

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

PRINTED: 07/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185457	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/19/2013
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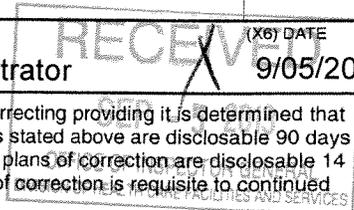
NAME OF PROVIDER OR SUPPLIER WINDSOR GARDENS	STREET ADDRESS, CITY, STATE, ZIP CODE 101 ISAAC GREER COURT BARDSTOWN, KY 40004
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>A Recertification Survey was conducted 07/09-11/13 and a Life Safety Code Survey was conducted on 07/09/13. Immediate Jeopardy was identified on 07/11/13 and was determined to exist on 03/09/13 related to the facility's failure to protect residents from potential abuse. An extended survey was initiated on 07/17/13 and concluded on 07/19/13 with Immediate Jeopardy ongoing at 42 CFR 483.13 Resident Behavior & Facility Practice (F225 and F226 at S/S "J"), and 42 CFR 483.75 Administration (F490 at S/S "J"). Substandard Quality of Care (SQC) was identified at 42 CFR 483.13. The facility was notified of the Immediate Jeopardy on 07/11/13.</p> <p>On 03/08/13, Resident #6, reported State Registered Nurse Aide (SRNA) #3 had kissed and hugged him/her like a lover. The direct care staff reported the allegation to the Director of Nursing (DON). However, the DON failed to report the allegation to the State Survey Agency, failed to conduct a thorough investigation, and failed to protect facility residents from potential abuse by allowing SRNA #3 to care for other residents during the investigation. In addition, the Administrator failed to provide guidance and oversight of the abuse investigation to ensure the facility's abuse policy was followed. Interview and record review also revealed Administrative staff was not knowledgeable regarding policy and procedures related to abuse.</p> <p>Resident #6 was transferred to the hospital on 07/10/13, prior to the annual survey, and did not return to the facility.</p> <p>The facility failed to submit an acceptable</p>	F 000	<p>F000 Initial Comment</p> <p>This Plan of Correction is prepared and submitted as required by law. By submitting the Plan of Correction, Windsor Gardens does not admit that the deficiencies listed on this form exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies and/or any statements, facts, and conclusions that form the basis of the alleged deficiencies.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Suzanne Reasbeck</i>	TITLE <i>X Administrator</i>	(X6) DATE <i>X 9/05/2013</i>
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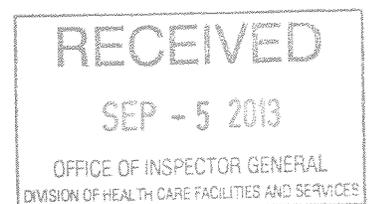
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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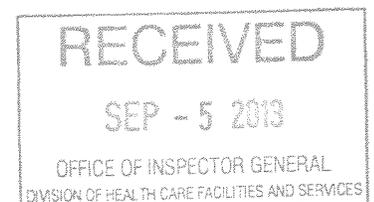
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F 000	Continued From page 1 Allegation of Compliance prior to the survey exit; therefore, the Immediate Jeopardy is ongoing.	F 000			
F 159 SS=C	<p>In addition, other deficiencies were cited during the Recertification survey with the highest S/S of an "E" for the Health survey and a S/S of a "F" for the Life Safety Code Survey.</p> <p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds</p>	F 159	<p>F159 483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>At the time of the deficiency, there were 13 skilled residents-five of those residents having a personal fund account with Windsor Gardens held in a petty cash fund. These thirteen skilled residents will be mailed a copy of the new policy along with a cover letter/explanation (see attached) no later than 8/31/13.</p> <p>A new policy regarding Resident Personal Funds has been developed (see Attachment). The policy states that Windsor Gardens CCRC will deposit any Skilled Nursing Resident's personal funds in excess of \$50.00 in an interest bearing account that is separate from any Windsor Gardens operating account. Credits will be made on all interest earned on the resident's account.</p> <p>The facility will maintain a SNF resident's personal funds to not exceed \$50.00 in a petty cash fund. Quarterly reports will be sent to the resident or resident representative.</p> <p>The new policy will be mailed to each resident/resident representative no later than 8/31/13. The new policy will replace the existing information regarding Resident Personal Funds in the Admission Packet for all residents of Windsor Gardens CCRC.</p> <p>To ensure this violation does not recur:</p> <ol style="list-style-type: none"> 1) The policy will be placed in the Policy and Procedure Manuals located at the Nurse Station in the Nursing Facility, the Front Desk in Assisted Living, and Nurse Station in the Memory Care Unit. 2) Current Resident Personal Funds information in the Admission Packets will be shredded by the Medical Records Clerk and replaced with the the new policy. 		



