

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 490	<p>Continued From page 321</p> <p>revealed she was unaware of a conflict with the night shift staff, and had not realized this was a concern through reviewing the interviews with staff. Even though staff had written statements regarding the conflict. The SSD stated the investigation was a team approach and the former Administrator, who was the Administrator during the investigation, reviewed the initial investigation report and the final five (5) day report. The SSD stated the former Administrator had decided the allegations from the morning of 07/03/14 were unsubstantiated, because they could not determine the timeframe in which Resident #26 was left wet. However, she indicated the incident was not thoroughly investigated.</p> <p>Interview with the HR Director revealed the former Administrator led and directed the investigation and due to a miscommunication she only had the information related to Resident #26 being left wet, and she just focused on this resident during the investigation. She stated she knew other residents were left wet; however, was unsure who they were and was not directed by the Administrator to follow up on investigations related to those residents. She assumed the Administrator was following up on the non interviewable residents who were left wet the morning of 07/03/14. She further acknowledged she was unaware there was a conflict between staff on the night shift on the South Unit, and had not noted this in completing her part of the investigation.</p> <p>Interview with the DON, on 07/23/14 at 6:10 PM, revealed she was informed of "people being left wet" on 07/03/14 by LPN#12 and the ADON/UM of the South Unit. She stated she had not</p>	F 490			

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F 490	<p>Continued From page 322</p> <p>reviewed the investigation. However, as the department head of nursing, she should have reviewed it, especially since it was related to resident care. She stated she should have been more involved in the investigation and had just learned of the conflict between SRNA #19 and #21 that day when talking to RN #6. Further interview revealed there should have been a process in place to address the non-interviewable residents who were left wet on 07/03/14, and skin assessments should have been performed on these residents.</p> <p>Interview on 07/31/14 at 10:14 AM, with the former Administrator, who was the Administrator in charge of the facility from 05/15/14 through 07/11/14, revealed she became aware on 07/03/14 that Resident #26 had been left wet the morning of 07/03/04 and other residents being left wet as well; however, she did not realize the other residents were left wet the same morning. She stated the facility did an investigation and during the investigation the DON made her aware of the conflict between SRNA #19 and SRNA #21. The Administrator stated she should have followed up on the conflict as this could impact resident care if the staff did not work together; however, she was unaware if anyone addressed the issue. She stated the issue should have been addressed by the HR Director or the SDN.</p> <p>Further interview with the former Administrator, revealed SRNA #19 was placed on suspension on 07/03/14 pending the outcome of the investigation. She further stated the investigation was conducted as a team with herself, the DON, the HR Director and the SSD, and they met as a team and discussed the findings of the investigation. The former Administrator stated,</p>	F 490			

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F 490	<p>Continued From page 323</p> <p>they decided the allegation related to Resident #24 being left wet was unsubstantiated due to conflicting statements from staff regarding how long the resident had been left wet. Continued interview, with the Former Administrator, revealed skin assessments should have been performed on the other residents (Resident #5, #28, #29, and #27) who were left wet as part of a thorough investigation. The Administrator stated she should have read and reviewed the investigation to ensure it was thorough; however, she did not review the written investigation.</p> <p>Interview on 07/31/14 at 11:47 AM, with the current Administrator, revealed he started on 07/09/14. He stated the former Administrator had covered operational issues and discussed findings from the survey conducted 06/30/14 through 07/03/14. The current Administrator reported the former Administrator discussed two (2) residents who were part of an investigation; however, he could not recall who the names of the residents. In addition, he could not recall for certain if the former Administrator told him about a conflict on the night shift between SRNA #19 and SRNA #21; however, he acknowledged he was aware there had been issues with SRNA #19.</p> <p>The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/30/14 that alleged removal of the IJ effective 07/29/14. Review of the AOC revealed the facility implemented the following:</p> <p>1. The facility opened and investigated the five (5) reported allegations of neglect identified on the 06/30/14 through 07/03/14 Survey for Residents #5, #26, #27, #28, and #29. Initial</p>	F 490			

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F 490	<p>Continued From page 324</p> <p>Reports were completed with the five (5) day follow up reports pending completion of the investigations. The allegations were investigated by the Clinical Nurse Executive, Corporate Nurse Consultant, Special Projects Administrator, Administrator, HR Director, SSD, Corporate Director of Compliance and Signature Care Consultant.</p> <p>2. One hundred percent (100%) of the resident population received head to toe assessments by the DON, the ADON, MDS Coordinator, Wound Care Nurse, SDC, Evening Nurse Supervisor, Corporate Nurse Consultant and Charge Nurses on 07/23/14.</p> <p>3. Residents with a BIMS of eight (8) or above were interviewed by the ADON, Admissions Director, Dietary Director, MDS Coordinators, Medical Records Director, Business Office Manager, Housekeeping Director, SDC, Supply Coordinator, Quality of Life Director or Chaplain which was completed on 07/25/14 for any abuse, neglect, or misappropriation concerns.</p> <p>4. Families and responsible parties were interviewed for residents with a BIMS below eight (8) which was initiated on 07/25/14 and as of 07/28/14, thirty-seven (37) of fifty-six (56) had been completed, for any abuse, neglect, or misappropriation concerns. The facility would continue to attempt contacting families and responsible parties daily to identify any concerns until remaining Power of Attorney's (POA's) had been reached. Concerns were addressed per policy and procedure as to reporting requirements and resident protection.</p> <p>5. Staff was interviewed for any abuse, neglect,</p>	F 490			

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F 490	<p>Continued From page 325</p> <p>or misappropriation concerns by the ADON, Admissions Director, Dietary Director, MDS Coordinators, Medical Records Director, Business Office Manager, Housekeeping Director, SDC, Quality of Life Director or Chaplain on 07/25/14. Initial reports were made on the allegations relative to those interviews.</p> <p>6. Initial Reports were made on 07/25/14 related to the alleged allegations relative to the interviews with residents, families, responsible parties, and staff. Thorough investigations were initiated on 07/25/14 by the Clinical Nurse Executive, Corporate Nurse Consultant, Special Projects Administrator, Administrator, HR Director, SSD, Corporate Director of Compliance and Signature Care Consultant on those residents identified with appropriate follow up reporting on the allegations received.</p> <p>7. Abuse, neglect and misappropriation audits, assessments, interviews and questionnaires were reviewed by the Special Projects Administrator, DON, Corporate Nurse Consultant or Chief Nurse Executive on 07/27-07/28/14 for any indications of abuse, neglect or misappropriation concerns.</p> <p>8. The Medical Director was notified of the Immediate Jeopardy on 07/25/14 by the DON and Special Projects Administrator. An Emergency Quality Assurance (QA) Meeting was held on 07/26/14 with the Corporate Director of Risk Management, Clinical Nurse Executive, Corporate Nurse Consultant, Medical Director, Special Projects Administrator, DON, HR Director, SSD and SDC related to the Immediate Jeopardy.</p> <p>9. The DON, two (2) ADONs, MDS Coordinators,</p>	F 490			

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F 490	<p>Continued From page 326</p> <p>SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions, Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Nurse were re-educated on 07/23/14 and the Administrator was re-educated on 07/28/14, upon his return, by the Corporate Nurse Consultant on the Abuse, Neglect and Misappropriation Policy and Procedure which included training, prevention, identification, investigation, protection and reporting, as well as, providing care per residents' individualized care plans. They could not return to work until the abuse, neglect, misappropriation education was provided and post test administered and a one hundred percent (100%) score was obtained on the post test. If a manager did not score a one hundred percent (100%) on post test, the manager was immediately re-educated and a post test was re-administered.</p> <p>10. The facility's Administrator, DON, ADON's, MDS Coordinators, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Nurse educated stakeholders related to the Abuse, Neglect, and Misappropriation Policy which included training, prevention, identification, investigation, protection and reporting, as well as, providing care per residents' individualized care plans starting on 07/23/14 and continued until 07/28/14. No staff would be allowed to work until this education was provided and the post test administered and a one hundred percent (100%)</p>	F 490		

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F 490	<p>Continued From page 327</p> <p>score obtained. Eighty-seven (87) of ninety-six (96) were completed by 07/28/14.</p> <p>11. Administrator, DON, ADON's, MDS Coordinators, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Nurse provided education to stakeholders which was initiated on 07/26/14 to nursing staff related to incontinence care and Activities of Daily Living (ADL's) care per the Care Plan and answering call lights. Calls and certified letters had been sent notifying staff they must complete training before returning to work relative to incontinence care and Activities of Daily Living (ADL's) Care per resident individualized Care Plan and answering call lights in a timely manner.</p> <p>12. Education regarding the Abuse, Neglect and Misappropriation Policy would be included in the orientation process for newly hired staff. No newly hired person would be able to work until this education was provided and a post test administered and one hundred percent (100%) score obtained provided by staff development.</p> <p>13. Staff assessment of knowledge test regarding abuse, neglect and misappropriation was being administered by the Administrator, DON, ADON's, MDS Coordinator, SDC, Dietary Director, Medical Records Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant</p>	F 490			

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F 490	<p>Continued From page 328</p> <p>Operations Director, Quality of Life Director and Wound Care Nurse to five (5) staff members on each shift and different staff members until the immediacy was removed.</p> <p>14. Ten (10) staff questionnaires would be administered daily to ensure continued understanding of the Abuse, Neglect and Misappropriation Policy. Results of the questionnaires, tests, ten (10) resident skin assessments of residents with a BIMS less than eight (8) per day, ten (10) residents with a BIMS greater than eight (8) interviews would be reviewed daily until the immediacy was resolved by the Administrator, DON, Nurse Consultant or Chief Nurse Executive. Any concerns revealed on the above to include injuries of unknown source would be reported immediately to the Abuse Coordinator, Administrator, DON, Corporate Nurse Coordinator, Regional Vice President of Operations, Special Projects Administrator, or Chief Nurse Executive.</p> <p>15. Results of the staff questionnaires, resident interviews and skin assessments would be reviewed daily by the Administrator, DON, Nurse Consultant or Chief Nurse Executive with results reported to the Quality Assurance (QA) Committee weekly to determine the further need of continued education or revision of plan. Based on the evaluation the QA Committee would decide at what frequency the staff questionnaire would need to continue. Concerns identified would be corrected immediately and reported to the Administrator or DON to ensure an investigation of suspected abuse, neglect or misappropriation was investigated/completed and reporting guidelines were met along with any reporting of violation of resident rights.</p>	F 490			

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F 490	<p>Continued From page 329</p> <p>16. Administrator, DON, ADONs, MDS Coordinator, SDC, Dietary Director, Business Office Manager, SSD, Chaplain, Admissions Director, Medical Records Director, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Director, Plant Operations Director, Quality of Life Director, Wound Care Nurse, Corporate Nurse Consultant, Regional Vice President or Clinical Nurse Executive would conduct call light audits through direct observation and monitoring tool daily twenty-four (24) hours a day seven (7) days a week on each shift to monitor compliance until the immediacy was removed. Then five (5) call lights daily on each shift (fifteen (15) total) ongoing and reported to QA Committee weekly during immediacy and monthly after immediacy was removed. Charge Nurses would provide direct observation of call light responsiveness and ensure all residents were getting needs met for plan of care each shift. Incontinence care observation would be completed for ten (10) residents daily until the immediacy was removed then ongoing for five (5) residents daily with results being reported to the QA Committee weekly during immediacy and monthly after the immediacy was removed.</p> <p>17. Human Resources (HR) Director performed an audit of staff files for any abuse, neglect or misappropriation concerns 7/26/14 through 7/27/14 and the items reviewed included coaching, counseling forms, suspension forms, termination forms, abuse registry checks, background checks and licensure to 07/03/14. Results of the audit was given to the Administrator, DON or Corporate Nurse Consultant on 07/27/14, to review for any abuse,</p>	F 490		

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F 490	<p>Continued From page 330 neglect or misappropriation concerns that needed reported. None were identified.</p> <p>18. Information on "Caring for the Caregiver" which addresses the signs of stress and burn out, showing the caregiver ways to cope and reduce stress and useful ways that friends could offer help to the caregiver were posted by the time clock on 07/27/14 by the Special Projects Administrator.</p> <p>19. A nurse from the regional team or corporate office had been onsite since 07/21/14 and would remain in the facility daily until the Immediate Jeopardy was lifted. The nurses from the regional team home office were assisting with investigations, observing staff treatment of residents, performing chart audits and providing oversight and consultation. The Chief Nurse Executive would be in daily contact with the Corporate Nurse Consultant and would review allegations.</p> <p>20. Grievances and Resident Questionnaires since 07/23/14 were reviewed by the Administrator, DON, Chief Nurse Executive, HR Director, Admissions Director or Regional Nurse Consultants 07/27/14 through 07/28/14 to determine if any items documented were a reportable event. All issues identified were reported and investigations initiated per the facility's policy and procedure. The Administrator, SSD, or the DON would review daily, the grievances and Incident/Accident Reports, until immediacy was lifted, starting 07/27/14 to determine if there were reportable allegations which had been identified, then daily Monday through Friday during the Morning Stand-Up Meeting. SSD or the DON would report to the</p>	F 490		
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F 490	<p>Continued From page 331</p> <p>Administrator any identified allegations of abuse, neglect or misappropriation immediately after their review. The Administrator would review any allegations of abuse, neglect or misappropriation for reporting to the Office of Inspector General, Adult Protective Services and Ombudsman and appropriate authorities as required by state law.</p> <p>21. The Administrator, DON, SSD would review and discuss abuse, neglect and misappropriation allegations daily to ensure the resident was protected, the perpetrator was removed from resident care area, reports to the State Survey Agency, APS and Ombudsman were filed timely, and a thorough investigation was completed. The Abuse Coordinator (SSD) would maintain an abuse, neglect and misappropriation investigation log starting on 07/27/14 that would include documentation of the following: validate protection of residents; perpetrator was removed from resident care area; reports to the State Survey Agency and Adult Protective Services (APS) were filed timely; and a thorough investigation was completed. The Abuse Coordinator and one of the following: Administrator, DON, Chief Nurse Executive or Regional Nurse Consultant would review the abuse, neglect and misappropriation log daily until removal of the Immediate Jeopardy, beginning on 07/27/14, to validate protection of the resident, that the perpetrator was removed from the resident care area, that reports to the State Survey Agency and APS and appropriate authorities required by state law, were filed timely, and a thorough investigation had been completed.</p> <p>22. In the event of any new reports of alleged abuse, neglect, or misappropriation of property,</p>	F 490		

