

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

PRINTED: 03/23/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185216	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/11/2010
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NAME OF PROVIDER OR SUPPLIER PINE MEADOWS HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1908 HILL RISE DRIVE LEXINGTON, KY 40504
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS A Recertification/Abbreviated survey was conducted on 03/09-11/10, and a Life Safety Code Survey was conducted on 03/11/10. Deficiencies were cited with the highest scope and severity of an "F". During the survey, complaints numbers ARO KY00014308, ARO KY00014377, ARO KY00014404, and ARO KY00014446 were investigated and determined to be substantiated with no deficient practice identified. An additional complaint number ARO KY00014379 was investigated which was determined to be unsubstantiated with no deficient practice identified.	F 000		
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(8) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and	F 156	<ol style="list-style-type: none"> 1. Administrator ordered Medicare/Medicaid posters from OIG that address residents rights related to Medicare/Medicaid eligibility and benefits. This was posted in frames in front lobby on 3/18/10. 2. No residents were found to be affected by the deficient practice. 3. Administrator/Business Office Manager discussed Medicare/Medicaid related to residents rights in Resident Council Meeting on 3/25/10. Administrator/Business Office Manager also submitted articles to family newsletters advising family members of these rights 	3/26/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *[Signature]* (X6) DATE: 4-12-10

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

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NAME OF PROVIDER OR SUPPLIER PINE MEADOWS HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1808 HILL RISE DRIVE LEXINGTON, KY 40504		
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F 156	<p>Continued From page 1</p> <p>the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (I)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and</p>	F 156	<p>Rights and to see administrator/business office manager for any questions. Admission coordinator will continue to review Medicare/Medicaid upon admission to facility. Care plan team leaders will seek out any questions during care plan process.</p> <p>4. Administrator/business office manager will meet with resident council for 90 days to seek out questions related to Medicare/Medicaid process. Care plan team leader will forward questions to administrator/BOM for follow up. Will review for 90 days in monthly QA meeting.</p>		

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F 156	<p>Continued From page 2</p> <p>misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart 1 of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to prominently display written information about how to apply for and use Medicare and Medicaid benefits and/or how to receive refunds for previous payments covered by such benefits.</p>	F 156		

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F 156	Continued From page 3 The findings include: Observation on 03/11/10 at 3:30 PM, revealed the facility did not have prominently posted information about how to apply for and use Medicare and Medicaid benefits. Interview with the Business Office Manager on 03/11/10 at 4:00 PM, revealed the facility was aware this information needed to be posted however, did not realize the generalized information which was displayed did not meet regulatory requirements.	F 156		
F 371 88=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure dietary sanitation as evidenced by observations of male dietary staff working in the kitchen without beard restraints. Additional observations revealed, the facility failed to ensure sanitation was maintained as evidenced by observation of the outdoor dumpsters overfilled and not covered. Further observation revealed the facility failed to ensure sanitation was	F 371	1. No residents were found to have been affected by the deficient practice. 2. The Dietary Manager/Assistant Dietary Manager conducted inservices to all cooks and dietary aides on 3/24/10 to insure that no other residents would be affected by the deficient practice in the future. The inservices included: F tag 371, beard restraints, dumpster overflow, and importance of appropriate drying techniques for dishes. 3. The assistant dietary manager/dietary manager will conduct walking rounds five (5) days per week for eight (8) weeks to identify and non-compliance with inserviced areas. The sanitation rounds will continue twice weekly thereafter to insure compliance. 4. The Dietary Manager will conduct an audit once weekly to identify any potential non-compliance with inserviced areas for eight (8) weeks. These audits will be reviewed at monthly QA	3/26/10

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F 371	<p>Continued From page 4</p> <p>maintained as evidenced by observation on three (3) separate occasions water pitchers with water drops inside, lids on and no ventilation for proper drying techniques.</p> <p>The findings include:</p> <p>During initial tour of the dietary department on 03/09/10 at 8:30 AM revealed, five (5) stored pitchers with lids however, water droplets were observed inside the pitchers, related to incomplete drying process. Observation on 03/10/10 at 8:30 AM revealed, two (2) water pitchers with lids on had water drops inside them. Observation on 03/11/10 at 4:05 PM revealed, three (3) water pitchers were noted with lids on and water in the bottom.</p> <p>Observation on 03/09/10 at 11:15 AM revealed, male dietary aides with facial hair were not wearing beard restraints. Review of the facility's policy related to Employee Sanitary Practices (undated) revealed, dietary staff were required to wear hairnets or restraints. Interview with the Dietary Manager on 03/10/10 at 12:30 PM, revealed male staff were required to wear hair restraints if facial hair was involved.</p> <p>Interview with the Dietary Manager on 03/10/10 at 12:30 PM revealed, water pitchers should have remained in the drying area until the drying process was completed. The Dietary Manager indicated staff had been educated on the dishwashing procedures.</p> <p>Review of the the facility's Dishwashing Policy and Procedures (undated) on 03/11/10 revealed, cleaned dishes must be allowed to air dry before storage.</p>	F 371	Meetings for ninety (90) days.	