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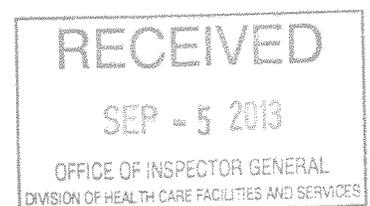
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F 159	<p>Continued From page 2 of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, and review of the facility's admission packet regarding Resident Personal Funds, it was determined the facility failed to allow residents to have personal funds in excess of fifty dollars (\$50.00). Therefore, all funds were placed in a non-interest bearing account. The census during the review was thirteen (13).</p> <p>The findings include:</p> <p>Review of the facility's admission packet revealed each resident was given information regarding Resident Personal Funds upon admission to the nursing facility. Review of this information (revised November 2012) revealed each resident may manage the use of his/her personal funds. The nursing facility accepts the responsibility for managing the resident's personal funds as evidenced by the facility's written</p>	F 159	<p>3) Staff involved in admissions - Administrator, DON, Social Services and Staff Nurses will be in-serviced by the Business Office Manager on the new policy no later than 8/31/13.</p> <p>4) Monthly audits of the Resident Personal Funds are to be completed by the Business Office Manager with a Monthly Resident Personal Fund Audit report (see attached) given to the Administrator on a monthly basis.</p> <p>5) The Monthly Resident Personal Fund Audit reports will be presented for review to the Q.A. Committee at the quarterly Q.A. Committee meetings.</p> <p>6) The Resident Personal Funds Policy will be reviewed annually by the Quality Assurance Committee, or sooner if deemed necessary.</p> <p>7) If any problems arise with resident fund accounts, a Q.A. Plan of Action will be developed, completed and presented at the following Q.A. Committee meeting for discussion.</p> <p>Completion Date:</p>	9/1/13	



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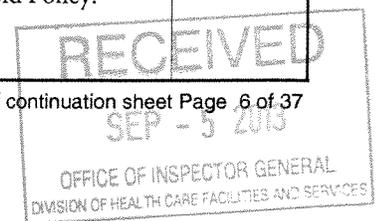
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F 159	<p>Continued From page 3</p> <p>acknowledgement, proper accounting and monitoring of such funds would be made. The facility would deposit any resident's personal funds in excess of \$50.00 (fifty dollars) in an interest bearing account. Further review revealed the facility would maintain a resident's personal funds not to exceed \$50.00 in the petty cash fund. The Business Office operates during normal business hours to assist with personal funds.</p> <p>Review of the written document titled "Resident Funds", not dated, revealed the nursing home residents could not have any more than \$50.00 in their account.</p> <p>Review of the Resident Trust Fund, on 07/10/13, revealed a total balance of \$130.49 (one hundred thirty dollars and forty-nine cents). There were five (5) residents with money in the trust fund. Review of the surety bond revealed it provided \$10,000.00 (Ten thousands dollars) coverage for the trust fund.</p> <p>Interview with the Business Office Manager, during review of the Resident Trust Fund, on 07/10/13 at 1:45 PM, revealed residents were not allowed to have more than \$50.00 in the Resident Trust Fund. She indicated she had told the residents they could use the petty cash fund. The Business Manager stated that had been all she had managed. Further interview revealed she had been trained by the former Business Office Manager and that she was unaware of the regulation.</p> <p>Continued interview with the Business Office Manager, on 07/11/13 at 9:34 AM, revealed she had called her corporate office and the nursing</p>	F 159		



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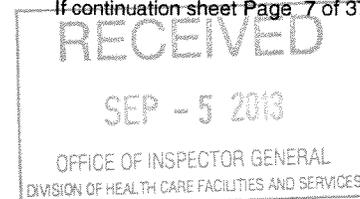
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F 205	<p>Continued From page 5</p> <p>Based on interview, record review, and review of the facility's policy, it was determined the facility failed to provide a notice of transfer/bed hold for one (1) of thirteen (13) sampled (Resident #6). Resident #6 was transferred to the hospital three (3) times; and, did not receive a transfer/bed hold notice for each hospital transfer.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Transfer or Discharges from the Facility, revised 04/25/13, revealed a transfer was defined as when a resident moved from the facility to another legally responsible institutional setting. The written notice should state the reason for the transfer, where the resident was being transferred to and the date of transfer.