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F 490	<p>Continued From page 332</p> <p>after the Immediate Jeopardy was removed, the Signature Care Consultant or Chief Nursing Executive would validate the resident was protected, report was filed timely, the perpetrator was removed from resident care area and a thorough investigation was completed.</p> <p>23. Beginning on 07/27/14, the care plan conferences for each resident would include any abuse, neglect or misappropriation concerns which the residents or families had. Resident safety would be validated and then the allegation would be reported to the Charge Nurse. The Abuse, Neglect and Misappropriation Policy would then be followed.</p> <p>24. Administrative oversight of the facility would be completed by the Special Projects Administrator, the Regional Vice President of Operations, Chief Nursing Officer, Signature Care Consultant, member of the regional staff team or Chief Operating Officer daily until removal of the immediacy beginning 07/21/14, then weekly for four (4) weeks, then monthly.</p> <p>25. A Quality Assurance Meeting would be held weekly for four (4) weeks beginning 07/26/14, then monthly for recommendations and further follow up regarding the above stated plan. At that time based upon evaluation the QA Committee would determine at what frequency any ongoing audits would need to continue.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <p>1. Review of the facilities investigations revealed the five (5) reported allegations involving Resident's #5, #27, #28, and #29 have been</p>	F 490			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/01/2014
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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F 490	<p>Continued From page 333</p> <p>completed with a five (5) day follow up. A re-investigation was done related to allegations for Resident #26.</p> <p>Interview, on 07/31/14 at 7:08 PM, with the Corporate Nurse Consultant revealed the facility had investigated the allegations regarding Resident's #5, #26, #27, #28, and #29 and found them all to be substantiated.</p> <p>2. Review of copies of resident head to toe assessments revealed all residents were assessed and the assessments were performed on 07/23/14 on North and South Hall, with a recorded census on 07/23/14 of fifty six (56) residents on North Hall and fifty-one (51) residents on South Hall. There was no concerns revealed during review of the skin assessments.</p> <p>Interview, on 07/31/14 at 5:26 PM, with the Wound Care Nurse revealed she was in charge of the skin assessments, and she and other nurses completed skin assessments on one hundred percent (100%) of the residents in the building.</p> <p>3. Review of Resident Interviews revealed residents with a BIMS of eight (8) and above were interviewed, which included forty-six (46) residents, related to abuse, neglect, and misappropriation concerns. Concerns were addressed per policy and procedure as to reporting requirements and resident protection.</p> <p>4. Review of family interviews for residents with a BIMS of less than eight (8) revealed thirty-seven (37) of fifty-six (56) of these interviews were completed as of 7/28/14 related to abuse, neglect, and misappropriation concerns.</p>	F 490		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 490	<p>Continued From page 334</p> <p>Concerns were addressed per policy and procedure as to reporting requirements and resident protection.</p> <p>Interview with the DON on 08/01/14 at 10:00 AM, revealed the interviewable residents were interviewed, as well as, the families of residents with a BIMS score of less than eight (8) and she reviewed the interviews for any concerns.</p> <p>5. Review of the Stakeholder (Staff) Investigative Interviews revealed they were conducted in reference to abuse, neglect and misappropriation concerns 7/23/14 through 7/25/14 for all regular and part-time staff.</p> <p>Interview on 07/31/14 with SRNA #24 at 2:00 PM; Activity Assistant at 2:15 PM; SRNA #37 at 2:20 PM; Dietary Aide #5 at 2:30 PM; SRNA #36 at 2:30 PM; SRNA #11 at 2:40 PM; Housekeeper #4 at 2:45 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; LPN #11 at 3:40 PM; SRNA #16 at 3:50 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; ADON/Unit Manager (UM) of the South Unit at 4:30 PM; ADON/UM of the North Unit at 4:45 PM; RN #5/Evening Shift Supervisor at 5:00 PM; LPN #3 at 5:17 PM; SRNA #35 at 5:49 PM; LPN #13 at 6:05 PM; Dietary Manager at 6:15 PM; and SRNA #4 at 7:40 PM revealed they were all interviewed and asked if they were aware of any abuse, neglect, or misappropriation.</p> <p>6. Review of the allegations relative to the interviews with residents, families, responsible parties, and staff concerns revealed they were investigated with initial reports completed.</p> <p>Interview with the Corporate Nurse Consultant on 07/31/14 at 7:08 PM revealed there was several</p>	F 490			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
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F 490	<p>Continued From page 335</p> <p>reportable allegations from the interviews which she assisted with conducting, and the facility investigated with follow up actions and reporting.</p> <p>7. Review of the Abuse, Neglect, and Misappropriation audits, assessments, interviews and questionnaires revealed they were reviewed by the DON, Corporate Nurse Consultant, Chief Nurse Executive or Special Projects Administrator on 07/27/14 and 07/28/14.</p> <p>Interview with the DON on 08/01/14 at 10:00 AM revealed they expanded on the abuse questions giving scenarios to the staff to have them choose which type of abuse was occurring in the scenarios. She stated she reviewed the abuse audits, assessments, interviews, and questionnaires.</p> <p>8. Review of the Quality Assurance Signature Sheet and Minutes revealed an Emergency QA meeting was held on Saturday, 07/26/14, with the Medical Director, Special Projects Administrator, Director of Nursing Services, Director of Clinical Risk Management, Staff Development, Certified Nurse Executive, Corporate Nurse Consultant, Human Resources Director, and Social Services Director to discuss current Immediate Jeopardy deficiencies and a Plan of Correction.</p> <p>Interview with the DON on 08/01/14 and the Corporate Nurse Consultant on 07/31/14 at 7:08 PM confirmed the QA Meeting was held on 07/26/14 with the Medical Director. Interview with the HR Director on 07/31/14 at 5:45 PM revealed during the emergency QA Meeting they discussed the Immediate Jeopardy deficiencies and the reason for the deficiencies as well as discussed the audits, interviews, questionnaires and</p>	F 490			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 490	<p>Continued From page 336 interviewing that was being done related to the deficiencies.</p> <p>9. Review of the sign in sheets dated 07/23/14 regarding training for the Administrative staff of the facility regarding the Abuse, Neglect and Misappropriation Policy revealed the Certified Nurse Executive educated the DON, ADON's, MDS Coordinator, SDC, Dietary Director, Business Office Manager, Social Services Director, Chaplain, Admissions Director, Medical Records, HR Director, Therapy Services Manager, Supply Manager, Environmental Services Manager, Plant Operations Director, Quality of Life Director and Wound Care Nurse received the training.</p> <p>Review of the sign in sheet on 07/28/14 for training on the Abuse, Neglect and Misappropriation Policy, revealed the Administrator of the facility was educated on skin assessments, interviews, the Abuse, Neglect, and Misappropriation Policy, and the Education session regarding the Plan of Correction.</p> <p>Interview with the ADON/UM of the South Unit on 07/31/14 at 3:30 PM, ADON/UM of the North Unit on 07/31/14 at 4:45 PM, HR Director on 07/31/14 at 5:45 PM, the Dietary Director on 07/31/14 at 6:15 PM, and the DON on 08/01/14 at 10:00 AM, revealed they received training on abuse, neglect and misappropriation and had to take a post test in which they had to score a one hundred percent (100%).</p> <p>Review of the post test administered for Department Administrative Managers revealed a score of one hundred percent (100%) related to abuse, neglect, and misappropriation education.</p>	F 490			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 490	Continued From page 337 Interview on 07/31/14 at 7:08 PM with the Corporate Nurse Consultant, revealed the Department Administrative Managers scored a one hundred percent (100%) on the post test related to abuse, neglect and misappropriation education. 10. Review of the inservices revealed education was conducted with stakeholders related to abuse, neglect, and misappropriation 07/23/14 through 07/28/14 in which they had to score a one hundred percent (100%) on the post test or retake the test. Interview with the Staff Development Coordinator (SDC) on 07/31/14 at 5:15 PM, and the SSD on 07/31/14 at 6:30 PM revealed she and other administrative staff educated the stakeholders related to abuse, neglect and misappropriation and completed these inservices. Interview on 07/31/14 with SRNA #24 at 2:00 PM; Activity Assistant at 2:15 PM; SRNA #37 at 2:20 PM; Dietary Aide #5 at 2:30 PM; SRNA #36 at 2:30 PM; SRNA #11 at 2:40 PM; Housekeeper #4 at 2:45 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; LPN #11 at 3:40 PM; SRNA #16 at 3:50 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; ADON/Unit Manager (UM) of the South Unit at 4:30 PM; ADON/UM of the North Unit at 4:45 PM; RN #5/Evening Shift Supervisor at 5:00 PM; LPN #3 at 5:17 PM; SRNA #35 at 5:49 PM; LPN #13 at 6:05 PM; Dietary Manager at 6:15 PM; and SRNA #4 at 7:40 PM revealed they were all educated on the facility's Abuse, Neglect and Misappropriation Policy, which included training, prevention, identification, investigation, protection and reporting.	F 490			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 490	Continued From page 338 Review of the sign in sheets from 07/23/14 through 07/28/14 revealed inservices were conducted with the facility staff regarding the Abuse and Neglect Policy. Review of the post-test revealed some staff had to be re-educated and staff eventually received a one hundred percent (100%) on the post tests. Documentation provided from the facility revealed telephone calls and certified letters were sent to staff who did not complete education and informed they could not return to work until the education was completed. Interview on 07/31/14 with SRNA #24 at 2:00 PM; Activity Assistant at 2:15 PM; SRNA #37 at 2:20 PM; Dietary Aide #5 at 2:30 PM; SRNA #36 at 2:30 PM; SRNA #11 at 2:40 PM; Housekeeper #4 at 2:45 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; LPN #11 at 3:40 PM; SRNA #16 at 3:50 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; ADON/Unit Manager (UM) of the South Unit at 4:30 PM; ADON/UM of the North Unit at 4:45 PM; RN #5/Evening Shift Supervisor at 5:00 PM; LPN #3 at 5:17 PM; SRNA #35 at 5:49 PM; LPN #13 at 6:05 PM; Dietary Manager at 6:15 PM; and SRNA #4 at 7:40 PM revealed they were all educated related to abuse, neglect, and misappropriation in which they had to score a one hundred percent (100%) on the post test or retake the test. 11. Review of the sign in sheets on 7/26/14 and documentation of education provided revealed additional education was conducted with stakeholders regarding incontinence care, ADL care per resident individualized plan of care, and answering call lights in a timely manner to the facility staff. Review of documentation provided	F 490			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 490	<p>Continued From page 339</p> <p>by the facility revealed telephone calls and certified letters were sent to staff who did not complete education and informed they could not return to work until the education was completed. Further review revealed the stakeholders had to score a one hundred percent (100%) on the post test or retake the test. Further review revealed all but four (4) prn (as needed) staff had taken the test and scored a one hundred percent (100)%.</p> <p>Interview on 07/31/14 with SRNA #24 at 2:00 PM; Dietary Aide #5 at 2:30 PM; Housekeeper #4 at 2:45 PM; Activity Assistant at 2:15 PM; Dietary Manager at 6:15 PM; ADON/Unit Manager (UM) of the South Hall at 4:30 PM; RN #5/Evening Shift Supervisor at 5:00 PM; ADON/UM of the North Unit at 4:45 PM; SRNA #16 at 3:50 PM; SRNA #36 at 2:30 PM; SRNA #37 at 2:20 PM; SRNA #11 at 2:40 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; SRNA #28 at 3:30 PM; LPN #11 at 3:40 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; LPN #3 at 5:17 PM; LPN #13 at 6:05 PM; SRNA #35 at 5:49 PM; and SRNA #4 at 7:40 PM revealed they all had received inservice training regarding incontinence care, ADL care per resident individualized plan of care, and answering call lights in a timely manner.</p> <p>12. Review of the new orientation schedule revealed all new employees will complete education regarding the facility's abuse and neglect and successfully complete post test.</p> <p>Interview with the SDC on 07/31/14 at 5:15 PM confirmed the abuse and neglect education was a part of the new orientation schedule for new employees.</p> <p>13. Review of the Stakeholder Assessment of</p>	F 490			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 490	<p>Continued From page 340</p> <p>Knowledge Tests regarding the Abuse, Neglect and Misappropriation Policy revealed the test was administered to five (5) stakeholders each shift and continued with different stakeholders.</p> <p>Interview on 07/31/14 with SRNA #24 at 2:00 PM; Dietary Aide #5 at 2:30 PM; Housekeeper #4 at 2:45 PM; Activity Assistant at 2:15 PM; Dietary Manager at 6:15 PM; ADON/Unit Manager (UM) of the South Hall at 4:30 PM; RN #5/Evening Shift Supervisor at 5:00 PM; ADON/UM of the North Unit at 4:45 PM; SRNA #16 at 3:50 PM; SRNA #36 at 2:30 PM; SRNA #37 at 2:20 PM; SRNA #11 at 2:40 PM; SRNA #5 at 2:55 PM; SRNA #34 at 3:30 PM; SRNA #28 at 3:30 PM; LPN #11 at 3:40 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; LPN #3 at 5:17 PM; LPN #13 at 6:05 PM; SRNA #35 at 5:49 PM; and SRNA #4 at 7:40 PM revealed they all had received the Assessment of Knowledge Test regarding abuse, neglect and misappropriation.</p> <p>14. Review of the questionnaires, skin assessments, and interviews revealed ten (10) stakeholder questionnaires, ten (10) skin assessments for residents with a BIMS of less than eight (8), and ten (10) interviews with residents with a BIMS of eight (8) or greater than eight (8) were administered daily related to understanding of the abuse, neglect, and misappropriation policy. Concerns were addressed per policy and procedure as to reporting requirements and resident protection.</p> <p>Interview with the DON on 08/01/10 at 10:00 AM revealed, the facility was still administering ten (10) questionnaires to stakeholders a day, performing ten (10) skin assessments a day for residents with a BIMS of less than eight (8), and</p>	F 490			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 490	<p>Continued From page 341</p> <p>conducting ten (10) interviews a day with residents who had a BIMS of eight (8) or greater related to abuse, neglect, and misappropriation.</p> <p>15. Review of the QA Minutes dated 07/26/14 revealed the stakeholder questionnaires, resident skin assessments and resident interviews were to be reviewed daily and results and were to be reported to QA weekly.</p> <p>Interview with the DON on 08/01/14 at 10:00 AM revealed the stakeholder questionnaires, skin assessments and resident interviews were reviewed daily by her and taken to the QA Meeting weekly.</p> <p>16. Review of the call light audits revealed monitoring was being done twenty-four hours (24) a day on each shift. Further review of the call light audits revealed five (5) call lights audits was being done daily on each shift (fifteen (15) total) which was ongoing. Review of the audits for Incontinence care revealed observation of incontinence care was completed for ten (10) residents daily. Review of the call light audits revealed an improvement in call light response time as the auditing continued.</p> <p>Interview on 07/31/14, with LPN #11 at 3:40 PM; RN #1 at 3:55 PM; LPN #12 at 4:10 PM; LPN #3 at 5:17 PM; and LPN #13 at 6:05 PM verified, as charge nurses they were providing direct observation of call light responsiveness and ensuring the residents were getting needs met as per the care plan.</p> <p>Interview with the DON on 08/01/14 at 10:00 AM, revealed call light audits were still being done twenty-four (24) hours a day on each shift and</p>	F 490		

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 490	Continued From page 342 observation of incontinence care was still being done for ten (10) residents daily and the results of the audits would be taken to the weekly QA Meeting. 17. Review of the audits revealed the Human Resources Director conducted an audit of the personnel charts for any history of abuse, neglect, or misappropriation concerns and no concerns were identified. Interview with the HR Director on 07/31/14 at 5:45 PM revealed she had performed an audit of the personnel files looking for any abuse charge, coaching/counseling/suspension/termination related to abuse, license verification, criminal background checks and abuse registry checks. 18. Observation on 07/31/14 at 11:00 AM revealed a sign was posted by the time clock to personnel to address Caring for the Caregiver - signs of stress and burn-out. Interview with SRNA #24, on 07/31/14 at 2:00 PM, revealed she was aware of the sign at the timeclock related to stress and burn out. Interview with the DON on 08/01/14 at 10:00 AM revealed there was a sign posted by the timeclock for personnel related to what to do if feeling stress and burn out. 19. Observation revealed a nurse from the corporate office of the facility was present on the facility throughout the survey. Interview on 07/31/14 at 7:08 PM with the Corporate Nurse Consultant revealed a Corporate Nurse had been in the building since	F 490			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 490	<p>Continued From page 343 07/21/14 on someone would remain at the facility until the immediacy was removed.</p> <p>20. Review of the Grievances and Resident Questionnaires since 07/23/14 revealed they were reviewed by the Administrator, DON, Chief Nurse Executive, HR Director, Admissions Director and/or Regional Nurse Consultants by 07/28/14. Concerns were addressed per policy and procedure as to reporting requirements and resident protection.</p> <p>Interview with the Administrator on 08/01/14 at 11:46 AM, revealed he had been reviewing daily the grievances, incident reports and resident and staff questionnaires to identify any reportable allegations and the facility was reviewing them daily Monday through Friday in the morning stand up meeting. He stated the DON and SSD were to report any allegations of abuse to him and he was to review the investigations to ensure there was corrective action, appropriate follow up, and reporting.</p> <p>21. Review of the Allegation Log, revealed the following; validate protection of residents, perpetrator removed from resident care area, reports to the Inspector General and APS were filed timely, and a thorough investigation was completed.</p> <p>Interview with the SSD on 07/31/14 at 6:30 PM revealed she was the Abuse Coordinator and she reviewed allegations of abuse and grievances daily with the Administrator. She stated Accident and Incident reports, allegations of abuse/neglect/misappropriation and grievances were reviewed daily in the clinical meeting Monday through Friday with the DON and other</p>	F 490		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/02/2014
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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F 490	<p>Continued From page 344</p> <p>Administrative Staff. She stated there was a new tool used for logging investigations which included the date of submission, resident name, description of allegation, perpetrator, date the five (5) day investigation was to be completed, and the date state agencies were notified of the findings. The SSD stated she was responsible for keeping the log up to date with new reportable allegations.</p> <p>22. Review of the facility binder provided to the surveyors related to the IJ, revealed documentation that in the event of any new reports of alleged abuse, neglect, or misappropriation the Signature Care Consultant or Chief Nursing Executive would be contacted prior to making the final five day investigation to the State Survey Agency to validate the resident was protected, report was filed timely, the perpetrator was removed from the patient area and a thorough investigation was completed.</p> <p>Interview with the Administrator on 08/01/14 at 11:46 AM, revealed in the event of any allegation of abuse, neglect or misappropriation, corporate was to review the investigation prior to sending the five (5) day final report to the State Survey Agency.</p> <p>23. Review of the facility binder provided to the surveyors related to the IJ, revealed documentation stating care plan conferences would include any abuse, neglect or misappropriation concerns that the families or residents may have.</p> <p>Interview with the DON on 08/01/14 at 10:00 AM, revealed all care plan conferences would include questioning residents and families about any</p>	F 490		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/01/2014
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F 490	Continued From page 345 concerns related to abuse, neglect or misappropriation. 24. Interview with the Administrator on 08/01/14 at 11:46 AM, revealed Corporate Administrative oversight of the facility was to continue until the immediacy was removed, then would continue weekly for four (4) weeks and then monthly. 25. Interview on 08/01/14 at 11:46 AM with the Administrator confirmed there would be a weekly QA meeting to include Corporate oversight weekly for four (4) weeks, then monthly and the last meeting was 07/26/14. He stated during the meeting they would discuss the audits and recommendations for frequency of continued audits related to the deficiencies cited.	F 490		
F 518 SS=K	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: A Recertification Survey/Extended Survey concluded on 07/03/14 identified Immediate Jeopardy in the areas of 42 CFR 483.25 Quality of Care (F-323) and 42 CFR 483.75 Administration (F-490, F-518 and F-520) all at a Scope and Severity (S/S) of a "K". After Supervisory review the Recertification Survey was re-opened and an Abbreviated Survey investigating KY00021980 was initiated on	F 518	F 518 Immediate corrective action for residents found to be affected: ◆ No residents were identified to be affected Identification of other residents that have the potential to be affected: ◆ All residents residing on the Northwest and Southwest halls have the potential to be affected. There is no construction at this time, thus no other residents are affected.	

