director, DON/ADON, MDS Nurse, Social Services and or Activities Department to meet monthly x 3 months beginning month of January 2015, then at least quarterly, to review all audit findings and review/revise plan and make recommendations.</p> <p>5. Date of Compliance Jan. 9, 2015</p>		



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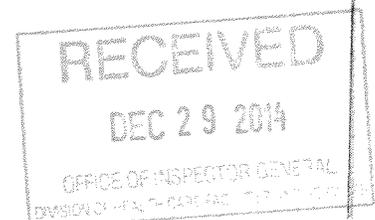
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F 441	<p>Continued From page 20 dated 12/01/14, revealed the resident was to have contact precautions for 10 days due to the Urinary Tract Infection.</p> <p>Observation of incontinent care, on 12/02/14 at 3:00 PM, revealed two Certified Nursing Assistants (CNA) #9 and #10, provided the incontinent care. Observation revealed the resident's suprapubic urinary catheter was leaking and the bed linens were saturated with urine. CNA #10 removed the brief and urine saturated linens with gloved hands with the assistance of CNA #9, by rolling the resident from side to side. CNA #10 then cleansed the resident's skin with a wipe, then proceeded to searched through items on top of the resident's bedside table and in the drawers looking for powder for the resident's bottom with the same gloved hands. CNA #9, was observed touching Resident #3's personal items with the same gloves she had on during incontinent care. CNA #10 obtained a clear plastic bag for CNA #9 and she placed the urine saturated linens in the bag. She then tied the bag and placed it on top of the garbage can that contained contaminated gloves, gowns and masks used by staff to provide care for Resident #3 who had been placed in contact precautions. CNA #10 removed her gloves and washed her hands and then picked up the bag containing the urine saturated linen from the top of the garbage can and exited the resident's room. She carried the bag of soiled linen to the soiled utility room.</p> <p>Interview with CNA #9 and #10, on 12/02/14 at 4:00 PM, revealed they did not realize they had not removed their contaminated gloves when they were searching through Resident #3's personal belongings looking for the powder. They stated</p>	F 441			



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F 441	Continued From page 21 they should have removed their gloves and washed their hands prior to touching the resident's personal items. CNA #9 stated she wasn't thinking when she picked up the bag of infectious linens. She stated she should have used gloves to transport the bag to the soiled utility room. Interview with RN #1, on 12/03/14 at 8:45 PM, revealed Resident #3 was in Contact Precautions due to an infectious Urinary Tract Infection. She stated the appropriate use of personal protective equipment was necessary to prevent the spread of infection. She stated the nurse aides should wear gloves to transport contaminated linens out of the resident's room. She was unaware CNA #9 inappropriately handled the contaminated bag of laundry. Interview with ADON, on 12/04/14 at 4:15 PM, revealed the appropriate disposal of contaminated linen would be to handle the bag with gloved hands. The ADON was unaware staff was transporting contaminated bags of linen with bare hands.	F 441		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents	F 497	F497 Life Care Center of Bardstown will continue to protect our residents by ensuring all C.N.A.'s employed will complete at least 12 hours of continuing education.	01/09/2015