</p> <p>Review of the facility's policy regarding Bed Hold, revised 07/06/06, revealed the purpose of the bed hold notice was to assure residents of a bed when hospitalized. The Social Service or Finance Department would be responsible for notifying residents, or their representative in writing of the facility bed hold policy on admission and prior to hospitalization or therapeutic leave.</p> <p>Review of the facility's document "Admission and Financial Agreement", not dated, revealed the facility would or would not hold the bed, as marked by the resident or legal representative, for the resident if the resident was transferred to the hospital. The admission agreement also stated Medicare would not pay to hold a bed for the resident if the resident was transferred to the hospital. Additionally, the facility would charge the resident or responsible party room and board</p>	F 205	<p>These five residents, along with Resident #6, were mailed letters of explanation regarding non-compliance of notices of Bed Hold Policy on 8/14/13. The Bed Hold Policy was included. The letter contained a portion to be completed and returned in a self-addressed stamped envelope. This portion contains options that the resident/resident representative "did" or "did not" understand the Bed Hold Policy at the time of transfer along with signature and date line. Residents/Resident Representatives were asked to reply by 8/22/13.</p> <p>The Wndsor Gardens CCRC Nursing Home Bed Hold Policy has been revised (see Attachment) with the following changes:</p> <ol style="list-style-type: none"> 1) Social Services will be responsible for notifying resident or resident's representative in writing of the facility bed hold policy upon admission. A copy with signature of resident or resident representative will be given to the resident/resident representative, a copy will be kept in the resident's chart and a copy will be kept in the Business Office. 2) The Charge Nurse will be responsible for notifying the resident or resident's representative in writing of the facility bed hold policy prior to or at the time of transfer for hospitalization or therapeutic leave via the Notice of Bed Hold Policy form created by the Business Office Manager on 8/1/13 (see Attachment). <p>The Notice of Bed Hold Policy includes:</p> <ol style="list-style-type: none"> 1) Date of Transfer 2) Resident's Name 3) Reason for Transfer 4) Place resident ins being transferred to 5) Date resident/resident representative was given copy of Notice of Bed Hold Policy form/ notified of Bed Hold Policy. 		



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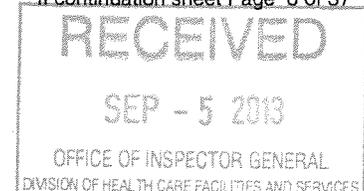
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F 205	<p>Continued From page 6 charges for each day of the bed hold.</p> <p>Review of Resident #6's Admission and Financial Agreement, dated 12/29/09, revealed the resident had Medicare and the facility would hold the resident's bed at a daily rate of \$210.00 (two hundred and ten dollars).</p> <p>Review of Resident #6 clinical record revealed, the facility admitted the resident on 01/10/10, and re-admitted on 02/01/13 with diagnoses of Congestive Heart Failure (CHF), Urinary Tract Infection (UTI), and Dysphagia. The facility assessed the resident, on 04/07/13, with a Quarterly Minimum Data Set (MDS) and found the resident to have impaired cognition with a Brief Interview Mental Status (BIMS) score of four (4). The facility transferred the resident to the hospital on 12/18/12, 01/30/13; and, on 07/10/13.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/11/13 at 9:47 AM, revealed when a resident was transferred from the facility, a transfer sheet was also sent with the resident. The LPN stated the transfer sheet included the resident's diagnoses and medical history, list of medications and physician orders, and the resident's status at time of transfer. The LPN stated she was not aware of a form for notice of bed hold.</p> <p>On 07/11/13 at 10:12 AM and 10:54 AM, interview with the Social Service Director revealed she was unaware of a Notice of Transfer to residents when they left the facility. She stated the Business Office Manager, or the MDS Coordinator would be responsible for the bed hold notice as they were responsible for Medicare billing.