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 518	<p>Continued From page 346</p> <p>07/22/14 and concluded with a new exit date of 08/01/14. A second Immediate Jeopardy was identified on 07/25/14 In the areas of 42 CFR 483.13 Resident Behavior and Facility Practice (F-224, F-225 and F-226), 42 CFR 483.30 Nursing Services (F-353), and 42 CFR 483.75 Administration (F-490) all at a Scope and Severity (S/S) of a "K".</p> <p>Based on observation, interview, record review, and review of the facility's Fire Emergency Plan and Evacuation Plan, during the 07/03/14 survey, it was determined the facility failed to have an effective system to ensure the facility's emergency evacuation plan was updated related to ongoing construction, and to ensure all employees were trained in emergency procedures related to safety and evacuation.</p> <p>On 06/24/14, construction began outside the Northwest hallway exit and and the Dining room exit and on 06/27/14 the Southwest hallway exit door had pavement removed, affecting the safe path to a public way for these three (3) exits. The facility failed to update the emergency evacuation plan related to the Northwest hallway, Dining room, and Southwest hallway exits and failed to provide training to staff regarding using the exits as a means of evacuation during the construction. Staff interviews revealed they would have used the affected exits to the outside if an emergency arose which required residents to be evacuated. (Refer to F-323)</p> <p>The facility's failure to ensure the emergency evacuation plan was updated and failure to have an effective system in place to ensure staff were adequately trained in emergency procedures related to safety and evacuation was likely to</p>	F 518	<p>Measures taken to assure there will not be a recurrence:</p> <ul style="list-style-type: none"> ◆ SCC in serviced Administrator and entire safety & QA committees consisting of DON, ADON, MDSN, SDC, WCN, DOA, BOM, RSM, MRM, DSM, ESD, SDC, POD and HRD/AIT, SSD, QoLD, QoL QoLA and Chaplain. Education was provided from June 30 to July 01, 2014 and covered construction planning and continued safety of the residents, additionally the construction plan and assignments, that delineated which staff was responsible for AOC were dispersed to all departments. ◆ Construction plan initiated on June 30, 2014 included new rounds, amended exit diagrams and placement of signage in appropriate areas that included all public and employee entrances indicating which doors closed related to construction. New signs related to "DO NOT USE" were placed on the affected doors. ◆ In-services performed for all staff from June 30 to July 01, 2014 by SCC, Administrator, DON, ADON, DSM, SDC, MDSN, ESD, HRD/AIT, ESNS, MRM, BOM, DOA, RSM, QoLD, QoLA, WCN, Chaplain and SSD for all staff. Education consisted of the new evacuation plan and continued safety of the residents. ◆ All residents of BIMS 8 or greater were informed of the construction and alternate evacuation routes and signs from June 30 to July 01, 2014 by the SSD and QoLD. 		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 518	<p>Continued From page 347</p> <p>cause risk for serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 06/30/14, and was determined to exist on 06/24/14. The facility was notified of the Immediate Jeopardy on 06/30/14.</p> <p>The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/03/14 with the facility alleging removal of the Immediate Jeopardy on 07/02/14. The Immediate Jeopardy was verified to be removed on 07/02/14, with remaining non-compliance at a Scope and Severity of a "E", while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure the emergency evacuation plan is updated and all staff are trained in emergency procedures related to safety and evacuation.</p> <p>The findings include:</p> <p>Review of the facility's, "Disaster Preparedness" Manual, dated January 2005, revealed a fire safety procedure plan which stated when preparing for an evacuation after a fire alarm sounded, staff should first check the primary exit route and if it was clear and safe use that exit. Further review of the fire safety procedure plan revealed no documented evidence it had been changed to address the construction taking place outside the Northwest hallway exit door, the Dining room exit door, or the Southwest hallway exit door. Additionally, the facility was unable to provide documented evidence they had developed and implemented a revised emergency evacuation plan specific to address the three (3) exits involved in construction.</p> <p>Review of the facility's, "Fire Safety Procedures</p>	F 518	<ul style="list-style-type: none"> ◆ Responsible parties of resident with BIMS less than 8 were notified of the construction and temporary evacuation routes from June 30 to July 01, 2014 by the Chaplain and DOA. ◆ Signs were placed on main entrance and employee doors that construction is in progress on June 30, 2014 by the HRD/AIT and POD. ◆ All new temporary diagrams were created for southwest hall, northwest hall, dining room, dietary services and laundry area by the POD and posted on all temporary alternate evacuation routes on June 30, 2014. ◆ Medical director was notified on June 30, 2014 by the DON and is in agreement with steps taken. ◆ All staff has been educated on environmental hazard identification by the SCC, Administrator, DON, ADON, DSM, SDC, MDSN, ESD, HRD/AIT, ESNS, MRM, BOM, DOA, RSM, QoLD, QoLA, WCN, Chaplain and SSD. This education was performed on August 25, 2014 to September 12, 2014. Any staff member not educated by September 12, 2014 will not be allowed to work a shift until being educated. 		

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

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FORM APPROVED
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F 518	<p>Continued From page 348</p> <p>Orientation Training", undated, revealed in an evacuation staff should first check the primary exit route, as indicated in the fire safety procedure plan, and use that exit if it was clear and safe.</p> <p>Review of the facility's, "South Nursing Department Fire Emergency Guidelines" and "North Nursing Department Fire Emergency Guidelines" both undated, revealed staff should check the primary exit route and if it was blocked use the secondary route.</p> <p>Review of the facility's maps for the Southwest hallway and Northwest hallway revealed the exit doors at the end of the hallways were noted to be used as an exit route. Review of the facility's map in the dining room revealed the exit door located there was noted to be used as an exit route.</p> <p>Review of the "Town Hall Meeting and Inservice Agenda" dated 06/20/14, revealed a bullet list which included "construction on drive". There was no written information regarding what the inservice included for reference. Continued review revealed there were twenty-eight (28) staff signatures listed on the inservice out of one hundred and fifty (150) employees in the facility. Further review of the facility's documentation revealed no documented evidence the facility had provided inservice training for all staff regarding the fire exits affected by the construction and on any changes to the facility's evacuation plan.</p> <p>Observations on 06/30/14 from 5:15 PM to 5:24 PM, of the three (3) areas affected by construction revealed: the dining room fire exit door had a concrete pad leading to a three and a</p>	F 518	<ul style="list-style-type: none"> Beginning August 02, 2014 the POD or PODA will conduct environmental hazards rounds weekly x4 weeks to identify any potential hazards and forward results to the Administrator. After the first 4 weeks, these will be conducted monthly and forwarded to the Administrator. Stakeholders were notified of the construction being completed and reverting back to the original evacuation plan on August 15-25, 2014. All stakeholders not completing this education were sent letters on August 25, 2014 notifying them of the change in plan. The individuals responsible for notifying the staff were HRD/AIT, PODA, POD, QoLA, ESNS, WNS, DOA, DON, Chaplain, RSM, ADON, MDSN, MRM, DSM, ESM, BOM, QoLD, SSD, SDC, or WCN. <p>Monitoring to assure continuing compliance:</p> <ul style="list-style-type: none"> Beginning August 06, 2014 the POD or PODA shall report all construction activity, plans and results of environmental hazards audits to the QA committee weekly x4 and then monthly for any further recommendations and resolutions. <p>Date of Compliance</p>	09-27-14	

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

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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F 518	<p>Continued From page 349</p> <p>half (3.5) inch drop off to gravel and rebar (common steel bar used widely in construction to reinforce concrete); the Northwest hallway fire exit had a ramp which led to a three (3) inch drop off from the ramp to gravel and rebar; and the Southwest hallway fire exit door had a ramp which led to a four and a half (4.5) inch drop off with gravel. Observation outside all three (3) of these fire exit doors revealed there was a dirt and rocky uneven surface.</p> <p>Additional observation on 06/30/14 revealed no signs were posted at the affected exits to alert staff these exits were not accessible due to the construction, and there were no new evacuation routes observed posted.</p> <p>Interview with the Director of Plant Operations, on 06/30/14 at 2:20 PM, revealed construction began on 06/24/14. Per interview, he was unaware of any updated evacuation plan related to the new construction. He stated staff including himself received no formal training related to any new evacuation plan due to construction although these three (3) exits were not safely accessible in case of an emergency evacuation.</p> <p>Interview, on 06/30/14 at 5:01 PM, with the Social Service Director (SSD) revealed she knew about the construction project. However, she was unaware of any new evacuation plan and thought the staff were to use the Northwest, and Southwest exits in the case of an emergency situation. The SSD stated staff should have been educated on a new evacuation plan due to construction because under the current evacuation plan the Northwest and Southwest exits as well as the dining room exit were to be used in the case of an emergency evacuation.</p>	F 518		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/02/2014
FORM APPROVED
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F 518	Continued From page 350 Interview, on 06/30/14 at 3:16 PM, with State Registered Nursing Assistant (SRNA) #1 revealed if an emergency situation arose she would have used the Northwest hallway, Southwest hallway, and Dining room exits to evacuate residents. She stated even though she was aware of the construction, as far as she knew those exits were not affected by it. Interview, on 06/30/14 at 3:20 PM, with Housekeeper #1 revealed she had not been told not to use the Northwest hallway, Southwest hallway or Dining room exits, and indicated she would have used the exits to evacuate residents in the case of an emergency. Interview, on 06/30/14, at 5:15 PM, with Licensed Practical Nurse (LPN) #4 revealed prior to 06/30/14 she had not been notified of any new evacuation routes or that there was construction outside the building. However, she received education today, 06/30/14, related to a new emergency plan after the State Survey Agency entered the building. Interview, on 06/30/14 at 5:17 PM, with the second shift Supervisor/Registered Nurse (RN) #5 revealed she did not formally inservice all of her staff not to use the exits affected by the construction; however, did verbally tell some of the staff. She stated formal inservicing related to a new evacuation plan in the case of an emergency had started that day, 06/30/14, after the State Survey Agency entered the building. Interview, on 06/30/14 at 5:30 PM, with Housekeeper #2 revealed his supervisor informed him of the construction in the back of	F 518			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/01/2014
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F 518	<p>Continued From page 351 the building; however, he had not received an inservice related to a new evacuation plan in case of emergency due to the construction.</p> <p>Interview, on 06/30/14 at 5:52 PM, with LPN #1 revealed she was not educated prior to 06/30/14 regarding not using the Northwest hallway and Southwest hallway exit doors because of the construction. She stated the State Survey Agency was already in the building before she received any inservicing. She indicated staff should have been formally inserviced regarding not using the affected exits "last" week when construction began.</p> <p>Interview, on 06/30/14 at 5:55 PM, with SRNA #3 revealed she had not been aware there was construction at the back of the facility until 06/30/14. She stated she had received education that day, 06/30/14, by the Assistant Director of Nursing (ADON)/Unit Manager of the North Hall. SRNA #3 indicated she had also been told that day staff was not use the affected exit doors at the back of the building.</p> <p>Interview, on 06/30/14 at 7:30 PM, with LPN #3 revealed even though she knew construction was taking place, she had not received any new information regarding a new evacuation plan. She indicated she was unaware of the affected exits which were not accessible because of the construction.</p> <p>Interview, on 06/30/14 at 5:17 PM, with the Assistant Director of Nursing (ADON)/Unit Manager for the South hall revealed before the construction started there had been no formal inservices related to a new evacuation plan in the case of an emergency; however, the facility had</p>	F 518		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 518	<p>Continued From page 352</p> <p>initiated formal inservicing that day, 06/30/14. She stated educating the staff prior to the construction would have been important, as the Northwest hallway and Southwest hallway exit doors were not accessible due to the construction.</p> <p>Interview, on 06/30/14 at 5:05 PM, with the Director of Nursing (DON) revealed she was told on 06/17/14 in a "Stand Up Meeting", that construction would start on 06/18/14; however, the construction was delayed and started at a later date. According to the DON, staff in the "Stand Up Meeting" were told not to use the exit doors in the Northwest hallway and Southwest hallway as the sidewalks were being replaced outside those doors. However, she had not been educated regarding alternate routes to use for emergency evacuation. The DON stated it would be important to have an alternate evacuation plan and to ensure all staff were inserviced on the plan. She stated the Staff Development Nurse (SDN) inserviced staff regarding the construction; however, she did not know if all staff had received the inservice and if alternate routes for emergencies was included in the inservice.</p> <p>Interview with the Staff Development Nurse (SDN) on 06/30/14 at 5:30 PM, revealed she was told by the Director of Plant Operations during a morning "Stand Up Meeting", about the construction project and was told staff could not use the exits to the back of the building including the Dining room exit. Continued interview revealed the DON had asked her to let staff know which doors would be inaccessible due to construction; however she was not told who to inservice and was not formally notified of new evacuation routes. She stated she did an</p>	F 518			

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

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--------------------	--	---------------	---	----------------------

F 518	<p>Continued From page 353</p> <p>Informal verbal inservice at the last "Town Hall Meeting", on 06/20/14, and told the staff present which doors would be inaccessible due to construction, which were the Southwest door, the Dining room door, and the kitchen door. She stated she also told staff to they could use the front doors, therapy doors, north side door and south side door, and the door to the employee parking lot for evacuation of residents. The SDN stated she also told staff during the inservice if the residents were in the dining room during an evacuation they were to use the employee parking lot doors or the front doors to exit. According to the SDN, she told staff in the inservice if residents needed to be evacuated from the Southwest wing they were to use the Southeast exit door to the parking lot. The SDN further stated she had also verbally inserviced the South Unit SRNAs and nurses, the Activity Director, the Minimum Data Set (MDS) Coordinators and the wound nurse related to the construction and which doors to use for an emergency evacuation. However, she stated she was unaware of the date of the inservice, and was unable to submit the inservice or signatures of staff present from the inservice. Further interview revealed she was unaware there was construction near the Northwest exit door and did not inservice staff related to that door. She stated she was unaware of any new formal evacuation plan in case of fire or other emergency.</p> <p>Review of the "Town Hall Meeting and Inservice Agenda" dated 06/20/14, revealed a bullet list which included "construction on drive". There was no written information in the inservice for reference. There were twenty-eight (28) signatures listed for the inservice out of one hundred and fifty (150) employees in the facility.</p>	F 518		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/02/2014
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 518	Continued From page 354 Interview with the Administrator on 06/30/14 at 7:00 PM, revealed she started at the facility on 05/15/14, and was told by the previous Administrator there would be construction which included replacing damaged pavement on the west or back side of the building. She stated during the "morning meetings" she discussed the construction project with the managers; however, they did not discuss the safety aspects related to the construction. She stated in hindsight she should have ensured there was a new emergency evacuation plan specifically addressing the three (3) exits affected during the construction, as well as, formal inservicing and education of staff related to which doors were affected related to construction and which doors were to be used for alternate routes. Further interview with the Administrator and previous Administrator on 07/01/14 at 12:00 PM, revealed it would be very important for staff to be aware of which doors led to the construction zone in order to ensure those doors were not used in the case of an emergency evacuation. The facility was unable to provide documented evidence they had developed and implemented a revised emergency evacuation plan specific to address the three (3) exits involved in construction. The facility provided an acceptable, credible Allegation of Compliance (AOC) on 07/03/14, which alleged removal of the Immediate Jeopardy (IJ), effective 07/02/14. Review of the AOC revealed the facility implemented the following: 1. The Regional Nurse Consultant (RNC)	F 518			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/01/2014
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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F 518	<p>Continued From page 355</p> <p>inserviced the Administrator and the entire Safety Committee (Human Resources Director/Safety Director, ADON North, Business Office Manager (BOM), Chaplain, Clinical Social Worker (CSW), Rehabilitation (Rehab) Manager, Medical Records Director, Dietary Director, Housekeeping Director, Activity Director, Staff Development Coordinator (SDC), Plant Operations Director, DON, ADON South, MDS LPN, MDS RN and Marketing Director, who were also the Quality Assurance (QA) Committee, on 06/30/14 during a Safety Committee meeting held to discuss the facility's Fire Safety Procedure for alternate evacuation routes due to construction. The education covered construction planning and continued safety of residents. Additionally, the construction plan and assignments, that delineated which staff member was responsible for what piece of the AOC, were dispersed to all departments by the Administrator and the Safety Committee Director. The construction plan included the creation of new routes and temporary exit diagrams, placement of signage outlining the construction plan in appropriate areas that included the front entrance, parking lot entrance and the doors which were closed related to the construction. New signs stating "DO NOT USE" were also placed on the affected doors.</p> <p>2. Inservices were initiated on 06/30/14 and 07/01/14, by the DON, Assistant Director of Nursing (ADON), Dietary Manager (DM), Staff Development, Business Office Manager (BOM), Housekeeping Director and Rehabilitation (Rehab) Director for all staff, including dietary, housekeeping, therapy, laundry and maintenance. The education consisted of the new evacuation plan and continued safety of residents. Additionally, no employee would be</p>	F 518		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 518	<p>Continued From page 356</p> <p>allowed to work until the education was provided and the post test completed to ensure compliance with exit routes. The Administrator maintained an employee roster to crosscheck with the training log to assure no employee was allowed to work until the education was received. One hundred and fifty-five (155) employees of one hundred and sixty-three (163) employees had been educated by 07/01/14. The facility did not utilize agency staff.</p> <p>3. All residents with a BIMS score of eight (8) or greater on their last MDS were informed of the construction and alternate evacuation routes, as well as, the the new evacuation signs. Forty-eight (48) residents met the criteria and were informed as indicated by the Activity Director and Social Service Director on 06/30/14 and 07/01/14.</p> <p>Responsible Parties of residents, who were frequent visitors to the facility, were notified of the construction and temporary evacuation routes, by telephone by the Chaplain and Marketing Director. Thirty (30) Responsible Parties were notified on 06/30/14 and 07/01/14, with plans to continue notifications daily until all resident families/responsible parties were notified.</p> <p>4. Signs were placed on the Main Entrance and the employee entrance doors on 06/30/14 by the Maintenance Director to inform all visitors that "Construction is in progress". Also, new temporary exit diagrams (maps) were created for the South West/North West/ Dining Room/Dietary Services/Laundry Area by the Safety Committee on 06/30/14 and posted on all temporary alternate evacuation routes. Signs were created and posted on all "temporarily closed" evacuation exits that stated, "STOP-DO NOT USE" by the</p>	F 518			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/01/2014
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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F 518	<p>Continued From page 357 Maintenance Director on 06/30/14.</p> <p>5. The Medical Director was notified of the IJ 07/01/14 by the DON.</p> <p>6. A QA meeting was held on 07/01/14 to review the new temporary exit diagrams for the South West/North West/Dining Room, Dietary Services and Laundry areas. Signs were created and posted on all areas of temporary alternate evacuation routes. Signs were created and posted on all temporarily closed evacuation exits to "STOP-DO NOT USE". The the entire plan was reviewed with the Medical Director on 07/01/14 during the QA meeting. The Medical Director approved the plan developed by the facility to address the IJ. Another QA meeting was scheduled for 07/09/14.</p> <p>7. Maintenance was to audit daily beginning 07/01/14, to ensure signage was in place on the Main Entrance and employee entrance door informing all visitors "Construction is in process". The maintenance audit was to include a daily check to ensure the new temporary exit diagrams created for the South West/North West/Dining Room, Dietary Services and Laundry area's remain posted on all temporary alternate evacuation routes and to ensure that signs created and posted on all "temporarily closed" evacuation exits saying "STOP-DO NOT USE" remain in place. The results of the audits will be turned in daily to the Administrator until the construction project is completed. The Administrator was do daily rounds of the signage to assure accuracy of maintenance audits until the project is completed.</p> <p>8. A staff questionnaire regarding exit routes and</p>	F 518		