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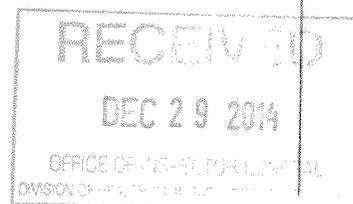
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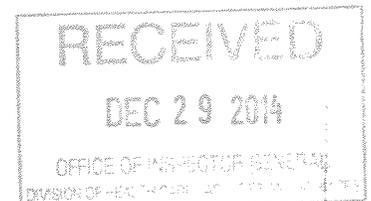
F 497	<p>Continued From page 22 as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's education records, it was determined the facility failed to provide evidence of the required twelve (12) hours per year of continued education for ten (10) of thirteen (13) Certified Nursing Assistants (CNA).</p> <p>The findings include:</p> <p>The facility did not provide a policy regarding CNA continued education hours.</p> <p>Review of the facility's continued education records for CNAs revealed CNA #1 had a hire date of 03/11/13 and had 11.5 hours. CNA #2 had a hire date of 03/24/12 and had 11.1 hours. CNA #3 had a hire date of 08/21/12 with 3.35 hours. CNA #6 had a hire date of 09/02/08 with 5.0 hours. CNA #8 had a hire date 01/02/12 with 5.75 hours. CNA #9 had a hire date of 03/16/12 and had 6.75 hours. CNA #10 had a hire date of 04/10/03 with 11.5 hours. CNA #11 had a hire date of 08/23/11 and had 7.70 hours. CNA #12 had a hire date of 10/04/11 and 4 hours of continued education. CNA #13 had a hire date of 05/13/12 and 10.5 hours.</p> <p>Interview with the Staff Development Coordinator, on 12/04/14 at 3:03 PM, revealed she was taught from previous staff to calculate CNA continued education hours from January to January, not from hire date to hire date. She indicated she</p>	F 497	<p>1. No specific residents were identified. All C.N.A.s presently employed will complete at least 12 (twelve) hours of continuing education provided by SDC/DON/ADON by 12/31/2014.</p> <p>Medical Director was made aware of this finding by DON on 12/19/2014 with no recommendations. All C.N.A's presently employed will have a performance evaluation by the DON/SDC/ADON/UM or Charge Nurse by 1/5/2015.</p> <p>2. DON/ADON to complete a onetime audit of all continuing education hours for each C.N.A to identify any C.N.A that does not have 12 hours of continuing education one year from employment date and that all C.N.A's have a performance evaluation per policy. This will be completed by 12/23/2014. Any issue identified will be corrected.</p> <p>3. DON to reeducate SDC regarding policy for at least 12 hours of continued education for C.N.A's within one year of hire date and policy for performance evaluations to be completed. This will be completed by 12/26/2014. DON/ADON to audit C.N.A's hours at least monthly x 6 months beginning 1/2015 to ensure all C.N.A's have 12 hours of continuing education.</p>	
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F 497	Continued From page 23 was aware some of the CNAs did not have the required educational hours.	F 497	SDC to provide education at least bi monthly to C.N.A.'s to ensure at least 12 hours of continued education is offered and completed this will begin 1/2015 and be on going. SDC to track number of completed education hours for each individual C.N.A by hire date beginning 12/22/2014 and will be on going. 4. QA Team consisting of Executive Director, DON/ADON, MDS Nurse, Social Services and or Activities Department to meet monthly x 3 months beginning month of January 2015, then at least quarterly, to review all audit findings and review/revise plan and make recommendations. 5. Date of Compliance Jan. 9, 2015	



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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1978 Original building, and 2013 Building Addition.</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (000)</p> <p>SMOKE COMPARTMENTS: Ten (10) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic, dry sprinkler system.</p> <p>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.</p> <p>A Recertification Life Safety Code Survey was conducted on 12/02/14. The facility was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Sharon K. Johnson, Executive Director* TITLE: _____ (X6) DATE: 12-23-14

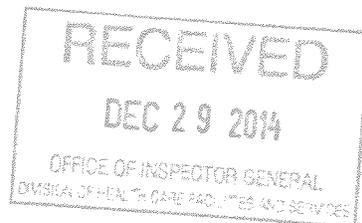
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

DEC 29 2014
OFFICE OF SURVEILLANCE AND INSPECTION
DIVISION OF HEALTH CARE SERVICES

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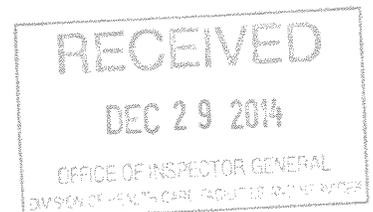
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K 018	<p>Continued From page 2</p> <p>thirty-five (35) residents, staff, and visitors. The facility has one-hundred (100) certified beds and the census was eighty-two (82) on the day of the survey.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation, on 12/02/14 at 10:02 AM, with the Maintenance Director revealed the door to Resident Room 325 would not latch when tested. The strike plate was not aligned with the latch and would not stay closed. <p>Interview, on 12/02/14 at 10:04 AM, with the Maintenance Director revealed he was unaware the door would not latch when closing and acknowledged it would not be able to resist the passage of smoke in the event of an emergency.</p> <ol style="list-style-type: none"> 2. Observation, on 12/02/14 at 1:09 PM, with the Maintenance Director revealed the door to Resident Room 223 was being held open with a trash can. When the trash can was removed, the door closed on its own and would not stay open. <p>Interview, on 12/02/14 at 1:11 PM, with the Maintenance Director revealed he was unaware the door would not stay open on its own and acknowledged the positioning of the trash can was an impediment in closing the door in the event of an emergency.</p> <p>The census of eighty-two (82) was verified by the Administrator, on 12/02/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 12/02/14.</p>	K 018	<ol style="list-style-type: none"> 3. The Executive Director educated the Maintenance Director on Life Safety Codes including resident doors and facility doors to ensure they all latch securely and that all resident room doors and facility doors stay open on its own and not being propped open. <ol style="list-style-type: none"> a. A weekly resident room and facility door audit will be conducted by the Maintenance Director and/or designee weekly for 30 days, bi-weekly for the next thirty days and once a month next 30 days and monthly thereafter to ensure all doors latch securely and that all resident room door and facility doors stay open on its own and not being propped open. 4. The Executive Director will do 10 random resident room door and facility door checks weekly for 30 days and 5 random resident room door and facility door checks weekly for the next 30 days to ensure all doors latch securely and that all resident room door and facility doors stay open on its own and not being propped open.