</p>	F 205	<p>6) Signature of person giving notification 7) Windsor Gardens CCRC Bed Hold Policy</p> <p>To ensure violation does not recur: 1) The Business Office Manager will verify that the Bed Hold Policy was given as part of the Admssion Packet by keeping a copy of the Bed Hold Policy signed by the resident/resident representative at time of admission. 2) The Business Office Manager will verify that the Notice of Bed Hold Policy has been completed by the Charge Nurse whenever a tranfer occus by keeping a copy of the Notice of Bed Hold Policy completed and signed by the Charge Nurse. 3) To maintain compliance, the Business Office Manager will conduct quarterly audits of the Notices of Bed Hold Policy and present the audits to the Quality Assurance Committee at the Q.A. quarterly meetings for review beginning with the October 2013 scheduled QA meeting.</p> <p>Completion Date:</p>	9/1/13	



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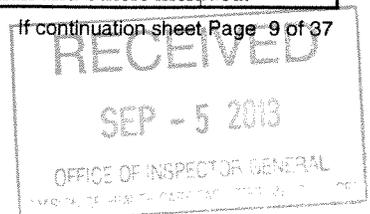
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F 205	Continued From page 7 Interview, on 07/11/13 at 1:36 PM, with the Director of Nursing (DON) revealed she was not aware of a notice of bed hold for residents. The DON stated the Business Office Manager would be responsible for the bed hold notice. Interview with the Business Office Manager, on 07/11/13 at 1:45 PM and 2:05 PM, revealed when the facility admitted residents, the resident's Admission Agreement stated if the facility would or would not hold a resident's bed if the resident transferred to the hospital. She stated the Admission Agreement was the only notification of the facility's bed hold policy, provided to residents and family members, and how much the resident would be billed. She stated she did not call or otherwise notify the family when a resident was transferred from the facility. The Business Office Manager stated the facility did not follow up with residents who had been at the facility for an extended period of time. She stated no one had re-informed Resident #6 or the resident's family of the bed hold notice since the resident was initially admitted several years ago. On 07/11/13 at 4:02 PM, interview with the MDS Coordinator revealed she was unaware of a notice of bed hold for residents. She stated she was not aware of who would be responsible for getting the information to the resident and family member.	F 205			
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or	F 225	F225 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS Completion Date: Windsor Gardens complies with the provisions outlined in this law. Per Windsor's employee	9/01/2013	



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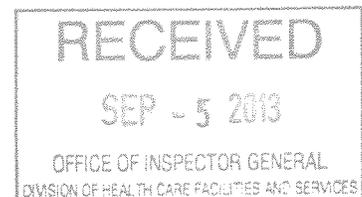
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F 225	<p>Continued From page 8</p> <p>mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 225	<p>handbook and in it's policy on abuse and neglect, personal reference checks, criminal investigation checks are done on all employees hired. The HR Director also verifies that potential employees are not listed on the Kentucky Nurse Aide Registry or have any actions taken against them by their licensing boards. There is no evidence or information to indicate that Windsor Gardens was not in compliance with this statute. SRNA #3, #4, #5, and all employees involved in investigating the alleged abuse incident were screened according to Windsor Gardens HR policy prior to being offered a job at Windsor Gardens.</p> <p>Per the Windsor Gardens's Abuse and Neglect policy used by the DON and SW to investigate the alleged abuse incident (March 8, 2013), the DON followed the policy by reporting the incident to the Administrator and to the SW. After beginning the investigation and gathering more information, the DON and SW called the 24 hour ELDER ABUSE HOTLINE number for the Lincoln Trail Dist. on March 12, 2013 to report the allegation. It was their belief that by reporting the incident to this number, the requirement to report the allegation had been met. An APS staff member investigated the incident on March 19 and found it unsubstantiated. Case # Report 1001524 is on file in the APS office in Frankfort. In an interview between the State Surveyor and the Administrator, the Administrator stated that she thought the incident had been reported.</p> <p>The revised Abuse and Neglect Policy has as its purpose the protection of residents from any kind of abuse by anyone. "Abuse" is defined at the beginning of the policy and the seven kinds of abuse also summarized.</p> <p>The procedure section of the policy includes sections on the following: Responsibility for Reporting Resident Abuse How to Report Abuse to Facility Management How to Notify Oversight Agencies Method of Abuse Notification</p> <p>Report Form A - a help guide with the phone numbers for the OIG, APS, Ombudsmen and others included.</p>		