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 518	Continued From page 358 evacuation plan was being administered by the Administrator, DON, ADONs, SDC, Dietary Director, BOM, Social Services Director (SSD), Chaplain, Admissions Director, Medical Records Director, and HR Director to five (5) staff members on each shift and different staff members until the immediacy was removed beginning 07/01/14. After the immediacy was removed ten (10) staff questionnaires were to be done daily to ensure continued understanding of exit routes and evacuation plan. All results of the questionnaires were to be reviewed by the Administrator, DON or Regional Nurse Consultant. The Administrator was to review all audits for completeness and accuracy, as well as, conduct "spot checks" of questionnaires to staff to ensure knowledge and accuracy of audits. Results of the staff questionnaires were to be reviewed by the QA Committee weekly to determine the further need of continued education or revision of the facility's plan. The QA Committee was to determine at what frequency the questionnaires for staff would need to continue. Any concerns identified were to be corrected immediately and reported to the Administrator. 9. A RNC has been onsite since 06/30/14, to assist with compliance with staff education, ensure daily audits were completed by the Maintenance Director and turned into the Administrator with no issues identified, and ensure daily staff questionnaires were completed as scheduled to ensure staff were aware of the new exits/evacuation plan. The Vice President (V/P) of Operations or Chief Nurse Executive were in daily contact with the RNC to review the above. Before the construction areas are re-opened, the areas are to be inspected by the	F 518			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
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F 518	<p>Continued From page 359</p> <p>Administrator and Maintenance Director to ensure the areas were safe for use.</p> <p>The State Agency validated the implementation of the facility's AOC as follows:</p> <p>1. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed she and the entire Safety Committee had been inserviced by the RNC on the construction plan, resident safety and the new, temporary evacuation routes and diagrams on 06/30/14 at approximately 8:15 PM.</p> <p>Review of the education information revealed the construction plan which included the creation of new routes and temporary exit diagrams, placement of signage at the front doors, parking lot entrance and doors which were to be closed related to the construction.</p> <p>2. Review of the education information, including the post tests, provided to all staff, revealed the education included education on the construction plan and new signs posted and included the following statement, "due to the recent construction on the back driveway of the facility, new evacuation routes have been implemented until further notice". Continued review of the education material revealed the alternate evacuation plan was included, as well as, the questions for the post test to ensure competency and understanding.</p> <p>Interviews on 07/02/14 with Certified Occupational Therapy Aide (COTA) #1 at 12:00 PM; the Rehab Manager at 12:02 PM; SRNA #5 at 12:03 PM; SRNA #6 at 1:55 PM; SRNA #7 at 1:58 PM; SRNA #8 at 2:01 PM; SRNA #9 at 2:04 PM; SRNA #10 at 2:07 PM; SRNA #11 at 2:10</p>	F 518			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
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F 518	<p>Continued From page 360</p> <p>PM; Housekeeper #3 at 2:20 PM; Housekeeper #1 at 2:23 PM; Maintenance Assistant #1 at 2:24 PM; Dietary Aide #3 at 2:28 PM; Dietary Aide #1 at 2:32 PM; SRNA #3 at 3:11 PM; SRNA #1 at 3:13 PM; SRNA #12 at 3:15 PM; SRNA #13 at 3:17 PM; SRNA #14 at 3:24 PM; SRNA #15 at 3:26 PM; LPN #8 at 5:30 PM; RN #1 at 5:35 PM; LPN #9 at 5:40 PM; and LPN #10 at 5:45 PM revealed they had been in-serviced on the construction plan and the new, temporary evacuation routes and the new temporary exit diagrams, along with taking a post test to ensure they understood the education material.</p> <p>Interview with the Administrator on 07/02/14 at 4:03 PM revealed she used an employee roster in conjunction with training logs to assure no employee worked without the education, she continued by stating that to ensure accuracy/staff understanding of the education, she would select two (2) completed post tests and re-interview that staff person.</p> <p>Review of documentation revealed the employee roster had been crosschecked against an employee training log to ensure employees had not worked without receiving the education and post test to ensure competency.</p> <p>3. Review of the education documents revealed all interviewable residents had been educated and a questionnaire was used to ensure resident understanding of the education related to the new evacuation plan and evacuation routes.</p> <p>Interviews with Resident #24 on 07/02/14 at 11:30 AM and Resident #23 at 11:35 AM, revealed they had been educated and completed a questionnaire related to the new construction and</p>	F 518			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/01/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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F 518	<p>Continued From page 361 new evacuation plans.</p> <p>Interview with the SSD on 07/02/14 at 2:37 PM, revealed it had been her assigned task to educate residents with a BIMS of eight (8) or greater on the construction plan and the new temporary evacuation routes while construction was in place. The SSD indicated she had performed her education with interviewable residents on 06/30/14 and 07/01/14.</p> <p>Review of the education documents revealed the same education tool used for interviewable residents had been used to educate residents' responsible parties regarding the construction and new evacuation plans.</p> <p>Record review of phone logs revealed Resident #25's family had been contacted regarding the construction and educated on the temporary evacuation routes.</p> <p>Interview with the SSD on 07/02/14 at 2:37 PM, revealed it had also been her assigned task to educate residents' responsible parties on the construction plan and the temporary evacuation routes while construction was in place. The SSD stated she initiated the education for responsible parties on 06/03/14 and 07/01/14. Continued interview revealed she had answered any questions the responsible parties might have had. She indicated she would continue notification and education until all responsible parties/families had been contacted. Further interview revealed she used the facility census sheet to ensure responsible parties of non-interviewable residents received the construction education.</p> <p>4. Observations, on 07/02/14 at 11:15 AM,</p>	F 518		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 518	<p>Continued From page 362</p> <p>revealed the new signage was in place at the Main Entrance and employee entrance doors as alleged on the AOC. Continued observation revealed the new temporary exit diagrams were also posted as alleged.</p> <p>Observation, on 07/02/14 at 11:32 AM, revealed signs stating "STOP-DO NOT USE" were posted on the "temporarily closed" evacuation exits.</p> <p>Interview with the Maintenance Director on 07/02/14 at 11:40 AM, revealed he had placed the new signage and temporary exit diagrams on 06/30/14 at approximately 8:30 PM.</p> <p>5. Interview with the facility's Medical Director on 07/02/14 at 5:20 PM, revealed he had been notified by the DON of the IJ on 07/01/14.</p> <p>6. Review of the minutes revealed a QA meeting was held on 07/01/14, and revealed the Medical Director was in attendance via telephone.</p> <p>Interview with the facility's Medical Director on 07/02/14 at 5:20 PM revealed he had been notified by the DON of the IJ on 07/01/14, during the QA meeting. He stated the plan implemented by the facility was a good plan, and he didn't think there was anything he would have added to the plan. Continued interview revealed he provided insight on Quality Measures and acted as a resource for facility staff education as part of his responsibilities as the Medical Director.</p> <p>7. Review of the daily Maintenance Audit logs beginning 07/01/14 revealed Maintenance was performing daily rounds to verify, by initialing the log, that the Main Entrance and employee entrance door signage remained in place to</p>	F 518			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/01/2014
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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--------------------	--	---------------	---	----------------------

F 518	<p>Continued From page 363</p> <p>inform visitors that construction was in progress, the temporary exit diagrams remained posted on all temporary evacuation routes and the "STOP-DO NOT USE" signs remained in place on the temporarily closed evacuation routes. Continued review of the Audit log revealed the Administrator was also initialing the log indicating she had performed walking rounds as verification of the accuracy of the Maintenance audits until the construction process is completed.</p> <p>Interview with the Maintenance Director on 07/02/14 at 11:40 AM, revealed maintenance was performing the daily audits and initialing the log for verification.</p> <p>Interview with the Administrator on 07/02/14 at 4:03 PM, revealed she was performing her walking rounds daily of the signage posted and initialing the maintenance audit log.</p> <p>8. Review of the staff education revealed a questionnaire related to the exit routes and evacuation plan. Review of the completed questionnaires revealed the Administrator, DON, ADON, SDC, Dietary Director, Medical Records Director or HR Director had administered the questionnaire.</p> <p>Interview with the Administrator on 07/02/14 at 4:03 PM revealed she, the DON or RNC had reviewed the questionnaires. She indicated she was performing "spot checks" of questionnaires as per the AOC. The Administrator stated the questionnaire results would be taken to the facility's QA Committee weekly and QA would determine the frequency at which the questionnaires would be used. According to the Administrator, if there were any concerns</p>	F 518		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/02/2014
FORM APPROVED
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F 518	Continued From page 364 identified they were to be reported to her. 9. Interview with the RNC on 07/02/14 at 4:45 PM revealed she had been on site daily since 06/30/14. Continued interview revealed she assisted the Administrator in any capacity she needed to ensure compliance with staff education and ensure the daily Maintenance audits were completed accurately and turned into the Administrator. Interview with the Chief Nursing Executive on 07/02/14 at 4:50 PM, via telephone, revealed she was in daily contact with the RNC and facility and acted as a resource when needed. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed prior to the construction areas being re-opened, she and the Maintenance Director will inspect the construction area to ensure it is safe to use and institute re-education for all staff, residents and/or their responsible party.	F 518			
F 520 SS=K	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and	F 520	F 520 Immediate corrective action for residents found to be affected: ◆ No residents were identified to be affected. However Bluegrass Care & Rehabilitation Center is committed to maintaining a quality assessment assurance committee consisting of the Administrator, DON, Medical Director, and at least three (3) other members of the facility's staff. This committee will meet at least quarterly to identify issues with respect to which quality assurance activities are necessary; and		

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

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 520	<p>Continued From page 365</p> <p>develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: A Recertification Survey/Extended Survey concluded on 07/03/14 identified Immediate Jeopardy in the areas of 42 CFR 483.25 Quality of Care (F-323) and 42 CFR 483.75 Administration (F-490, F-518 and F-520) all at a Scope and Severity (S/S) of a "K". After Supervisory review the Recertification Survey was re-opened and an Abbreviated Survey investigating KY00021980 was initiated on 07/22/14 and concluded with a new exit date of 08/01/14. A second Immediate Jeopardy was identified on 07/25/14 in the areas of 42 CFR 483.13 Resident Behavior and Facility Practice (F-224, F-225 and F-226), 42 CFR 483.30 Nursing Services (F-353), and 42 CFR 483.75 Administration (F-490) all at a Scope and Severity (S/S) of a "K".</p> <p>Based on observation, record review, interview, review of the facility's policy and Evacuation Plan, during the 07/03/14 survey, it was determined the facility failed to have an effective system to</p>	F 520	<p>develops and implements appropriate plans of action to correct identified quality deficiencies. <i>However, the QA Committee has been meeting weekly beginning September 17, 2014.</i></p> <ul style="list-style-type: none"> ◆ As the QA process would incorporate all identified quality deficiencies as stated above, please refer to this section under all alleged deficiencies contained within the 2567 as they would be incorporated individually herein. Specific ID Prefix tags identified within this section are F323, F490, F518, F520, F224, F225, F226 and F353. ◆ Resident #8, 14, 16, 17, 24, 32, 33, 36, and three un-sampled residents C, D, and E have all had grievances completed with Resident #24 having an updated pain assessment and care plan completed July 23 to July 25, 2014 by SSD, Administrator, DON, MRM, QoLA, ESD, DOA, MDSN, HRD/AIT and QoLD to include follow-up and resolution reported to all appropriate state agencies. Resident #35 discharged from the facility on July 10, 2014. <p>Identification of other residents that have the potential to be affected:</p> <ul style="list-style-type: none"> ◆ As the QA process would incorporate all identified quality deficiencies as stated above, please refer to this section under all alleged deficiencies contained within the 2567 as they would be incorporated individually herein. Specific ID Prefix tags identified within this section are F323, F490, F518, F520, F224, F225, F226 and F353. 		

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

PRINTED: 09/02/2014
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/01/2014
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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F 520	<p>Continued From page 366</p> <p>Identify a Quality Assurance (QA) concern, and develop and implement appropriate plans of action.</p> <p>The facility's QA system's failure to develop and implement appropriate plans of action prevented the facility from ensuring effective measures were in place for appropriate evacuation of residents from the Northwest and Southwest hallways and dining room in case of fire or other emergencies, due to the exits not being accessible related to construction. The primary emergency exit routes for the Northwest and Southwest Hallways were the exits at the end of the hallways leading outside per the facility's evacuation plan; however, observation revealed those were the exits inaccessible due to the construction. This could potentially affect sixty (60) residents out of the facility's one hundred and twenty-four (124) residents in the event of an emergency evacuation. In addition, the map posted in the dining room revealed arrows leading to the outside exit, as the emergency exit route from the dining room. Observation revealed there was construction outside the dining room door exit. The facility's QA system failed to identify, develop and implement plans of action to address: the construction outside the facility leaving the three (3) emergency exit doors without a safe path to a public way; the need for a revised evacuation plan in the case of a fire or other emergency related to the three (3) emergency exit doors; and the need to ensure staff was trained and knowledgeable of which fire exits were appropriate for evacuation during the construction. (Refer to F-323, F-490 and F-518)</p> <p>The facility's failure to develop and implement an evacuation plan during construction which</p>	F 520	<ul style="list-style-type: none"> ◆ All residents with BIMs of 8 or above were interviewed on July 23 to July 25, 2014 by SSD, HRD/AIT, QoLD, QoLA, MRM, Chaplain, BOM, DOA, ADON, SDC, SCC and ESNS with any concerns voiced taken through the grievance process for follow-up and resolution. ◆ All residents with a BIMS below 8, Responsible Parties, POA or Guardian were interviewed on July 23 to August 04, 2014 by SSD, HRD/AIT, DOA, MRM, Chaplain, BOM, ABOM, ESD, DSM, SCC, ADON, QoLA and QoLD with any concerns taken through the grievance process for follow-up and resolution. Anyone unable to contact were sent certified letters on July 29, 2014. <p>Measures taken to assure there will not be a recurrence:</p> <ul style="list-style-type: none"> ◆ As the QA process would incorporate all identified quality deficiencies as stated above, please refer to this section under all alleged deficiencies contained within the 2567 as they would be incorporated individually herein. Specific ID Prefix tags identified within this section are F323, F490, F518, F520, F224, F225, F226 and F353. ◆ All staff will be in serviced on July 23 to July 30, 2014 by the SDC, SCC, HRD/AIT, SSD, ESNS, DON, ADON, WCN, RSM, QoLD, QoLA, BOM, Assistant BOM (ABOM), Administrative Assistant (AA), MRM, DSM, ESD, POD, DOA, MDSN, Weekend Nurse 	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 520	<p>Continued From page 367</p> <p>affected fire/emergency exits was likely to to cause risk for serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 06/30/14 and determined to exist on 06/24/14. The facility was notified of the Immediate Jeopardy on 06/30/14.</p> <p>The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/03/14 with the facility alleging removal of the Immediate Jeopardy on 07/02/14. The Immediate Jeopardy was verified to be removed on 07/02/14, with remaining non-compliance at 42 CFR 483.75 Administration at a Scope and Severity of a "E", while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance continues to monitor to ensure the residents' environment remains as free of accidental hazards as was possible; and each resident receives adequate supervision to prevent accidents.</p> <p>Based on observation, interview, record review, review of the facility's policy and investigation reports and call light audits, during the 08/01/14 survey, it was determined the facility failed to have an effective system to develop and implement appropriate plans of action to ensure resident grievances were acted upon and resolved regarding call light issues. (Refer to F-166)</p> <p>The findings include:</p> <p>Review of the facility's, "Performance Improvement Plan" Policy, dated February 2009, revealed it was the intent of the facility to conduct an ongoing performance improvement program designed to: systematically monitor and evaluate</p>	F 520	<p><i>Supervisor (WNS), SSD or Chaplain related to Grievance policy and procedure. Re-education was initiated on August 25, 2014 and was completed by September 12, 2014.</i></p> <ul style="list-style-type: none"> ◆ <i>Education has been provided by the SCC on July 23 to July 28, 2014 to all department heads related to following the grievance policy and procedure and assuring all concerns are investigated and follow-up is completed timely.</i> ◆ <i>Any staff member not receiving the education by September 12, 2014 will not be allowed to work a shift until the education has been provided by the SDC, SCC, HRD/AIT, SSD, ESNS, DON, ADON, RSM, QoLD, QoLA, BOM, ABOM, AA, MRM, DSM, ESD, POD, DOA, MDSN, WNS, SSD, Administrator or Chaplain.</i> ◆ <i>Beginning September 12, 2014 Residents and families attending care plan conferences shall be asked by the SSD, MDSN, QoLD or Licensed Nurse if there have been any concerns and if grievance process has been initiated and followed. If resident or responsible party does not attend the care plan conference the SDC, HRD/AIT, SSD, ESNS, DON, ADON, RSM, QoLD, QoLA, BOM, ABOM, AA, MRM, DSM, ESD, POD, DOA, MDSN, WNS, SSD, Administrator or Chaplain. shall attempt to contact via phone x3 for response.</i> 	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 520	<p>Continued From page 368</p> <p>the quality and appropriateness of resident care; pursue opportunities to improve resident care; resolve identified problems; and identify opportunities for improvement in a timely manner. Further review revealed the Performance Improvement (PI) Committee and the facility would use the risk management approach to establish key quality indicators designed to monitor effectiveness of established systems across departments.</p> <p>Reference F-323, F-490, F-518</p> <p>1. Review of the facility's, "Disaster Preparedness" Manual, dated January 2005, revealed the fire safety procedure plan noted when preparing for an evacuation when the fire alarm was sounded the primary exit route should be checked first, and if this exit was safe and clear staff should use that exit if evacuation was ordered.</p> <p>Review of the facility's, "North Nursing Department Fire Emergency Guidelines" and "South Nursing Department Fire Emergency Guidelines", both undated, revealed staff was to check the primary exit route and if it was blocked they were to use the secondary route.</p> <p>Observation of the maps posted across from the nurse's station on the North and South units on 06/30/14, revealed the maps had arrows pointing towards the exit doors at the end of the Northwest and Southwest hallways leading to the outside indicating those doors were an exit route. Additionally, review of the map posted in the dining room on 06/30/14, revealed arrows leading from the dining room to the exit door, which led outside the building, as an exit route from the</p>	F 520	<ul style="list-style-type: none"> ◆ <i>Beginning August 02, 2014, five audits are being completed daily across all shifts by SDC, HRD/AIT, SSD, ESNS, DON, ADON, RSM, QoLD, QoLA, BOM, ABOM, AA, MRM, DSM, ESD, POD, DOA, MDSN, WNS, Administrator, Chaplain or Licensed Nurse related to call light observations to assure answered timely and patient care needs met. This will be ongoing until instructed otherwise by QA Committee.</i> ◆ <i>Beginning August 02, 2014 five resident interviews daily of residents with BIMS of 8 or above by the SDC, HRD/AIT, SSD, ESNS, DON, ADON, RSM, QoLD, QoLA, BOM, ABOM, AA, MRM, DSM, ESD, POD, DOA, MDSN, WNS, SSD, Administrator, Chaplain or Weekend Manager on Duty (MOD) to address call lights and any care issues. This will be ongoing until instructed otherwise by QA Committee.</i> ◆ <i>SCC educated the SSD on July 24, 2014 relative to responsibility to address complaints and grievances timely with appropriate follow up per company policy and regulatory guidelines. This is to include any complaints from Resident Council.</i> <p>Monitoring to assure continuing compliance:</p> <ul style="list-style-type: none"> ◆ As the QA process would incorporate all identified quality deficiencies as stated above, please refer to this section under all alleged deficiencies contained within the 2567 as they would be incorporated individually herein. Specific ID Prefix tags 		