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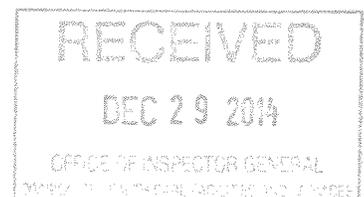
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K 018	Continued From page 3 Reference NFPA 101 (2000 Edition). 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 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 1 in. (2.5 cm) shall be permitted for corridor doors. 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: 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. 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 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with	K 018	The QA team consisting of the Executive Director, DON/ADON, MDS Nurse, Social Services, Maintenance Director and or Activities to meet monthly x 3 months beginning the month of January 2015 and then at least quarterly to review all audit findings and make further recommendations as needed. 5. Date of Completion Jan. 9, 2019.



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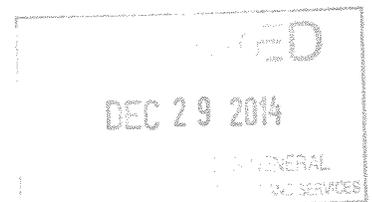
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K 018	Continued From page 4 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (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 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 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 National Fire Protection	K 029	K-029 NFPA 101 LIFE SAFETY CODE STANDARD Life Care Center of Bardstown will continue to protect our residents by providing door closures on facility doors that have the potential to store hazardous supplies. The deficient practice affected one door closure that was missing from the Central Supply Storage Room. 1. An automatic door closure was installed on the Central Supply Storage Room by the Maintenance Director.	01/09/2015



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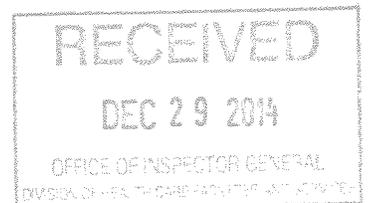
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/02/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
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K 029	<p>Continued From page 5</p> <p>Association (NFPA) standards. The deficiency had the potential to affect one (1) of ten (10) smoke compartments, ten (10) residents, staff and visitors. The facility had one-hundred (100) certified beds and the census was eighty-two (82) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 12/02/14 at 10:07 AM, with the Maintenance Director revealed the door to the Central Supply Storage Room located in the West Front Hall, was not equipped with a self-closing device.</p> <p>Interview, on 12/02/14 at 10:09 AM, with the Maintenance Director revealed the Room had recently been converted to a Central Supply Storage Room as part of the facility's renovation project. He stated the door was always closed and locked and acknowledged the room was used to store combustible materials and required to be self-closing.</p> <p>The census of eighty-two (82) was verified by the Administrator, on 12/02/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 12/02/14.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a</p>	K 029	<p>2. A complete audit was conducted by the Maintenance Director on all facility doors to ensure no other facility room has the potential to store hazardous supplies and was without an automatic door closure. All facility doors that have the potential to store hazardous supplies had an automatic door closure.</p> <p>3. The Executive Director educated the Maintenance Director on Life Safety Codes including the requirement to have an automatic door closure on all facility doors that have the potential to store hazardous supplies.</p> <p>a. A weekly facility door audit will be conducted by the Maintenance Director and/or designee weekly for 30 days, bi-weekly for the next thirty days and once a month next 30 days and monthly thereafter to ensure all facility doors that have the potential to store hazardous supplies have an automatic door closure.</p>
(X5) COMPLETION DATE			