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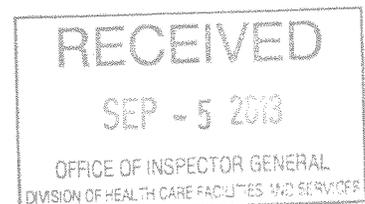
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F 225	<p>Continued From page 9</p> <p>Based on interview, record review and review of the facility's abuse policy and investigation, it was determined the facility failed to have an effective system to ensure all alleged violations of mistreatment, neglect, or abuse were thoroughly investigated and reported to the State Survey Agency and failed to ensure residents were protected from further potential abuse for one (1) of thirteen (13) sampled residents (Resident #6).</p> <p>On 03/08/13, the facility received an allegation of abuse from Resident #6, who reported State Registered Nurse Aide (SRNA) #3 had kissed and hugged her/him like a lover would. The resident had reported the allegation to SRNA #4 and SRNA #5 and they reported the allegation to the Director of Nursing (DON). The DON called the facility and spoke with SRNA #3 on 03/09/13 and informed him not to provide direct care for Resident #6; however, SRNA #3 continued to care for other residents. In addition, SRNA #3 was allowed to work and provide care to facility residents for six (6) days during the abuse investigation.</p> <p>Interview and review of the facility's investigation revealed the facility failed to report the allegation of abuse to Adult Protection Services (APS) until 03/12/13, five days after receiving the allegation, and did not report the allegation to the Division of Long Term Care, Office of Inspector General (OIG) per facility policy. Review of the facility's investigation revealed a thorough investigation was not conducted and did not include interviews with other residents and staff, and a skin assessment was not conducted on Resident #6 for signs of abuse. Interview with the DON and Social Worker (who conducted the investigation)</p>	F 225	<p>To ensure that Windsor Gardens Nursing Home is acting to prevent occurrences of mistreatment, neglect and abuse of resident and misappropriation of resident property, guidelines for the prevention of abuse are included in the policy. The Abuse Prohibition section of the Long Term Survey Manual has been included in the policy. This section includes:</p> <ul style="list-style-type: none"> Screening potential hires Training employees on recognizing abuse Prevention of abuse Identification of possible incidents/allegation which need investigation Investigation of incidents and allegations Protection of residents during an investigation Reporting of incidents, investigations, and facility response to the results of their investigations. <p>The policy includes 3 tools developed to insure that a thorough reporting and investigation process occurs and that there is documentation of all the actions taken. The three tools are:</p> <p>Report Form A, This form records the Who, What, When, Where and How residents were protected when there is a reported allegation. The Abuse & Neglect Policy Checklist lists the steps to be followed when investigating an allegation. Who to contact and a record of when the contact was made is included as is a place to record the staff that comes to investigate the allegation from the oversight agencies like OIG, APS or the District Ombudsman. There is a section to record the findings of the Investigation. The contents of Report Form A and the Abuse & Neglect Policy Checklist will be used to summarize a 5 day report to be given to the OIG by either the Administrator, the DON, the SW or other Manager conducting the investigation.</p>		