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

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F 520	<p>Continued From page 369 dining room.</p> <p>On 06/30/14 at 2:20 PM, interview with the Director of Plant Operations revealed on 06/24/14 construction started with removal of the concrete pavement outside of the Northwest hallway and the dining room exit, and on 06/27/14 the concrete pavement was removed outside the Southwest hallway exit door. The Director of Plant Operations stated he was not aware of the facility having a revised evacuation plan related to construction. He stated staff, including himself, had not received any formal training related to a new evacuation plan due to construction, even though those three (3) exits were not accessible in case of an emergency evacuation because of the construction.</p> <p>Observations on 06/30/14 from 5:15 PM until 5:24 PM of the dining room exit door revealed a concrete pad leading to a three and a half (3.5) inch drop off which led to rebar (steel bar used in construction to reinforce concrete) and gravel. Observation of the Northwest hallway exit door revealed a ramp leading to a three (3) inch drop off to gravel and rebar. Additionally, observation of the Southwest hallway exit door revealed a ramp leading to a four and a half (4.5) inch drop off to gravel.</p> <p>Interview, on 06/30/14 at 5:05 PM and 07/03/14 at 7:00 PM, with the Director of Nursing (DON) revealed on 06/17/14, she was told construction would be starting on 06/18/14 and they were told to stay clear of the exit doors to the Northwest and Southwest hallways exits because the sidewalks were being replaced outside those doors. However, she had not been educated as to the alternate routes to use for emergency</p>	F 520	<p>identified within this section are F323, F490, F518, F520, F224, F225, F226 and F353.</p> <ul style="list-style-type: none"> ◆ <i>The Administrator will be responsible for monitoring the grievance process to be assured all grievances have been completed per the policy and procedure by reviewing each grievance and the grievance log weekly beginning September 22, 2014 until instructed otherwise by the QA Committee.</i> ◆ <i>Beginning August 06, 2014 all audits and observations as well as grievances will be brought to the QA committee weekly x 4 weeks and then monthly ongoing by the SSD in order to track and trend and to provide additional recommendations for ongoing process improvements.</i> <p>Date of Completion:</p>	09/27/2014	

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

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OMB NO. 0938-0391

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F 520	<p>Continued From page 370</p> <p>evacuation due to those exits being inaccessible. The DON stated it would be important for the facility to have an alternate evacuation plan and ensure staff were inserviced on this because staff would be unable to get wheelchairs out the exits by the construction. According to the DON, she did not remember bringing up any safety concerns related to the construction in the last QA Meeting. She further stated the facility had no QA Nurse, and all the department heads were responsible for bringing their audits and tracking and trending related to their departments to the QA meetings to discuss findings.</p> <p>Interview with the Staff Development Nurse (SDN) on 06/30/14 at 5:30 PM, revealed she was aware there was construction taking place outside the building as new concrete was being put on the driveway in the back of the building. She stated she was told staff could not use the exits at the back of the building including the dining room exit and she had provided a verbal inservice to some staff, on 06/20/14, related to the construction and which exit doors to use for an emergency evacuation. However, she was unaware there was construction near the Northwest hallway exit door and had not inserviced staff related to the door being inaccessible. She stated she was unaware of the facility having any new formal evacuation plan in case of fire or other emergency prior to or since the construction began.</p> <p>Interview, on 06/30/14 at 7:00 PM, with the Administrator revealed she had been informed on 05/15/14, by the previous Administrator, construction was to begin on 06/17/14 to include replacement of damaged pavement on the back side of the building which was the west side. She</p>	F 520		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 520	<p>Continued From page 371</p> <p>stated however, the construction was delayed and did not start until 06/24/14. Per interview, the Administrator had discussed the construction would consist of taking up the old concrete and re-pouring concrete at the back of the building every few days in the morning meetings. However, she stated during those morning meetings they had not discussed any safety aspects related to the construction. The Administrator explained the facility evacuation plan stated if for some reason an exit could not be used, staff were to use another exit; but she stated if all staff was not aware they could not use certain fire exit doors, this could cause a delay in getting residents evacuated from the building in an emergency situation. The Administrator indicated this was her first time having construction in a building as Administrator and therefore, had not thought about needing a new emergency evacuation plan for the facility. She stated in hindsight though she should have ensured there was a new emergency evacuation plan specific to address the three (3) emergency fire exits not available for use during the construction. Per interview the Administrator revealed the last QA meeting was 06/18/14, prior to the initiation of construction. She stated she had told the QA Committee in that meeting, construction was getting ready to start. The QA Committee had discussed the construction; however, they had not identified or discussed any safety aspects related to the fire exit doors which would be inaccessible during the construction.</p> <p>The facility provided an acceptable, credible Allegation of Compliance (AOC) on 07/03/14, which alleged removal of the Immediate Jeopardy (IJ), effective 07/02/14. Review of the AOC</p>	F 520		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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--	--	--	--

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F 520	<p>Continued From page 372 revealed the facility implemented the following:</p> <ol style="list-style-type: none"> 1. The Regional Nurse Consultant (RNC) inserviced the Administrator and the entire Safety Committee (Human Resources Director/Safety Director, ADON North, Business Office Manager (BOM), Chaplain, Clinical Social Worker (CSW), Rehabilitation (Rehab) Manager, Medical Records Director, Dietary Director, Housekeeping Director, Activity Director, Staff Development Coordinator (SDC), Plant Operations Director, DON, ADON South, MDS LPN, MDS RN and Marketing Director, who were also the Quality Assurance (QA) Committee, on 06/30/14 during a Safety Committee meeting held to discuss the facility's Fire Safety Procedure for alternate evacuation routes due to construction. The education covered construction planning and continued safety of residents. Additionally, the construction plan and assignments, that delineated which staff member was responsible for what piece of the AOC, were dispersed to all departments by the Administrator and the Safety Committee Director. The construction plan included the creation of new routes and temporary exit diagrams, placement of signage outlining the construction plan in appropriate areas that included the front entrance, parking lot entrance and the doors which were closed related to the construction. New signs stating "DO NOT USE" were also placed on the affected doors. 2. Inservices were initiated on 06/30/14 and 07/01/14, by the DON, Assistant Director of Nursing (ADON), Dietary Manager (DM), Staff Development, Business Office Manager (BOM), Housekeeping Director and Rehabilitation (Rehab) Director for all staff, including dietary, housekeeping, therapy, laundry and 	F 520		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 520	<p>Continued From page 373</p> <p>maintenance. The education consisted of the new evacuation plan and continued safety of residents. Additionally, no employee would be allowed to work until the education was provided and the post test completed to ensure compliance with exit routes. The Administrator maintained an employee roster to crosscheck with the training log to assure no employee was allowed to work until the education was received. One hundred and fifty-five (155) employees of one hundred and sixty-three (163) employees had been educated by 07/01/14. The facility did not utilize agency staff.</p> <p>3. All residents with a BIMS score of eight (8) or greater on their last MDS were informed of the construction and alternate evacuation routes, as well as, the the new evacuation signs. Forty-eight (48) residents met the criteria and were informed as indicated by the Activity Director and Social Service Director on 06/30/14 and 07/01/14.</p> <p>Responsible Parties of residents, who were frequent visitors to the facility, were notified of the construction and temporary evacuation routes, by telephone by the Chaplain and Marketing Director. Thirty (30) Responsible Parties were notified on 06/30/14 and 07/01/14, with plans to continue notifications daily until all resident families/responsible parties were notified.</p> <p>4. Signs were placed on the Main Entrance and the employee entrance doors on 06/30/14 by the Maintenance Director to inform all visitors that "Construction is in progress". Also, new temporary exit diagrams (maps) were created for the South West/North West/ Dining Room/Dietary Services/Laundry Area by the Safety Committee on 06/30/14 and posted on all temporary alternate</p>	F 520		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 520	<p>Continued From page 374</p> <p>evacuation routes. Signs were created and posted on all "temporarily closed" evacuation exits that stated, "STOP-DO NOT USE" by the Maintenance Director on 06/30/14.</p> <p>5. The Medical Director was notified of the IJ 07/01/14 by the DON.</p> <p>6. A QA meeting was held on 07/01/14 to review the new temporary exit diagrams for the South West/North West/Dining Room, Dietary Services and Laundry areas. Signs were created and posted on all areas of temporary alternate evacuation routes. Signs were created and posted on all temporarily closed evacuation exits to "STOP-DO NOT USE". The the entire plan was reviewed with the Medical Director on 07/01/14 during the QA meeting. The Medical Director approved the plan developed by the facility to address the IJ. Another QA meeting was scheduled for 07/09/14.</p> <p>7. Maintenance was to audit daily beginning 07/01/14, to ensure signage was in place on the Main Entrance and employee entrance door informing all visitors "Construction is in process". The maintenance audit was to include a daily check to ensure the new temporary exit diagrams created for the South West/North West/Dining Room, Dietary Services and Laundry area's remain posted on all temporary alternate evacuation routes and to ensure that signs created and posted on all "temporarily closed" evacuation exits saying "STOP-DO NOT USE" remain in place. The results of the audits will be turned in daily to the Administrator until the construction project is completed. The Administrator was do daily rounds of the signage to assure accuracy of maintenance audits until</p>	F 520			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/01/2014
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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(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 520	<p>Continued From page 375 the project is completed.</p> <p>8. A staff questionnaire regarding exit routes and evacuation plan was being administered by the Administrator, DON, ADONs, SDC, Dietary Director, BOM, Social Services Director (SSD), Chaplain, Admissions Director, Medical Records Director, and HR Director to five (5) staff members on each shift and different staff members until the immediacy was removed beginning 07/01/14. After the immediacy was removed ten (10) staff questionnaires were to be done daily to ensure continued understanding of exit routes and evacuation plan. All results of the questionnaires were to be reviewed by the Administrator, DON or Regional Nurse Consultant. The Administrator was to review all audits for completeness and accuracy, as well as, conduct "spot checks" of questionnaires to staff to ensure knowledge and accuracy of audits. Results of the staff questionnaires were to be reviewed by the QA Committee weekly to determine the further need of continued education or revision of the facility's plan. The QA Committee was to determine at what frequency the questionnaires for staff would need to continue. Any concerns identified were to be corrected immediately and reported to the Administrator.</p> <p>9. A RNC has been onsite since 06/30/14, to assist with compliance with staff education, ensure daily audits were completed by the Maintenance Director and turned into the Administrator with no issues identified, and ensure daily staff questionnaires were completed as scheduled to ensure staff were aware of the new exits/evacuation plan. The Vice President (V/P) of Operations or Chief Nurse Executive</p>	F 520		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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F 520	<p>Continued From page 376</p> <p>were in daily contact with the RNC to review the above. Before the construction areas are re-opened, the areas are to be inspected by the Administrator and Maintenance Director to ensure the areas were safe for use.</p> <p>The State Agency validated the implementation of the facility's AOC as follows:</p> <ol style="list-style-type: none"> Interview with the Administrator on 07/02/14 at 4:03 PM, revealed she and the entire Safety Committee had been inserviced by the RNC on the construction plan, resident safety and the new, temporary evacuation routes and diagrams on 06/30/14 at approximately 8:15 PM. Review of the education information revealed the construction plan which included the creation of new routes and temporary exit diagrams, placement of signage at the front doors, parking lot entrance and doors which were to be closed related to the construction. <p>2. Review of the education information, including the post tests, provided to all staff, revealed the education included education on the construction plan and new signs posted and included the following statement, "due to the recent construction on the back driveway of the facility, new evacuation routes have been implemented until further notice". Continued review of the education material revealed the alternate evacuation plan was included, as well as, the questions for the post test to ensure competency and understanding.</p> <p>Interviews on 07/02/14 with Certified Occupational Therapy Aide (COTA) #1 at 12:00 PM; the Rehab Manager at 12:02 PM; SRNA #5</p>	F 520			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/01/2014
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F 520	<p>Continued From page 377</p> <p>at 12:03 PM; SRNA #6 at 1:55 PM; SRNA #7 at 1:58 PM; SRNA #8 at 2:01 PM; SRNA #9 at 2:04 PM; SRNA #10 at 2:07 PM; SRNA #11 at 2:10 PM; Housekeeper #3 at 2:20 PM; Housekeeper #1 at 2:23 PM; Maintenance Assistant #1 at 2:24 PM; Dietary Aide #3 at 2:28 PM; Dietary Aide #1 at 2:32 PM; SRNA #3 at 3:11 PM; SRNA #1 at 3:13 PM; SRNA #12 at 3:15 PM; SRNA #13 at 3:17 PM; SRNA #14 at 3:24 PM; SRNA #15 at 3:26 PM; LPN #8 at 5:30 PM; RN #1 at 5:35 PM; LPN #9 at 5:40 PM; and LPN #10 at 5:45 PM revealed they had been in-serviced on the construction plan and the new, temporary evacuation routes and the new temporary exit diagrams, along with taking a post test to ensure they understood the education material.</p> <p>Interview with the Administrator on 07/02/14 at 4:03 PM revealed she used an employee roster in conjunction with training logs to assure no employee worked without the education, she continued by stating that to ensure accuracy/staff understanding of the education, she would select two (2) completed post tests and re-interview that staff person.</p> <p>Review of documentation revealed the employee roster had been crosschecked against an employee training log to ensure employees had not worked without receiving the education and post test to ensure competency.</p> <p>3. Review of the education documents revealed all interviewable residents had been educated and a questionnaire was used to ensure resident understanding of the education related to the new evacuation plan and evacuation routes.</p> <p>Interviews with Resident #24 on 07/02/14 at 11:30</p>	F 520		

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 520	<p>Continued From page 378</p> <p>AM and Resident #23 at 11:35 AM, revealed they had been educated and completed a questionnaire related to the new construction and new evacuation plans.</p> <p>Interview with the SSD on 07/02/14 at 2:37 PM, revealed it had been her assigned task to educate residents with a BIMS of eight (8) or greater on the construction plan and the new temporary evacuation routes while construction was in place. The SSD indicated she had performed her education with interviewable residents on 06/30/14 and 07/01/14.</p> <p>Review of the education documents revealed the same education tool used for interviewable residents had been used to educate residents' responsible parties regarding the construction and new evacuation plans.</p> <p>Record review of phone logs revealed Resident #25's family had been contacted regarding the construction and educated on the temporary evacuation routes.</p> <p>Interview with the SSD on 07/02/14 at 2:37 PM, revealed it had also been her assigned task to educate residents' responsible parties on the construction plan and the temporary evacuation routes while construction was in place. The SSD stated she initiated the education for responsible parties on 06/03/14 and 07/01/14. Continued interview revealed she had answered any questions the responsible parties might have had. She indicated she would continue notification and education until all responsible parties/families had been contacted. Further interview revealed she used the facility census sheet to ensure responsible parties of non-interviewable residents</p>	F 520			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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F 520	<p>Continued From page 379 received the construction education.</p> <p>4. Observations, on 07/02/14 at 11:15 AM, revealed the new signage was in place at the Main Entrance and employee entrance doors as alleged on the AOC. Continued observation revealed the new temporary exit diagrams were also posted as alleged.</p> <p>Observation, on 07/02/14 at 11:32 AM, revealed signs stating "STOP-DO NOT USE" were posted on the "temporarily closed" evacuation exits.</p> <p>Interview with the Maintenance Director on 07/02/14 at 11:40 AM, revealed he had placed the new signage and temporary exit diagrams on 06/30/14 at approximately 8:30 PM.</p> <p>5. Interview with the facility's Medical Director on 07/02/14 at 5:20 PM, revealed he had been notified by the DON of the IJ on 07/01/14.</p> <p>6. Review of the minutes revealed a QA meeting was held on 07/01/14, and revealed the Medical Director was in attendance via telephone.</p> <p>Interview with the facility's Medical Director on 07/02/14 at 5:20 PM revealed he had been notified by the DON of the IJ on 07/01/14, during the QA meeting. He stated the plan implemented by the facility was a good plan, and he didn't think there was anything he would have added to the plan. Continued interview revealed he provided insight on Quality Measures and acted as a resource for facility staff education as part of his responsibilities as the Medical Director.</p> <p>7. Review of the daily Maintenance Audit logs beginning 07/01/14 revealed Maintenance was</p>	F 520		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 520	<p>Continued From page 380</p> <p>performing daily rounds to verify, by initialing the log, that the Main Entrance and employee entrance door signage remained in place to inform visitors that construction was in progress, the temporary exit diagrams remained posted on all temporary evacuation routes and the "STOP-DO NOT USE" signs remained in place on the temporarily closed evacuation routes. Continued review of the Audit log revealed the Administrator was also initialing the log indicating she had performed walking rounds as verification of the accuracy of the Maintenance audits until the construction process is completed.</p> <p>Interview with the Maintenance Director on 07/02/14 at 11:40 AM, revealed maintenance was performing the daily audits and initialing the log for verification.</p> <p>Interview with the Administrator on 07/02/14 at 4:03 PM, revealed she was performing her walking rounds daily of the signage posted and initialing the maintenance audit log.</p> <p>8. Review of the staff education revealed a questionnaire related to the exit routes and evacuation plan. Review of the completed questionnaires revealed the Administrator, DON, ADON, SDC, Dietary Director, Medical Records Director or HR Director had administered the questionnaire.</p> <p>Interview with the Administrator on 07/02/14 at 4:03 PM revealed she, the DON or RNC had reviewed the questionnaires. She indicated she was performing "spot checks" of questionnaires as per the AOC. The Administrator stated the questionnaire results would be taken to the facility's QA Committee weekly and QA would</p>	F 520			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/01/2014
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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--------------------	--	---------------	---	----------------------