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F 371	Continued From page 5 Observation on 03/11/10 at 10:45 AM revealed, both of the facility's dumpsters were not covered with lids and one dumpsters was overfilled. Interview with the Dietary Manager on 03/11/10 at 11:00 AM, revealed the dumpsters should have been covered. Interview with the Maintenance Assistant on 03/11/10 at 3:30 PM revealed, dumpsters were to be emptied on Mondays, Tuesdays, Thursdays and Saturdays. The interview revealed, the sanitation company would come and empty the dumpsters more frequently if needed.	F 371			

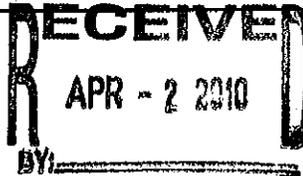
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K 000	INITIAL COMMENTS A Life Safety Code survey was conducted on 03-11-10 for compliance with Title 42, Code of Federal Regulations, 483.70 (a) (Life Safety from fire, requirements for Long Term Care Facilities)NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest scope and severity being a "F".	K 000		
K 060 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Initiation of the required fire alarm systems is by manual means in accordance with 9.6.2 and by means of any required sprinkler system water flow alarms, detection devices, or detection systems. 19.3.4.2, 9.6.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure a required water flow alarm for the facility sprinkler system was maintained in working order.</p> <p>The findings include:</p> <p>Observations during the Life Safety Code Inspection on 03-11-10 at 4:00 PM, with the Director of Maintenance, revealed the OS&Y tamper switch valve located in the automatic sprinkler riser room of the facility was noted to have an electronic monitoring device. Review of the monitoring company's faxed document of the Fire Alarm test report revealed the OS&Y tamper switch had alarmed five times within the period of 01-2010 through 03-11-2010. Record review and interview with the Maintenance Director on 03-11-10 at 4:00 PM revealed the Fire Alarm</p>	K 060		<ol style="list-style-type: none"> 1. Facility maintenance director/designee contacted Able Alarm company regarding cited deficient practice. Per services manager alarm system functioned as it should. 2. No residents were found to have been affected by the deficient practice. 3. Maintenance director reviewed service record with Able Alarm technician for dates reviewed by Life Safety Inspector during survey. These dates were noted to have been times when system was being serviced and preventative maintenance being performed. Alarm company was aware and involved with this service review and inspection. 4. Maintenance director/designee will continue to insure that quarterly inspections are conducted. These will be reviewed at monthly QA meetings for 90 days. Maintenance director will continue to communicate with Able Alarm technician regarding any future repairs/system checks.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Deborah Hall</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4-2-10</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 060	Continued From page 1 Panel did not activate and alert the facility as this device was designed to notify the facility by alarm if the water was shut off to the sprinkler system. The Director of Maintenance further stated from the monitoring records he did not know how long the trouble alarm had been this way. Refer to NFPA 101 Life Safety Code (2000 Edition). 9.7.2.1* Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.	K 060		
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING	K 066	1. Corrective action is that all extra ashtrays have been removed. Metal self-closing (NFPA compliant) have been ordered. These were put in place on 4/30/10	4/2/2010

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K 066	<p>Continued From page 2 or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the smoking area met minimum requirements as established in NFPA Standard 101.</p> <p>The findings include:</p> <p>Observation during the Life Safety Code inspection on 03-11-10, at 11:10 AM, revealed the smoking areas in two of the court yards failed to have metal containers with self-closing cover devices into which ashtrays could be emptied.</p> <p>Interview on 03-11-10 at 11:10 AM, revealed the Maintenance Director was not aware of the requirements regarding these containers.</p> <p>Actual NFPA Standard: 19.7.4 Smoking. Smoking</p>	K 066	<ol style="list-style-type: none"> 2. No residents were found to have been affected by this practice. 3. Systemic changes put into place are that Environmental Services Director has been inserviced on 3/24/10 to purchase only NFPA 101 approved ash trays. 4. This will be monitored by Environmental Services Director checking monthly for compliance. Will be reviewed monthly in QA meeting for 90 days. 	