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F 225	<p>Continued From page 10</p> <p>revealed this was their first abuse investigation and they did not know to report the allegation to the State Survey Agency. Interview revealed they thought they were following facility's policy when they removed SRNA #3 from direct care of Resident #6. Interview with the Administrator revealed she had not been involved with the investigation and did not provide guidance nor oversight to those who were conducting the investigation.</p> <p>Resident #6 was transferred to the hospital on 07/10/13, prior to the annual survey, and did not return to the facility.</p> <p>The facility's failure to ensure all abuse allegations were reported immediately to the State Survey Agency, to ensure the protection of residents after an allegation of abuse, and to thoroughly investigate an allegation of abuse has caused or is likely to cause serious injury, harm, impairment or death to a resident. The Immediate Jeopardy and Substandard Quality of Care (SQC) was identified on 07/11/13 and is ongoing at 42 CFR 483.13 Resident Behavior & Facility Practice, F225 at a S/S "J". The Immediate Jeopardy was determined to exist on 03/09/13. The facility was notified of the Immediate Jeopardy on 07/11/13.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Abuse and Neglect, revised 01/06/06, revealed the abuse policy contained definitions of abuse but did not include the investigation component and gave no guidance on how to investigate an allegation of abuse. According to the abuse policy, the facility</p>	F 225	<p>An Abuse & Neglect Tracking Form is the final tool included in the policy. It is intended to track all incidents of Abuse and Neglect reported and investigated in the facility over a period of time. (From annual State Survey to annual State Survey)</p> <p>All three forms are to be completed by the DON, SW, Charge Nurse, Manager, conducting the investigation. The three forms when completed will be given to the Administrator. The Administrator will review the forms and will compile a report of the content. The information will become a part of the Administrative report to the quarterly Quality Assurance meeting and the Board of Director meeting.</p> <p>The final page of the revised policy includes a list of contact information for the Office of Inspector General (Louisville and Frankfort); for Adult Protective Services; for Child Protective Services; for the District Ombudsman, for the facility Medical Director; for the Bardstown Police Dept. Each office includes a phone and fax number, and the address. Revised policy was approved 7/18/13.</p> <p>Protection of Residents: The DON talked with SRNA#3 on March 9, 2013, before he clocked in to work. He denied the allegation, but to protect residents, the DON removed SRNA #3 from direct care of the resident and told him that to protect himself and other residents he heeded to ask another staff person to accompany him when he delivered care to any resident on the unit. (These two actions were reported by the DON to the Administrator.)</p> <p>In the revised Abuse and Neglect Policy (July 18, 2013) there is a section entitled "Protection." This section states, "To protect residents from harm during an investigation, the individual(s) alleged to be involved in the abuse is/are removed from providing all direct resident care by being suspended from the facility during the pending investigation."</p>		



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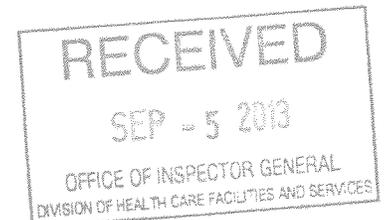
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F 225	<p>Continued From page 11</p> <p>would immediately report the allegation to Adult Protective Services (APS) and the Division of Long Term Care (OIG) [the State Survey Agency]. A five (5) day follow-up of the incident would be performed and reported to the above state agencies. Further review of the policy revealed to protect residents from harm during the investigation, the individual (s) alleged to be involved in the abuse would be removed from providing direct resident care during the pending investigation.</p> <p>Review of the facility's investigation of the allegation of abuse revealed an incident report was completed on 03/08/13 at 7:30 PM, when Resident #6 reported inappropriate behaviors by SRNA #3. The report stated the resident was talking to SRNA #4 and #5 stating that SRNA #3 told the resident if it wasn't for their ages, they could be lovers. The resident went on to say SRNA #3 would kiss him/her and do things that lovers would do. When the aides question the resident on how SRNA #3 had kiss him/her, the resident said, "the way I want him to kiss me when the doors are closed." SRNA #4 and #5 reported the allegation to the charge nurse and SRNA #4 and the charge nurse called the DON. The next day, 03/09/13, SRNA #3 reported to work and was told by the DON (via telephone) not to give direct care to Resident #6. The investigative report revealed the Administrator was informed of the allegation on 03/09/13. Written statements of SRNA #4 and #5 were obtained.