F 520	<p>Continued From page 381</p> <p>determine the frequency at which the questionnaires would be used. According to the Administrator, if there were any concerns identified they were to be reported to her.</p> <p>9. Interview with the RNC on 07/02/14 at 4:45 PM revealed she had been on site daily since 06/30/14. Continued interview revealed she assisted the Administrator in any capacity she needed to ensure compliance with staff education and ensure the daily Maintenance audits were completed accurately and turned into the Administrator.</p> <p>Interview with the Chief Nursing Executive on 07/02/14 at 4:50 PM, via telephone, revealed she was in daily contact with the RNC and facility and acted as a resource when needed.</p> <p>Interview with the Administrator on 07/02/14 at 4:03 PM, revealed prior to the construction areas being re-opened, she and the Maintenance Director will inspect the construction area to ensure it is safe to use and institute re-education for all staff, residents and/or their responsible party.</p> <p>Reference F-166</p> <p>2. Review of the facility's policy titled, "Investigating a Resident Grievance or Complaint", dated December 2010, revealed grievances and/or complaints would be investigated and recorded on the grievance/complaint log. The Policy noted the Administrator would assign the responsibility of investigating grievances and complaints to the Social Services Director (SSD) or designee who</p>	F 520		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 520	<p>Continued From page 382</p> <p>would initiate an investigation. The policy revealed the investigation and report were to include a follow-up/recommendation for corrective action, a resolution, date of the resolution and was to be reviewed by the Administrator within three (3) working days of the facility receiving the complaint/grievance. The Policy stated the resident or responsible party was to be notified of the findings.</p> <p>Review of the Resident Council Minutes for April, May, June and July of 2014 revealed the residents had complained of their call bells not being answered timely in the past two (3) months. Interview with residents during the Group Interview and also individual resident interviews revealed they continued to complain of their call bells not being answered timely. However, review of the facility's documentation regarding grievance forms and call light audits revealed no documented evidence the facility had attempted to resolve the residents' grievances regarding call bells, until 06/03/14, even though this had been an ongoing concern expressed by residents since April 2014.</p> <p>Interview with the SSD, on 07/03/14 at 4:08 PM and on 07/25/14 at 7:20 PM, revealed to address the Resident Council's concerns related to their call lights not being answered timely, she developed an audit for call lights to be performed across all shifts and during shift changes. The SSD indicated the call light audits had been initiated "a few months ago".</p> <p>Per interview, on 07/03/14 at 3:42 PM, with the Activities Director, with Registered Nurse (RN) #4/Assistant Director of Nursing (ADON) at 4:35 PM, and at 6:41 PM with the Staff Development</p>	F 520			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 520	<p>Continued From page 383</p> <p>Coordinator (SDC) revealed call light audits were being conducted on all shifts. The Activity Director stated residents had voiced concerns in the Resident Council Meetings regarding staff taking a long time to answer their call lights, which were placed on grievance forms and given to the Social Services Director (SSD) to investigate. RN #4/ADON revealed the SSD was responsible for the audits of the call lights and the audits were supposed to be reviewed in the facility's Quality Assurance (QA) meetings.</p> <p>The June 2014 call light audits were reviewed and revealed only the 7:00 AM to 3:00 PM, and 3:00 PM to 11:00 PM shift had been audited. Continued review revealed no documented evidence of call light audits conducted on the 11:00 PM to 7:00 AM shift.</p> <p>Further interview with the SSD, on 07/03/14 at 4:08 PM and on 07/25/14 at 7:20 PM, revealed call light audits had not been completed during the 11:00 PM to 7:00 AM shift because there were not "a lot" of complaints related to the night shift. She stated after becoming aware of problems regarding night shift on 07/03/14, after surveyor intervention, the call light audits had been initiated at that time on night shift. However, the SSD indicated the call light audits should have been done during night shift also, as the QA process had been for audits to be performed across all shifts.</p> <p>Interview, on 07/03/14 at 5:20 PM and 08/01/14 at 9:34 AM with the Director of Nursing (DON), revealed once a week administrative staff discussed with residents how the staff responsible for their care was doing with answering their call lights. The DON reported if a</p>	F 520			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2014
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F 520	<p>Continued From page 384</p> <p>concern was identified, she would talk to residents more often regarding this. Per interview, the DON indicated residents' concerns were why the facility was continuing with the call light audits. She stated the facility had been aware of call lights being an issue related to Resident Council concerns and resident interviews which had been taken to the QA meetings and discussed. The DON stated when concerns were identified and taken to QA and audits implemented, and if the issue continued to be a concern, audits were increased. Per interview, she stated since "most" of the call light concerns had been related to evening shift and weekends the audits had been performed during those timeframe's, and stated the audits had been performed from the information "we had". She reported the SSD analyzed the "findings" of the call light audits and looked for "patterns on when it" took longer for staff to answer the call lights.</p> <p>Interview, on 07/03/14 at 7:25 PM, with the former Administrator and on 07/31/14 at 10:14 PM revealed she had not attended the facility's June 2014 Quality Assurance (QA) Meeting. She stated the facility was conducting call light audits when she became Administrator, and she knew call lights were an issue in the Resident Counsel Meetings. However, the Administrator reported she was not sure if the call light audits were being conducted on night shift. The Administrator indicated the audits may have been more effective if the time it took for each call light to be answered was the focus, instead of looking at the average time for a call light to be answered. She did not think the current QA effort to improve the timeliness of answering call bells had been effective to correct the problem.</p>	F 520			

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/01/2014
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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(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

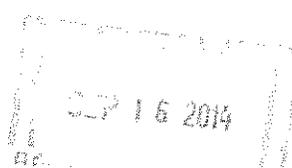
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2014
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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K 000	<p>INITIAL COMMENTS</p> <p>Building: 01</p> <p>Plan Approval: 06/15/77</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type V (111) Unprotected</p> <p>Smoke Compartment: Six (6)</p> <p>Fire Alarm: Complete Fire alarm System</p> <p>Sprinkler System: Complete Sprinkler System (Dry)</p> <p>Generator: Type II Diesel and Type II Natural Gas</p> <p>A Standard Life Safety Code Survey was initiated on 06/30/14 and concluded on 07/02/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety From Fire) K-0038, and K-0048 (Life Safety From Fire) at a Scope and Severity at a "K" level. Immediate Jeopardy (IJ) was identified on 06/30/14 and determined to exist on 06/24/14, with the potential of affecting residents in sixty (60) of the facility's licensed beds. The facility was notified of the IJ on 06/30/14. The facility provided a credible Allegation of Compliance (AOC) on 07/03/14 alleging removal of the IJ on 07/02/14. Based on the facility's implementation of the AOC, IJ was verified to be removed on</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *ADMINISTRATOR* (X8) DATE *09/16/2014*

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

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

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FORM APPROVED
OMB NO. 0938-0391

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K 000	Continued From page 1 07/02/14 as alleged. The facility is licensed for one hundred and twenty-four (124) beds and the census during the survey was one hundred and twenty-four (124).	K 000			
K 038 SS=K	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access was arranged so exits were readily accessible at all times in accordance National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of eight (8) exits, sixty (60) residents, staff and visitors. The facility's failure to ensure the exit access was arranged so exits were readily accessible at all times in accordance National Fire Protection Association (NFPA) standards, was likely to cause risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 06/30/14 and determined to exist on 06/24/14. The facility was notified of the Immediate Jeopardy on 06/30/14. Additioanlly, based on observation and interview, it was determined the facility failed to ensure	K 038	K038 Immediate corrective action for residents found to be affected: ◆ No residents were identified to be affected Identification of other residents that have the potential to be affected: ◆ All residents residing on the Northwest and Southwest halls have the potential to be affected. There is no construction at this time, thus no other residents are affected.		

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K 038	<p>Continued From page 2</p> <p>locks were used according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments.</p> <p>The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/03/14 with the facility alleging removal of the Immediate Jeopardy on 07/02/14. The Immediate Jeopardy was verified to be removed on 07/02/14 as alleged, prior to exiting the facility on 07/03/14.</p> <p>The findings include:</p> <p>1. Observation on 06/30/14 at 2:20 PM, with the Director of Plant Operations, revealed the Southwest Hall exit, the Southwest Hallway exit, Northwest Hallway exit and dining room exits were not useable due to the exits discharging into an ongoing construction zone. There was no hard surface to a public way from any of the exits. Continued observation revealed the exit doors were equipped with access-controlled magnetic locks which could be released with a manual release device; the doors were operational at the time of inspection. Observation further revealed the exits did not have any signage indicating the exits were not to be used in an emergency. The exits lead to an uneven surface which was made up of large rock, dirt and rebar. In the event of fire or other emergency the existing conditions at the affected exits would prohibit evacuation of residents by wheeled devices and ambulatory residents would be at extreme risk of falls even with assistance. Interview with the Director of Plant Operations at the time of observation revealed all exits in the construction area were still being used. Further interview revealed the Director of Plant Operations was unaware of any</p>	K 038	<p>Measures taken to assure there will not be a recurrence:</p> <ul style="list-style-type: none"> ◆ Signature Care Consultants (SCCs) in serviced Administrator and entire safety & Quality Assurance (QA) committees consisting of Director of Nursing (DON), Assistant Director of Nursing (ADON), MDS Nurse (MDSN), Staff Development Coordinator (SDC), Wound Care Nurse (WCN), Director of Admissions (DOA), Business Office Manager (BOM), Rehab Services Manager (RSM), Medical Records Manager (MRM), Dietary Services Manager (DSM), Environmental Services Director (ESD), Plant Operations Director (POD) and Human Resources Director/Administrator In Training (HRD/AIT), Social Services Director (SSD), Quality of Life Director (QoLD), QoL Assistant (QoLA) and Chaplain. Education was provided from June 30 to July 01, 2014 and covered construction planning and continued safety of the residents, additionally the construction plan and assignments, that delineated which staff was responsible for AOC were dispersed to all departments. ◆ Construction plan initiated on June 30, 2014 included new rounds, amended exit diagrams and placement of signage in appropriate areas that included all public and employee entrances indicating which doors closed related to construction. New signs related to "DO NOT USE" were placed on the affected doors. 	

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K 038	<p>Continued From page 3</p> <p>staff training conducted regarding exits affected by the construction.</p> <p>Interview, on 06/30/2014 at 2:32 PM, with the Administrator revealed the facility had discussed the construction project in a town hall meeting on 06/20/2014. Continued interview revealed department heads were supposed to make staff aware of the construction project. The Administrator was not aware of any training involving staff regarding the emergency exits being affected by the construction.</p> <p>Interview, on 06/30/14 at 3:16 PM, with State Registered Nursing Assistant (SRNA) #1, revealed she was aware of the construction due to seeing the construction and hearing staff talk about it. Further interview revealed however, she would still use the exit in an emergency.</p> <p>Interview, on 06/30/14 at 3:20 PM, with a member of the housekeeping staff, Housekeeper #1, revealed she was made aware of the construction from the Housekeeping Supervisor. Further interview revealed she was not sure if the exit was still usable, and she was never told to not use the exit. She indicated she would still use the exit in an emergency.</p> <p>Continued interview, on 06/30/2014 at 3:23 PM, with the Director of Plant Operations revealed on 06/24/14 the facility began construction by removing the concrete pavement outside the Northwest Hallway exit door and the dining room exit, and by 06/27/14, the Southwest Hallway exit door had pavement removed, affecting the safe path to a public way for these three (3) exits.</p> <p>Observation, on 06/30/14 at 5:15 PM, with the</p>	K 038	<ul style="list-style-type: none"> ◆ In-services performed for all staff from June 30 to July 01, 2014 by SCC, Administrator, DON, ADON, DSM, SDC, MDSN, ESD, HRD/AIT, Evening Shift Nurse Supervisor (ESNS), MRM, BOM, DOA, RSM, QoLD, QoLA, WCN, Chaplain and SSD for all staff. Education consisted of the new evacuation plan and continued safety of the residents. ◆ All residents of BIMS 8 or greater were informed of the construction and alternate evacuation routes and signs from June 30 to July 01, 2014 by the SSD and QoLD. ◆ Responsible parties of resident with BIMS less than 8 were notified of the construction and temporary evacuation routes from June 30 to July 01, 2014 by the Chaplain and DOA. ◆ Signs were placed on main entrance and employee doors that construction is in progress on June 30, 2014 by the HRD/AIT and POD. ◆ All new temporary diagrams were created for southwest hall, northwest hall, dining room, dietary services and laundry area by the POD and posted on all temporary alternate evacuation routes on June 30, 2014. ◆ Medical Director was notified on June 30, 2014 by the DON and is in agreement with steps taken. 	
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K 038	<p>Continued From page 4</p> <p>Director of Plant Operations, revealed: the dining room exit had a 3.5 inch drop-off from the concrete pad to the gravel and rebar area; the Northwest Hallway had a 3.0 inch drop-off from the ramp to the concrete and rebar area; and the Southwest Hallway had a 4.5 drop-off leading to large gravel.</p> <p>Interview, on 06/30/14 at 7:00 PM, with the Administrator revealed she started at the facility on 05/15/14 and was told by the previous Administrator on that date there would be construction which included replacing damaged pavement on the west side of the building. She stated during the facility's morning meetings she discussed with the managers the construction would consist of tearing up the concrete and re-pouring the concrete at the back of the building; however, they did not discuss the safety aspects related to the construction. She stated, in hindsight she should have ensured there was a new emergency evacuation plan specific to address the three (3) exits affected during the construction, as well as, formal inservicing and education with staff related to construction and which doors were to be used for alternate routes. The facility was unable to provide documented evidence that they had developed and implemented an emergency evacuation plan specific to address the three (3) exits involved in construction.</p> <p>2. Observation on 06/30/14 at 2:00 PM, with the Director of Plant Operations, revealed two (2) locks on the conference door. Further observation revealed when both locks were locked it took two (2) motions to release the door. Interview with Director of Plant Operation, at the time of observation, revealed he was not aware</p>	K 038	<p>Monitoring to assure continuing compliance:</p> <ul style="list-style-type: none"> ◆ QA Committee meeting to assess existing plans was held on July 01, 2014 with Administrator, DON, Medical Director, HRD/AIT, MRM, POD and DOA attending. ◆ Beginning August 06, 2014, the POD shall report all construction activity, plans and safety to the QA committee weekly x4 and then monthly for any further recommendations and resolutions. <p>Date of Completion: 09/23/2014</p>		

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K 038	<p>Continued From page 5 the locks were a deficiency in the Life Safety Code.</p> <p>Observation on 07/01/14 at 10:41 AM, with the Director of Plant Operations revealed the walk-in cooler and walk-in freezer both had locks on the outside. These locks when secured would prevent someone from exiting the walk-in freezer and walk-in cooler. Interview with the Director of Plant Operations, at the time of observation, revealed the locks had been placed on the walk-in freezer and walk-in cooler to prevent staff from stealing from them after the kitchen had closed.</p> <p>The findings related to the locks were confirmed with the Administrator at the exit conference.</p> <p>The facility provided an acceptable, credible Allegation of Compliance (AOC) on 07/03/14, which alleged removal of the Immediate Jeopardy (IJ), effective 07/02/14. Review of the AOC revealed the facility implemented the following:</p> <p>1. The Regional Nurse Consultant (RNC) inserviced the Administrator and the entire Safety Committee (Human Resources Director/Safety Director, ADON North, Business Office Manager (BOM), Chaplain, Clinical Social Worker (CSW), Rehabilitation (Rehab) Manager, Medical Records Director, Dietary Director, Housekeeping Director, Activity Director, Staff Development Coordinator (SDC), Plant Operations Director, DON, ADON South, MDS LPN, MDS RN and Marketing Director, who were also the Quality Assurance (QA) Committee, on 06/30/14 during a Safety Committee meeting held to discuss the facility's Fire Safety Procedure for alternate evacuation routes due to construction. The</p>	K 038		
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K 038	<p>Continued From page 6</p> <p>education covered construction planning and continued safety of residents. Additionally, the construction plan and assignments, that delineated which staff member was responsible for what piece of the AOC, were dispersed to all departments by the Administrator and the Safety Committee Director. The construction plan included the creation of new routes and temporary exit diagrams, placement of signage outlining the construction plan in appropriate areas that included the front entrance, parking lot entrance and the doors which were closed related to the construction. New signs stating "DO NOT USE" were also placed on the affected doors.</p> <p>2. Inservices were initiated on 06/30/14 and 07/01/14, by the DON, Assistant Director of Nursing (ADON), Dietary Manager (DM), Staff Development, Business Office Manager (BOM), Housekeeping Director and Rehabilitation (Rehab) Director for all staff, including dietary, housekeeping, therapy, laundry and maintenance. The education consisted of the new evacuation plan and continued safety of residents. Additionally, no employee would be allowed to work until the education was provided and the post test completed to ensure compliance with exit routes. The Administrator maintained an employee roster to crosscheck with the training log to assure no employee was allowed to work until the education was received. One hundred and fifty-five (155) employees of one hundred and sixty-three (163) employees had been educated by 07/01/14. The facility did not utilize agency staff.</p> <p>3. All residents with a BIMS score of eight (8) or greater on their last MDS were informed of the construction and alternate evacuation routes, as</p>	K 038			