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K 066	Continued From page 3 regulations shall be adopted and shall include not less than the following provisions: (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066		
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure oxygen cylinders were stored according to NFPA standards. The findings include: Observation during the Life Safety Code inspection on 03-11-10 at 11:55 AM with the	K 076		

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K 076	<p>Continued From page 4</p> <p>Director of Maintenance revealed twenty-three (23) E-Tanks of oxygen full, with the potential for forty (40) E-Tanks to be stored in the oxygen storage room. This room was observed located at the Five-hundred hall nurse's station. In addition, the door failed to have a forty-five minute fire resistance rating.</p> <p>An interview with the Maintenance Director and the Unit Nurse on 03-11-10 at 11:55 AM revealed they were not aware of oxygen storage requirements.</p> <p>NFPA 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ul style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction 	K 076	<ol style="list-style-type: none"> 1. Have ordered 1 hour fire resistance rated door which will replace old door. 2. No residents were found to be affected by this deficient practice. 3. Maintenance director will inservice all maintenance staff regarding oxygen storage requirements. Staff Development coordinator /Maintenance director will inservice all nursing staff regarding oxygen storage requirements. Maintenance director will check during building rounds to insure that oxygen is only stored in appropriate storage area. 4. Results of maintenance rounds regarding oxygen storage will be reviewed for 90 days in monthly QA meeting. 	4/12/2010

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2010
NAME OF PROVIDER OR SUPPLIER PINE MEADOWS HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504	
(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)	(X6) COMPLETION DATE
K 076	Continued From page 5 NFPA: 99, 1999 8-6.4.1.7 All labeling shall be durable and withstand cleansing or disinfection. 8-6.4.2* Signs.	K 076		
K 135 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Flammable and combustible liquids are used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for flammable and combustible liquids are constructed in accordance with NFPA 30, Flammable and Combustible Liquids Code, NFPA 99. 4.3, 10.7.2.1. This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure flammable materials were stored safely in the event of a fire. The findings include: Observation during the Life Safety Code Inspection on 03-11-10 at 11:00 AM revealed propane was stored in a gas grill located in the court yard. The court yard was located outside of the building but within the center of the facility where there was no exit to the street. Interview with the Maintenance Director on 03-11-10 at 11:00 AM revealed, when staff refill the propane tank for the gas grill, they transport	K 135	1. Propane tank stored in courtyard was removed immediately. Staff who would have occasion to use propane tank grill have been inserviced on 3/24/2010 regarding propane safety instructions and regulations. 2. No residents were found to have been affected by the deficient practice. 3. Only approved/inserviced department managers will be allowed usage of grill with propane tank. 4. Maintenance director will monitor use	4/12/2010

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K 135	Continued From page 6 the propane tank through the facility. The Maintenance Director stated he was aware that flammable products such as propane should not be in the facility. NFPA 2000 8.4 SPECIAL HAZARD PROTECTION 8.4.1 General. 8.4.1.1* Protection from any area having a degree of hazard greater than that normal to the general occupancy of the building or structure shall be provided by one of the following means: (1) Enclose the area with a fire barrier without windows that has a 1-hour fire resistance rating in accordance with Section 8.2. (2) Protect the area with automatic extinguishing systems in accordance with Section 9.7. (3) Apply both 8.4.1.1(1) and (2) where the hazard is severe or where otherwise specified by Chapters 12 through 42. NFPA 99, 10-7.2.1* Flammable and Combustible liquids shall be used from and stored in approved containers in accordance with ; NFPA 30- 4.3.3 Storage cabinets that meet at least one of the following sets of requirements shall be acceptable for storage of liquids: (a) Storage cabinets that are designed and constructed to limit the internal temperature at the center of the cabinet and 1 in. (25 mm) from the top of the cabinet to not more than 325°F (162.8°C), when subjected to a 10-minute fire test that simulates the fire exposure of the standard time-temperature curve specified in NFPA 251, Standard Methods of Tests of Fire Endurance of Building Construction and Materials, shall be	K 135	And storage of propane tanks. Maintenance director or assistant director will be present at all functions where propane grill will be utilized. A distance of a minimum of 20 feet from building will be maintained. This will be reviewed for 90 days at monthly QA meeting.	

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K 135	Continued From page 7 acceptable. All joints and seams shall remain tight and the door shall remain securely closed during the test.	K 135		