</p> <p>Continued review of the facility's investigation revealed the Social Worker documented she had interviewed Resident #6 on 03/11/13 regarding</p>	F 225	<p>Residents impacted by allegation:</p> <p>The deficient practice negatively impacted resident #6. A skin assessment was not performed on her at the time of the allegation. She was interviewed by the SW on 3/11/13 regarding the allegation. She did not recall the allegation and stated, "I'm fine." Resident #6 was transferred to the hospital on 7/10/13 and passed away that morning from an illness unrelated to the abuse allegation incident.</p> <p>A total of 35 residents of the unit were potentially at risk since the abuse allegation of March 8, 2013. (This number represents the number of unit residents on March 8 through July 22, 2013.)</p> <p>Three assessment tools were used to assess the residents who were impacted by the IJ:</p> <p>1) BIMS scores were obtained from MDS 3.0 on each resident potentially impacted.</p> <p>Based on the patient's BIMS score, one of the two other assessments (Interviews and Skin Assessments) were conducted by the SW, DON, MDS Nurse or Charge Nurse.</p> <p>2) Interviews - Interviews with the 12 current residents who are alert and oriented, were conducted by the SW, DON and MDS Nurse. The results of those interviews revealed no evidence of abuse, or other resident rights violations. Five residents were discharged from the unit during this time period and were not contacted.</p> <table border="1"> <thead> <tr> <th>RM#</th> <th>DATE</th> <th>INTERVIEWED BY</th> </tr> </thead> <tbody> <tr> <td>A01</td> <td>7/15/13</td> <td>LPN/MDS Coordinator</td> </tr> <tr> <td>B02</td> <td>7/12/13</td> <td>RN/DON</td> </tr> <tr> <td>B03</td> <td>7/15/13</td> <td>RN/DON</td> </tr> <tr> <td>B04</td> <td>7/15/13</td> <td>LPN/MDS Coordinator</td> </tr> <tr> <td>B05</td> <td>7/12/13</td> <td>LPN/MDS Coordinator</td> </tr> <tr> <td>B10</td> <td>7/12/13</td> <td>RN/DON</td> </tr> <tr> <td>C03</td> <td>7/12/13</td> <td>SS/Act Coordinator</td> </tr> <tr> <td>C04A</td> <td>7/12/13</td> <td>SS/Act Coordinator</td> </tr> <tr> <td>C05</td> <td>7/12/13</td> <td>SS/Act Coordinator</td> </tr> <tr> <td>C06</td> <td>7/12/13</td> <td>SS/Act Coordinator</td> </tr> <tr> <td>C07</td> <td>7/15/13</td> <td>LPN/MDS Coordinator</td> </tr> <tr> <td>C11</td> <td>7/15/13</td> <td>LPN/MDS Coordinator</td> </tr> </tbody> </table>	RM#	DATE	INTERVIEWED BY	A01	7/15/13	LPN/MDS Coordinator	B02	7/12/13	RN/DON	B03	7/15/13	RN/DON	B04	7/15/13	LPN/MDS Coordinator	B05	7/12/13	LPN/MDS Coordinator	B10	7/12/13	RN/DON	C03	7/12/13	SS/Act Coordinator	C04A	7/12/13	SS/Act Coordinator	C05	7/12/13	SS/Act Coordinator	C06	7/12/13	SS/Act Coordinator	C07	7/15/13	LPN/MDS Coordinator	C11	7/15/13	LPN/MDS Coordinator		
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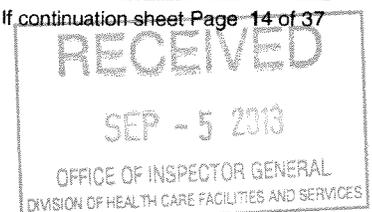
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F 225	<p>Continued From page 12</p> <p>the allegation. The resident could not recall the the allegation and stated, "I'm fine." The record revealed the facility assessed Resident #6 to have a severe cognition impairment with a Brief Interview Mental Screen (BIMS) score of a three. On 03/12/13, SRNA #3 was interviewed and made aware of the allegation. SRNA #3 denied the allegation.</p> <p>Interview with SRNA #5, on 07/11/13 at 11:20 AM, revealed she was working the evening of 03/08/13. She stated SRNA #4 and herself had toileted Resident #6 and was assisting the resident back to the bed. The resident was placed in bed and that was when the resident told them that they were not doing it liked SRNA #3. When they asked the resident what he/she meant, the resident told them SRNA #3 would kiss him/her before leaving. She stated they questioned the resident about the kiss and the resident became frustrated with them and kept saying it was not like SRNA #3 did it. SRNA #5 stated they could not figure out what they were doing wrong. The resident mentioned something about them being lovers and SRNA #3 would not be happy with him/her saying all this. The resident told the SRNAs that SRNA #3 had kissed him/her like a lover would. SRNA #5 said she could not recall all the details but stood by her written statement of 03/08/13. She further stated SRNA #4 had called the DON and told her everything the resident had told them. SRNA #5 stated she was not interviewed about the incident.