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K 038	<p>Continued From page 7</p> <p>well as, the the new evacuation signs. Forty-eight (48) residents met the criteria and were informed as indicated by the Activity Director and Social Service Director on 06/30/14 and 07/01/14.</p> <p>Responsible Parties of residents, who were frequent visitors to the facility, were notified of the construction and temporary evacuation routes, by telephone by the Chaplain and Marketing Director. Thirty (30) Responsible Parties were notified on 06/30/14 and 07/01/14, with plans to continue notifications daily until all resident families/responsible parties were notified.</p> <p>4. Signs were placed on the Main Entrance and the employee entrance doors on 06/30/14 by the Maintenance Director to inform all visitors that "Construction is in progress". Also, new temporary exit diagrams (maps) were created for the South West/North West/ Dining Room/Dietary Services/Laundry Area by the Safety Committee on 06/30/14 and posted on all temporary alternate evacuation routes. Signs were created and posted on all "temporarily closed" evacuation exits that stated, "STOP-DO NOT USE" by the Maintenance Director on 06/30/14.</p> <p>5. The Medical Director was notified of the IJ 07/01/14 by the DON.</p> <p>6. A QA meeting was held on 07/01/14 to review the new temporary exit diagrams for the South West/North West/Dining Room, Dietary Services and Laundry areas. Signs were created and posted on all areas of temporary alternate evacuation routes. Signs were created and posted on all temporarily closed evacuation exits to "STOP-DO NOT USE". The the entire plan was reviewed with the Medical Director on</p>	K 038			

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K 038	<p>Continued From page 8</p> <p>07/01/14 during the QA meeting. The Medical Director approved the plan developed by the facility to address the IJ. Another QA meeting was scheduled for 07/09/14.</p> <p>7. Maintenance was to audit daily beginning 07/01/14, to ensure signage was in place on the Main Entrance and employee entrance door informing all visitors "Construction is in process". The maintenance audit was to include a daily check to ensure the new temporary exit diagrams created for the South West/North West/Dining Room, Dietary Services and Laundry area's remain posted on all temporary alternate evacuation routes and to ensure that signs created and posted on all "temporarily closed" evacuation exits saying "STOP-DO NOT USE" remain in place. The results of the audits will be turned in daily to the Administrator until the construction project is completed. The Administrator was do daily rounds of the signage to assure accuracy of maintenance audits until the project is completed.</p> <p>8. A staff questionnaire regarding exit routes and evacuation plan was being administered by the Administrator, DON, ADONs, SDC, Dietary Director, BOM, Social Services Director (SSD), Chaplain, Admissions Director, Medical Records Director, and HR Director to five (5) staff members on each shift and different staff members until the immediacy was removed beginning 07/01/14. After the immediacy was removed ten (10) staff questionnaires were to be done daily to ensure continued understanding of exit routes and evacuation plan. All results of the questionnaires were to be reviewed by the Administrator, DON or Regional Nurse Consultant. The Administrator was to review all</p>	K 038			

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K 038	<p>Continued From page 9</p> <p>audits for completeness and accuracy, as well as, conduct "spot checks" of questionnaires to staff to ensure knowledge and accuracy of audits. Results of the staff questionnaires were to be reviewed by the QA Committee weekly to determine the further need of continued education or revision of the facility's plan. The QA Committee was to determine at what frequency the questionnaires for staff would need to continue. Any concerns identified were to be corrected immediately and reported to the Administrator.</p> <p>9. A RNC has been onsite since 06/30/14, to assist with compliance with staff education, ensure daily audits were completed by the Maintenance Director and turned into the Administrator with no issues identified, and ensure daily staff questionnaires were completed as scheduled to ensure staff were aware of the new exits/evacuation plan. The Vice President (V/P) of Operations or Chief Nurse Executive were in daily contact with the RNC to review the above. Before the construction areas are re-opened, the areas are to be inspected by the Administrator and Maintenance Director to ensure the areas were safe for use.</p> <p>The State Agency validated the implementation of the facility's AOC as follows:</p> <p>1. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed she and the entire Safety Committee had been inserviced by the RNC on the construction plan, resident safety and the new, temporary evacuation routes and diagrams on 06/30/14 at approximately 8:15 PM.</p> <p>Review of the education information revealed the</p>	K 038			

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K 038	<p>Continued From page 10</p> <p>construction plan which included the creation of new routes and temporary exit diagrams, placement of signage at the front doors, parking lot entrance and doors which were to be closed related to the construction.</p> <p>2. Review of the education information, including the post tests, provided to all staff, revealed the education included education on the construction plan and new signs posted and included the following statement, "due to the recent construction on the back driveway of the facility, new evacuation routes have been implemented until further notice". Continued review of the education material revealed the alternate evacuation plan was included, as well as, the questions for the post test to ensure competency and understanding.</p> <p>Interviews on 07/02/14 with Certified Occupational Therapy Aide (COTA) #1 at 12:00 PM; the Rehab Manager at 12:02 PM; SRNA #5 at 12:03 PM; SRNA #6 at 1:55 PM; SRNA #7 at 1:58 PM; SRNA #8 at 2:01 PM; SRNA #9 at 2:04 PM; SRNA #10 at 2:07 PM; SRNA #11 at 2:10 PM; Housekeeper #3 at 2:20 PM; Housekeeper #1 at 2:23 PM; Maintenance Assistant #1 at 2:24 PM; Dietary Aide #3 at 2:28 PM; Dietary Aide #1 at 2:32 PM; SRNA #3 at 3:11 PM; SRNA #1 at 3:13 PM; SRNA #12 at 3:15 PM; SRNA #13 at 3:17 PM; SRNA #14 at 3:24 PM; SRNA #15 at 3:26 PM; LPN #8 at 5:30 PM; RN #1 at 5:35 PM; LPN #9 at 5:40 PM; and LPN #10 at 5:45 PM revealed they had been in-serviced on the construction plan and the new, temporary evacuation routes and the new temporary exit diagrams, along with taking a post test to ensure they understood the education material.</p>	K 038			

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

PRINTED: 08/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2014
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K 038	<p>Continued From page 11</p> <p>Interview with the Administrator on 07/02/14 at 4:03 PM revealed she used an employee roster in conjunction with training logs to assure no employee worked without the education, she continued by stating that to ensure accuracy/staff understanding of the education, she would select two (2) completed post tests and re-interview that staff person.</p> <p>Review of documentation revealed the employee roster had been crosschecked against an employee training log to ensure employees had not worked without receiving the education and post test to ensure competency.</p> <p>3. Review of the education documents revealed all interviewable residents had been educated and a questionnaire was used to ensure resident understanding of the education related to the new evacuation plan and evacuation routes.</p> <p>Interviews with Resident #24 on 07/02/14 at 11:30 AM and Resident #23 at 11:35 AM, revealed they had been educated and completed a questionnaire related to the new construction and new evacuation plans.</p> <p>Interview with the SSD on 07/02/14 at 2:37 PM, revealed it had been her assigned task to educate residents with a BIMS of eight (8) or greater on the construction plan and the new temporary evacuation routes while construction was in place. The SSD indicated she had performed her education with interviewable residents on 06/30/14 and 07/01/14.</p> <p>Review of the education documents revealed the same education tool used for interviewable residents had been used to educate residents'</p>	K 038			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 038	<p>Continued From page 12 responsible parties regarding the construction and new evacuation plans.</p> <p>Record review of phone logs revealed Resident #25's family had been contacted regarding the construction and educated on the temporary evacuation routes.</p> <p>Interview with the SSD on 07/02/14 at 2:37 PM, revealed it had also been her assigned task to educate residents' responsible parties on the construction plan and the temporary evacuation routes while construction was in place. The SSD stated she initiated the education for responsible parties on 06/03/14 and 07/01/14. Continued interview revealed she had answered any questions the responsible parties might have had. She indicated she would continue notification and education until all responsible parties/families had been contacted. Further interview revealed she used the facility census sheet to ensure responsible parties of non-interviewable residents received the construction education.</p> <p>4. Observations, on 07/02/14 at 11:15 AM, revealed the new signage was in place at the Main Entrance and employee entrance doors as alleged on the AOC. Continued observation revealed the new temporary exit diagrams were also posted as alleged.</p> <p>Observation, on 07/02/14 at 11:32 AM, revealed signs stating "STOP-DO NOT USE" were posted on the "temporarily closed" evacuation exits.</p> <p>Interview with the Maintenance Director on 07/02/14 at 11:40 AM, revealed he had placed the new signage and temporary exit diagrams on 06/30/14 at approximately 8:30 PM.</p>	K 038		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 038	Continued From page 13 5. Interview with the facility's Medical Director on 07/02/14 at 5:20 PM, revealed he had been notified by the DON of the IJ on 07/01/14. 6. Review of the minutes revealed a QA meeting was held on 07/01/14, and revealed the Medical Director was in attendance via telephone. Interview with the facility's Medical Director on 07/02/14 at 5:20 PM revealed he had been notified by the DON of the IJ on 07/01/14, during the QA meeting. He stated the plan implemented by the facility was a good plan, and he didn't think there was anything he would have added to the plan. Continued interview revealed he provided insight on Quality Measures and acted as a resource for facility staff education as part of his responsibilities as the Medical Director. 7. Review of the daily Maintenance Audit logs beginning 07/01/14 revealed Maintenance was performing daily rounds to verify, by initialing the log, that the Main Entrance and employee entrance door signage remained in place to inform visitors that construction was in progress, the temporary exit diagrams remained posted on all temporary evacuation routes and the "STOP-DO NOT USE" signs remained in place on the temporarily closed evacuation routes. Continued review of the Audit log revealed the Administrator was also initialing the log indicating she had performed walking rounds as verification of the accuracy of the Maintenance audits until the construction process is completed. Interview with the Maintenance Director on 07/02/14 at 11:40 AM, revealed maintenance was performing the daily audits and initialing the log	K 038			

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

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OMB NO. 0938-0391

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K 038	<p>Continued From page 14 for verification.</p> <p>Interview with the Administrator on 07/02/14 at 4:03 PM, revealed she was performing her walking rounds daily of the signage posted and initialing the maintenance audit log.</p> <p>8. Review of the staff education revealed a questionnaire related to the exit routes and evacuation plan. Review of the completed questionnaires revealed the Administrator, DON, ADON, SDC, Dietary Director, Medical Records Director or HR Director had administered the questionnaire.</p> <p>Interview with the Administrator on 07/02/14 at 4:03 PM revealed she, the DON or RNC had reviewed the questionnaires. She indicated she was performing "spot checks" of questionnaires as per the AOC. The Administrator stated the questionnaire results would be taken to the facility's QA Committee weekly and QA would determine the frequency at which the questionnaires would be used. According to the Administrator, if there were any concerns identified they were to be reported to her.</p> <p>9. Interview with the RNC on 07/02/14 at 4:45 PM revealed she had been on site daily since 06/30/14. Continued interview revealed she assisted the Administrator in any capacity she needed to ensure compliance with staff education and ensure the daily Maintenance audits were completed accurately and turned into the Administrator.</p> <p>Interview with the Chief Nursing Executive on 07/02/14 at 4:50 PM, via telephone, revealed she was in daily contact with the RNC and facility and</p>	K 038			

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

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K 038	<p>Continued From page 15 acted as a resource when needed.</p> <p>Interview with the Administrator on 07/02/14 at 4:03 PM, revealed prior to the construction areas being re-opened, she and the Maintenance Director will inspect the construction area to ensure it is safe to use and institute re-education for all staff, residents and/or their responsible party.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.</p> <p>7.1.6.1 General. Walking surfaces in the means of egress shall comply with 7.1.6.2 through 7.1.6.4.</p> <p>Exception: Existing walking surfaces shall be permitted where approved by the authority having jurisdiction.</p> <p>7.1.6.2 Changes in Elevation. Abrupt changes in elevation of walking surfaces shall not exceed 1/4 in. (0.6 cm). Changes in elevation exceeding 1/4 in. (0.6 cm), but not exceeding 1/2 in. (1.3 cm), shall be beveled 1 to 2. Changes in elevation exceeding 1/2 in. (1.3 cm) shall be considered a change in level and shall be subject to the requirements of 7.1.7.</p> <p>7.1.6.3 Level. Walking surfaces shall be nominally level. The slope of a walking surface in the direction of travel shall not exceed 1 in 20 unless the ramp requirements of 7.2.5 are met. The slope perpendicular to the direction of travel shall not exceed 1 in 48.</p>	K 038			

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

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K 038	Continued From page 16 7.1.6.4* Slip Resistance. Walking surfaces shall be slip resistant under foreseeable conditions. The walking surface of each element in the means of egress shall be uniformly slip resistant along the natural path of travel. 7.1.7.1 Changes in level in means of egress shall be achieved either by a ramp or a stair where the elevation difference exceeds 21 in. (53.3 cm). 7.1.7.2* Changes in level in means of egress not in excess of 21 in. (53.3 cm) shall be achieved either by a ramp or by a stair complying with the requirements of 7.2.2. The presence and location of ramped portions of walkways shall be readily apparent. The tread depth of such stair shall be not less than 13 in. (33 cm), and the presence and location of each step shall be readily apparent. 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of	K 038			

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K 038	<p>Continued From page 17 refuge as provided in Chapters 22 and 23.</p> <p>Center for Medicare and Medicaid services survey and certification letter: 05-38</p> <p>Reference: NFPA 101 (2000 edition) 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in.(122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation.</p> <p>Exception No. 1:* Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor.</p> <p>Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.</p> <p>7.2.1.5.1 Doors shall be arranged to be opened</p>	K 038			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 038	<p>Continued From page 18</p> <p>readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.</p> <p>Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through 23.</p> <p>Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met:</p> <p>(a) Permission to use this exception is provided in Chapters 12 through 42 for the specific occupancy.</p> <p>(b) On or adjacent to the door, there is a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high on a contrasting background that reads as follows:</p> <p>THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED</p> <p>(c) The locking device is of a type that is readily distinguishable as locked.</p> <p>(d) A key is immediately available to any occupant inside the building when it is locked. Exception No. 2 shall be permitted to be revoked by the authority having jurisdiction for cause.</p> <p>Exception No. 3: Where permitted in Chapters 12 through 42, key operation shall be permitted, provided that the key cannot be removed when the door is locked from the side from which egress is to be made.</p>	K 038			

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

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K 048 SS=K	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to ensure there was a written plan for the protection of all residents, and for their evacuation in the event of an emergency. The deficiency had the potential to affect three (3) of eight (8) exits, sixty (60) residents, staff and visitors.</p> <p>The facility's failure to ensure there was a written plan for the protection of all residents according National Fire Protection Association (NFPA) standard, was likely to cause risk for serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 06/30/14 and determined to exist on 06/24/14. The facility was notified of the Immediate Jeopardy on 06/30/14.</p> <p>The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/03/14 with the facility alleging removal of the Immediate Jeopardy on 07/02/14. The Immediate Jeopardy was verified to be removed on 07/02/14 as alleged, prior to exiting the facility on 07/03/14.</p> <p>The findings include:</p> <p>Observation on 06/30/14 at 2:20 PM, with the Director of Plant Operations, revealed the Southwest Hallway, Northwest Hallway and dining</p>	K 048	<p>K048</p> <p>Immediate corrective action for residents found to be affected:</p> <ul style="list-style-type: none"> No residents were identified to be affected <p>Identification of other residents that have the potential to be affected:</p> <ul style="list-style-type: none"> All residents residing on the Northwest and Southwest halls have the potential to be affected. There is no construction at this time, thus no other residents are affected. <p>Measures taken to assure there will not be a recurrence:</p> <ul style="list-style-type: none"> SCC inserviced Administrator and entire safety & QA committees consisting of DON, ADON, BOM, RSM, MRM, DSM, ESD, SDC, POD and HRD/AIT, SSD, DOA, MDSN, WCN, QoLD, QoLA and Chaplain. Education was provided from June 30 to July 01, 2014 and covered construction planning and continued safety of the residents, additionally the construction plan and assignments, that delineated which staff was responsible for AOC were dispersed to all departments. Construction plan initiated on June 30, 2014 included new rounds, amended exit diagrams and placement of signage in appropriate areas that included all public and employee entrances indicating which doors closed related to construction. New signs related to "DO NOT USE" were placed on the affected doors. 	
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K 048	<p>Continued From page 20</p> <p>room exits were not useable due to the exits discharging into an ongoing construction zone. There was no hard surface to a public way from these exits. Continued observation revealed the affected exits did not have any signage indicated the exits were not to be used in an emergency. The exits lead to an uneven surface that was made up of large rock, dirt and rebar. In the event of fire or other emergency the existing conditions at the affected exits would prohibit evacuation of residents by wheeled devices and ambulatory residents would be at extreme risk of falls even with assistance. Interview with the Director of Plant Operations revealed all exits in the construction area were still being used. Further interview revealed he was unaware of any staff training conducted regarding the exits affected by the construction.</p> <p>Interview, on 06/30/2014 at 2:32 PM, with the Administrator revealed the facility had discussed the construction project in a town hall meeting on 06/20/2014. Further interview revealed department heads were supposed to make staff aware of the construction project. The Administrator was not aware of any training involving staff regarding the emergency exits affected by the construction and stated the facility had not developed an alternate evacuation plan.</p> <p>Interview, on 06/30/14 at 3:16 PM, with State Registered Nursing Assistant (SRNA) #1, revealed she was aware of the construction as she had seen the construction and heard staff talking about it. Further interview revealed she would use the exits in an emergency.</p> <p>Interview, on 06/30/14 at 3:20 PM, Housekeeper #1 revealed she was made aware of the</p>	K 048	<ul style="list-style-type: none"> ◆ In-services performed from June 30 to July 01, 2014 by DON, ADON, DSM, SDC, MDSN, ESD, HRD/AIT, ESNS, SCC, BOM, DOA, RSM, QoLD, WCN, WNS, Chaplain and SSD for all staff. Education consisted of the new evacuation plan and continued safety of the residents. ◆ All residents of BIMS 8 or greater were informed of the construction and alternate evacuation routes and signs from June 30 to July 01, 2014 by the SSD and QoLD. ◆ Responsible parties of resident with BIMS less than 8 were notified of the construction and temporary evacuation routes from June 30 to July 01, 2014 by the Chaplain and DOA. ◆ Signs were placed on main entrance and employee doors that construction is in progress on June 30, 2014 by the HRD/AIT and POD. ◆ All new temporary diagrams were created for southwest hall, northwest hall, dining room, dietary services and laundry area by the POD and posted on all temporary alternate evacuation routes on June 30, 2014. ◆ Medical director was notified on June 30, 2014 by the DON and is in agreement with steps taken. 		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2014
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
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K 048	<p>Continued From page 21</p> <p>construction by the Housekeeping Supervisor. Further interview revealed she was not sure if the exit was still usable and she was never told to not use the exit. Housekeeper #1 indicated she would use the exit in an emergency.</p> <p>Interview, on 06/30/2014 at 3:23 PM, with the Director of Plant Operations, revealed on 06/24/14, the facility began construction by removing the concrete pavement outside the Northwest Hallway exit door and the dining room exit door, and by 06/27/14, the Southwest Hallway exit door had pavement removed, affecting the safe path to a public way for those three (3) exits.</p> <p>Observation on 06/30/14 at 5:15 PM, with the Director of Plant Operations, revealed: the dining room exit had a 3.5 inch drop-off from the concrete pad to the gravel and rebar area; the Northwest Hallway had a 3.0 inch drop-off from the ramp to the concrete and rebar area; and the Southwest Hallway had a 4.5 drop-off leading to large gravel.</p> <p>Interview with the Administrator on 06/30/14 at 7:00 PM, revealed she was informed by the previous Administrator when she started at the facility on 05/15/14 there would be construction which included replacing damaged pavement on the west or back side of the building. She stated she had discussed the construction in the morning meetings with the department managers telling them the construction would consist of tearing up the concrete and re-pouring the concrete at the back of the building. However, she stated they had not discussed the safety aspects related to the construction nor had they developed a written plan for alternate evacuation.</p>	K 048	<p>Monitoring to assure continuing compliance:</p> <ul style="list-style-type: none"> QA Committee meeting to assess existing plans was held on July 01, 2014 with Administrator, DON, Medical Director, HRD/AIT, MRM, POD and DOA attending. Beginning August 06, 2014, the POD shall report all construction activity, plans and safety to the QA committee weekly x4 and then monthly for any further recommendations and resolutions. <p>Date of Completion: 09/23/2014</p>		