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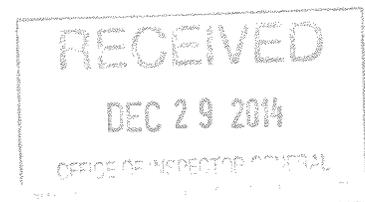
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K 029	Continued From page 6 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option 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 combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029	4. The Executive Director will do 10 random resident room door and facility door checks weekly for 30 days and 5 random resident room door and facility door checks weekly for the next 30 days to ensure all facility doors that have the potential to store hazardous supplies have an automatic door closure. The QA team consisting of the Executive Director, DON, ADON, MDS Nurse, Social Services, Maintenance Director and or Activities to meet monthly x 3 months beginning the month of January 2015 and then at least quarterly to review all audit findings and make further recommendations as needed. 5. Date of Completion Jan. 9, 2019.	01/09/2015
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in	K 056		



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K 056	<p>Continued From page 7</p> <p>accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</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 National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of ten (10) smoke compartments, approximately forty (40) residents, staff and visitors. The facility has one-hundred (100) certified beds and the census was eighty-two (82) on the day of the survey. The facility failed to ensure sprinkler head spray patterns were not obstructed.</p> <p>The findings include:</p> <p>1. Observation, on 12/02/14 at 9:35 AM, with the Maintenance Director revealed the sprinkler head located at the cross-corridor doors within the West Back Hall had its spray pattern obstructed by a surface mounted exit light fixture. The light fixture was positioned less than four (4) inches from the sprinkler head and extended further down from the ceiling than the sprinkler head fusible link did.</p> <p>Interview, on 12/02/14 at 9:37 AM, with the Maintenance Director revealed he was unaware</p>	K 056	<p>K-056</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Life Care Center of Bardstown will continue to protect our residents by ensuring sprinkler head spray patterns are not obstructed.</p> <p>The deficient practice affected two areas in which the sprinkler heads located at the cross-corridor doors within the West Back Hall had its spray pattern obstructed by a surface mounted exit light fixture. The second the sprinkler head located within the Rehab Linen closet had its spray pattern obstructed by a surface mounted light fixture.</p> <p>1. Both sprinkler heads were addressed by the Maintenance Director and there is nothing obstructing the spray pattern on either sprinkler head.</p> <p>2. A complete audit was conducted facility wide by the Maintenance Director to ensure no other sprinkler heads had their spray pattern obstructed. There was no other sprinkler heads identified.</p> <p><i>1-9-15</i> <i>M.D. Gibson</i></p> <p><i>DJPB</i> <i>1-5-15</i></p>



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K 056

Continued From page 8
the positioning of the surface mounted light fixtures would obstruct the spray pattern of the sprinkler head upon activation of the automatic sprinkler system.

2. Observation, on 12/02/14 at 12:58 PM, with the Maintenance Director revealed the sprinkler head located within the Rehab Linen Closet had its spray pattern obstructed by a surface mounted light fixture. The light fixture was positioned less than twelve (12) inches from the sprinkler head and extended further down from the ceiling than the sprinkler head fusible link did.

Interview, on 12/02/14 at 1:00 PM, with the Maintenance Director revealed he was unaware the positioning of the surface mounted light fixtures would obstruct the spray pattern of the sprinkler head upon activation of the automatic sprinkler system.

The census of eighty-two (82) was verified by the Administrator, on 12/02/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 12/02/14.

Reference:
NFPA 101 (2000 Edition)
4.6.12.1. Every required sprinkler system shall be continuously maintained in proper operating condition.
NFPA 13 (1999 Edition)
5-5.5.2* Obstructions to Sprinkler Discharge

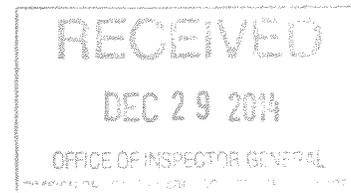
K 056

3. The Executive Director educated the Maintenance Director on Life Safety Codes including the sprinkler heads to ensure no sprinkler head had their spray pattern obstructed.

a. A weekly sprinkler head audit will be conducted by the Maintenance Director and/or designee weekly for 30 days, bi-weekly for the next thirty days and once a month next 30 days and monthly thereafter to ensure no sprinkler head had their spray pattern obstructed.

4. The Executive Director will do 5 random sprinkler head checks weekly for 30 days and 5 random sprinkler head checks bi-weekly for the next 30 days to ensure no sprinkler head had their spray pattern obstructed.

The QA team consisting of the Executive Director, DON, ADON, MDS Nurse, Social Services, Maintenance Director and or Activities to meet monthly x 3 months beginning the month of January 2015 and then at least quarterly to review all audit findings and make further recommendations as needed.



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K 056	Continued From page 9 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). 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.	K 056		