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

PRINTED: 08/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2014
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K 048	<p>Continued From page 22</p> <p>She stated, in hindsight she should have ensured there was a new emergency evacuation plan specific to address the three (3) exits affected during the construction. The Administrator stated she also should have ensured formal inservicing and education with the staff related to construction and which doors were to be used for alternate routes. The facility was unable to provide documented evidence that they had developed and implemented an new emergency evacuation plan specifically to address the three (3) exits involved in construction.</p> <p>The facility provided an acceptable, credible Allegation of Compliance (AOC) on 07/03/14, which alleged removal of the Immediate Jeopardy (IJ), effective 07/02/14. Review of the AOC revealed the facility implemented the following:</p> <p>1. The Regional Nurse Consultant (RNC) inserviced the Administrator and the entire Safety Committee (Human Resources Director/Safety Director, ADON North, Business Office Manager (BOM), Chaplain, Clinical Social Worker (CSW), Rehabilitation (Rehab) Manager, Medical Records Director, Dietary Director, Housekeeping Director, Activity Director, Staff Development Coordinator (SDC), Plant Operations Director, DON, ADON South, MDS LPN, MDS RN and Marketing Director, who were also the Quality Assurance (QA) Committee, on 06/30/14 during a Safety Committee meeting held to discuss the facility's Fire Safety Procedure for alternate evacuation routes due to construction. The education covered construction planning and continued safety of residents. Additionally, the construction plan and assignments, that delineated which staff member was responsible for what piece of the AOC, were dispersed to all</p>	K 048			

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

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OMB NO. 0938-0391

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K 048	<p>Continued From page 23</p> <p>departments by the Administrator and the Safety Committee Director. The construction plan included the creation of new routes and temporary exit diagrams, placement of signage outlining the construction plan in appropriate areas that included the front entrance, parking lot entrance and the doors which were closed related to the construction. New signs stating "DO NOT USE" were also placed on the affected doors.</p> <p>2. Inservices were initiated on 06/30/14 and 07/01/14, by the DON, Assistant Director of Nursing (ADON), Dietary Manager (DM), Staff Development, Business Office Manager (BOM), Housekeeping Director and Rehabilitation (Rehab) Director for all staff, including dietary, housekeeping, therapy, laundry and maintenance. The education consisted of the new evacuation plan and continued safety of residents. Additionally, no employee would be allowed to work until the education was provided and the post test completed to ensure compliance with exit routes. The Administrator maintained an employee roster to crosscheck with the training log to assure no employee was allowed to work until the education was received. One hundred and fifty-five (155) employees of one hundred and sixty-three (163) employees had been educated by 07/01/14. The facility did not utilize agency staff.</p> <p>3. All residents with a BIMS score of eight (8) or greater on their last MDS were informed of the construction and alternate evacuation routes, as well as, the the new evacuation signs. Forty-eight (48) residents met the criteria and were informed as indicated by the Activity Director and Social Service Director on 06/30/14 and 07/01/14.</p>	K 048			

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

PRINTED: 08/19/2014
FORM APPROVED
OMB NO. 0938-0391

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K 048	<p>Continued From page 24</p> <p>Responsible Parties of residents, who were frequent visitors to the facility, were notified of the construction and temporary evacuation routes, by telephone by the Chaplain and Marketing Director. Thirty (30) Responsible Parties were notified on 06/30/14 and 07/01/14, with plans to continue notifications daily until all resident families/responsible parties were notified.</p> <p>4. Signs were placed on the Main Entrance and the employee entrance doors on 06/30/14 by the Maintenance Director to inform all visitors that "Construction is in progress". Also, new temporary exit diagrams (maps) were created for the South West/North West/ Dining Room/Dietary Services/Laundry Area by the Safety Committee on 06/30/14 and posted on all temporary alternate evacuation routes. Signs were created and posted on all "temporarily closed" evacuation exits that stated, "STOP-DO NOT USE" by the Maintenance Director on 06/30/14.</p> <p>5. The Medical Director was notified of the IJ 07/01/14 by the DON.</p> <p>6. A QA meeting was held on 07/01/14 to review the new temporary exit diagrams for the South West/North West/Dining Room, Dietary Services and Laundry areas. Signs were created and posted on all areas of temporary alternate evacuation routes. Signs were created and posted on all temporarily closed evacuation exits to "STOP-DO NOT USE". The the entire plan was reviewed with the Medical Director on 07/01/14 during the QA meeting. The Medical Director approved the plan developed by the facility to address the IJ. Another QA meeting was scheduled for 07/09/14.</p>	K 048			

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

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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K 048	<p>Continued From page 25</p> <p>7. Maintenance was to audit daily beginning 07/01/14, to ensure signage was in place on the Main Entrance and employee entrance door informing all visitors "Construction is in process". The maintenance audit was to include a daily check to ensure the new temporary exit diagrams created for the South West/North West/Dining Room, Dietary Services and Laundry area's remain posted on all temporary alternate evacuation routes and to ensure that signs created and posted on all "temporarily closed" evacuation exits saying "STOP-DO NOT USE" remain in place. The results of the audits will be turned in daily to the Administrator until the construction project is completed. The Administrator was do daily rounds of the signage to assure accuracy of maintenance audits until the project is completed.</p> <p>8. A staff questionnaire regarding exit routes and evacuation plan was being administered by the Administrator, DON, ADONs, SDC, Dietary Director, BOM, Social Services Director (SSD), Chaplain, Admissions Director, Medical Records Director, and HR Director to five (5) staff members on each shift and different staff members until the immediacy was removed beginning 07/01/14. After the immediacy was removed ten (10) staff questionnaires were to be done daily to ensure continued understanding of exit routes and evacuation plan. All results of the questionnaires were to be reviewed by the Administrator, DON or Regional Nurse Consultant. The Administrator was to review all audits for completeness and accuracy, as well as, conduct "spot checks" of questionnaires to staff to ensure knowledge and accuracy of audits. Results of the staff questionnaires were to be reviewed by the QA Committee weekly to</p>	K 048		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2014
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K 048	<p>Continued From page 26</p> <p>determine the further need of continued education or revision of the facility's plan. The QA Committee was to determine at what frequency the questionnaires for staff would need to continue. Any concerns identified were to be corrected immediately and reported to the Administrator.</p> <p>9. A RNC has been onsite since 06/30/14, to assist with compliance with staff education, ensure daily audits were completed by the Maintenance Director and turned into the Administrator with no issues identified, and ensure daily staff questionnaires were completed as scheduled to ensure staff were aware of the new exits/evacuation plan. The Vice President (V/P) of Operations or Chief Nurse Executive were in daily contact with the RNC to review the above. Before the construction areas are re-opened, the areas are to be inspected by the Administrator and Maintenance Director to ensure the areas were safe for use.</p> <p>The State Agency validated the implementation of the facility's AOC as follows:</p> <p>1. Interview with the Administrator on 07/02/14 at 4:03 PM, revealed she and the entire Safety Committee had been inserviced by the RNC on the construction plan, resident safety and the new, temporary evacuation routes and diagrams on 06/30/14 at approximately 8:15 PM.</p> <p>Review of the education information revealed the construction plan which included the creation of new routes and temporary exit diagrams, placement of signage at the front doors, parking lot entrance and doors which were to be closed related to the construction.</p>	K 048			

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

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K 048	<p>Continued From page 27</p> <p>2. Review of the education information, including the post tests, provided to all staff, revealed the education included education on the construction plan and new signs posted and included the following statement, "due to the recent construction on the back driveway of the facility, new evacuation routes have been implemented until further notice". Continued review of the education material revealed the alternate evacuation plan was included, as well as, the questions for the post test to ensure competency and understanding.</p> <p>Interviews on 07/02/14 with Certified Occupational Therapy Aide (COTA) #1 at 12:00 PM; the Rehab Manager at 12:02 PM; SRNA #5 at 12:03 PM; SRNA #6 at 1:55 PM; SRNA #7 at 1:58 PM; SRNA #8 at 2:01 PM; SRNA #9 at 2:04 PM; SRNA #10 at 2:07 PM; SRNA #11 at 2:10 PM; Housekeeper #3 at 2:20 PM; Housekeeper #1 at 2:23 PM; Maintenance Assistant #1 at 2:24 PM; Dietary Aide #3 at 2:28 PM; Dietary Aide #1 at 2:32 PM; SRNA #3 at 3:11 PM; SRNA #1 at 3:13 PM; SRNA #12 at 3:15 PM; SRNA #13 at 3:17 PM; SRNA #14 at 3:24 PM; SRNA #15 at 3:26 PM; LPN #8 at 5:30 PM; RN #1 at 5:35 PM; LPN #9 at 5:40 PM; and LPN #10 at 5:45 PM revealed they had been in-serviced on the construction plan and the new, temporary evacuation routes and the new temporary exit diagrams, along with taking a post test to ensure they understood the education material.</p> <p>Interview with the Administrator on 07/02/14 at 4:03 PM revealed she used an employee roster in conjunction with training logs to assure no employee worked without the education, she continued by stating that to ensure accuracy/staff</p>	K 048			

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

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FORM APPROVED
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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K 048	<p>Continued From page 28</p> <p>understanding of the education, she would select two (2) completed post tests and re-interview that staff person.</p> <p>Review of documentation revealed the employee roster had been crosschecked against an employee training log to ensure employees had not worked without receiving the education and post test to ensure competency.</p> <p>3. Review of the education documents revealed all interviewable residents had been educated and a questionnaire was used to ensure resident understanding of the education related to the new evacuation plan and evacuation routes.</p> <p>Interviews with Resident #24 on 07/02/14 at 11:30 AM and Resident #23 at 11:35 AM, revealed they had been educated and completed a questionnaire related to the new construction and new evacuation plans.</p> <p>Interview with the SSD on 07/02/14 at 2:37 PM, revealed it had been her assigned task to educate residents with a BIMS of eight (8) or greater on the construction plan and the new temporary evacuation routes while construction was in place. The SSD indicated she had performed her education with interviewable residents on 06/30/14 and 07/01/14.</p> <p>Review of the education documents revealed the same education tool used for interviewable residents had been used to educate residents' responsible parties regarding the construction and new evacuation plans.</p> <p>Record review of phone logs revealed Resident #25's family had been contacted regarding the</p>	K 048		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 048	<p>Continued From page 29 construction and educated on the temporary evacuation routes.</p> <p>Interview with the SSD on 07/02/14 at 2:37 PM, revealed it had also been her assigned task to educate residents' responsible parties on the construction plan and the temporary evacuation routes while construction was in place. The SSD stated she initiated the education for responsible parties on 06/03/14 and 07/01/14. Continued interview revealed she had answered any questions the responsible parties might have had. She indicated she would continue notification and education until all responsible parties/families had been contacted. Further interview revealed she used the facility census sheet to ensure responsible parties of non-interviewable residents received the construction education.</p> <p>4. Observations, on 07/02/14 at 11:15 AM, revealed the new signage was in place at the Main Entrance and employee entrance doors as alleged on the AOC. Continued observation revealed the new temporary exit diagrams were also posted as alleged.</p> <p>Observation, on 07/8/02/14 at 11:32 AM, revealed signs stating "STOP-DO NOT USE" were posted on the "temporarily closed" evacuation exits.</p> <p>Interview with the Maintenance Director on 07/02/14 at 11:40 AM, revealed he had placed the new signage and temporary exit diagrams on 06/30/14 at approximately 8:30 PM.</p> <p>5. Interview with the facility's Medical Director on 07/02/14 at 5:20 PM, revealed he had been notified by the DON of the IJ on 07/01/14.</p>	K 048			

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

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K 048	<p>Continued From page 30</p> <p>6. Review of the minutes revealed a QA meeting was held on 07/01/14, and revealed the Medical Director was in attendance via telephone.</p> <p>Interview with the facility's Medical Director on 07/02/14 at 5:20 PM revealed he had been notified by the DON of the IJ on 07/01/14, during the QA meeting. He stated the plan implemented by the facility was a good plan, and he didn't think there was anything he would have added to the plan. Continued interview revealed he provided insight on Quality Measures and acted as a resource for facility staff education as part of his responsibilities as the Medical Director.</p> <p>7. Review of the daily Maintenance Audit logs beginning 07/01/14 revealed Maintenance was performing daily rounds to verify, by initialing the log, that the Main Entrance and employee entrance door signage remained in place to inform visitors that construction was in progress, the temporary exit diagrams remained posted on all temporary evacuation routes and the "STOP-DO NOT USE" signs remained in place on the temporarily closed evacuation routes. Continued review of the Audit log revealed the Administrator was also initialing the log indicating she had performed walking rounds as verification of the accuracy of the Maintenance audits until the construction process is completed.</p> <p>Interview with the Maintenance Director on 07/02/14 at 11:40 AM, revealed maintenance was performing the daily audits and initialing the log for verification.</p> <p>Interview with the Administrator on 07/02/14 at 4:03 PM, revealed she was performing her walking rounds daily of the signage posted and</p>	K 048			

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

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--------------------	--	---------------	---	----------------------

K 048	<p>Continued From page 31 initialing the maintenance audit log.</p> <p>8. Review of the staff education revealed a questionnaire related to the exit routes and evacuation plan. Review of the completed questionnaires revealed the Administrator, DON, ADON, SDC, Dietary Director, Medical Records Director or HR Director had administered the questionnaire.</p> <p>Interview with the Administrator on 07/02/14 at 4:03 PM revealed she, the DON or RNC had reviewed the questionnaires. She indicated she was performing "spot checks" of questionnaires as per the AOC. The Administrator stated the questionnaire results would be taken to the facility's QA Committee weekly and QA would determine the frequency at which the questionnaires would be used. According to the Administrator, if there were any concerns identified they were to be reported to her.</p> <p>9. Interview with the RNC on 07/02/14 at 4:45 PM revealed she had been on site daily since 06/30/14. Continued interview revealed she assisted the Administrator in any capacity she needed to ensure compliance with staff education and ensure the daily Maintenance audits were completed accurately and turned into the Administrator.</p> <p>Interview with the Chief Nursing Executive on 07/02/14 at 4:50 PM, via telephone, revealed she was in daily contact with the RNC and facility and acted as a resource when needed.</p> <p>Interview with the Administrator on 07/02/14 at 4:03 PM, revealed prior to the construction areas being re-opened, she and the Maintenance</p>	K 048		
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K 048	<p>Continued From page 32</p> <p>Director will inspect the construction area to ensure it is safe to use and institute re-education for all staff, residents and/or their responsible party.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator ' s position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply.</p> <p>19.7.2.1* For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and</p>	K 048			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2014
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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K 048	<p>Continued From page 33</p> <p>summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy ' s fire safety plan.</p> <p>19.7.2.2 A written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>19.7.2.3 All health care occupancy personnel shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions:</p> <ol style="list-style-type: none"> (1) When the individual who discovers a fire must immediately go to the aid of an endangered person (2) During a malfunction of the building fire alarm system <p>Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and then shall execute immediately their duties as outlined</p>	K 048		
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K 048	Continued From page 34 in the fire safety plan. 19.7.3 Maintenance of Exits. Proper maintenance shall be provided to ensure the dependability of the method of evacuation selected. Health care occupancies that find it necessary to lock exits shall, at all times, maintain an adequate staff qualified to release locks and direct occupants from the immediate danger area to a place of safety in case of fire or other emergency.	K 048			