</p> <p>Interview with SRNA #4, on 07/11/13 at 1:36 PM, revealed the same details as SRNA #5. She stated SRNA #3 was usually the one who placed Resident #6 in bed, but he was off that night. The</p>	F 225	<p>3) Skin assessments – Eight of the 35 residents have a BIMS score of 8 or less, and skin assessments were completed on them by the Charge Nurses. No untoward findings were noted which would indicate abuse.</p> <table border="1"> <thead> <tr> <th>RM#</th> <th>DATE</th> <th>COMPLETED BY</th> </tr> </thead> <tbody> <tr> <td>A04</td> <td>7/12/13</td> <td>RN</td> </tr> <tr> <td>B07</td> <td>7/13/13</td> <td>RN</td> </tr> <tr> <td>B08</td> <td>7/13/13</td> <td>RN</td> </tr> <tr> <td>B12</td> <td>7/13/13</td> <td>RN</td> </tr> <tr> <td>C09A</td> <td>7/14/13</td> <td>RN</td> </tr> <tr> <td>C10B</td> <td>7/12/13</td> <td>RN</td> </tr> <tr> <td>A02</td> <td>7/15/13</td> <td>LPN</td> </tr> <tr> <td>B09</td> <td>7/13/13</td> <td>RN</td> </tr> </tbody> </table> <p>Should an abuse allegation or Rights Violation occur in the future, the charge nurse will call the DON and the Administrator to determine the correct/best kind of assessment tool or action(s) to take to protect residents. The three checklists included in the Abuse and Neglect Policy are to be used on ALL Resident Rights violations and Allegations of Abuse. A nursing assessment performed by charge nurse or another nurse on duty is always the first step taken. Other assessment tools that might be used are: resident BIMS Scores, Interviews with resident(s), family members, and other staff, and a Skin Screening. (A list of possible questions to be used in interviews was developed as part of the Plan of Correction. The list titled "Questions for Rights Violation Interviews" is a part of the Abuse & Neglect Policy. Questions on the list are geared to various types of abuse, i.e., verbal, theft, intimidation, etc.)</p>	RM#	DATE	COMPLETED BY	A04	7/12/13	RN	B07	7/13/13	RN	B08	7/13/13	RN	B12	7/13/13	RN	C09A	7/14/13	RN	C10B	7/12/13	RN	A02	7/15/13	LPN	B09	7/13/13	RN	
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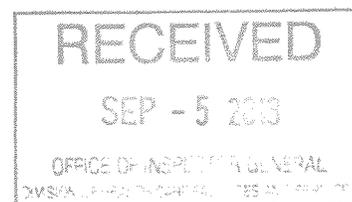
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F 225	<p>Continued From page 13</p> <p>resident appeared to be upset because SRNA #3 was not working. The resident kept saying we were not doing things like SRNA #3 did. When they asked the resident what things, the resident replied he/she was talking about SRNA #3 kissing her like a lover. SRNA #4 did not feel comfortable about what the resident was saying so she reported it to the charge nurse and called the DON herself to report the incident. SRNA #4 stated she provided a written statement regarding the incident but was not interviewed during the investigation. She revealed SRNA #3 was off that evening (03/08/13) but worked the next evening (03/09/13).</p> <p>Interview with SRNA #3, on 07/11/13 at 2:15 PM, revealed he had cared for Resident #6 often over the four years he had worked at the nursing facility and was very familiar with the resident's care. He stated "he routinely kissed residents on the forehead like you would a family member". He denied any sexual actions toward the resident. He continued by stating he was made aware of the allegation the next day (03/09/13) when he arrived to work and was told he could not care for Resident #6. He did provided care to other residents. He was interviewed by the DON and Social Worker but could not recall the date. He talked to the Administrator because he was upset and told the Administrator he had kissed the resident on the forehead, but denied anything else had happened.</p> <p>Interview with the DON, on 07/10/13 at 2:20 PM, (during Task 5-G Abuse Prohibition Review) revealed she had conducted only one allegation of abuse (The allegation involving Resident #6) since the last standard survey and this was the</p>	F 225	<p>From July 11, 2013 through July 22, 2013, there were in-services implemented. The Administrator and DON worked together to identify topics and presenters who could provide them, the facility managers, and Nursing Home employees with information that could be used to "learn again" about Resident Rights and How to Protect Them. It was also important that information be presented on how to conduct a Rights Violation investigation. In-services included:</p> <p>7/12/13 Hand-in-Hand Abuse & Neglect Module Presented to: Nursing Home Staff working day (6A-6P) & evening (6P-6A) shifts on the unit. Presenter: HR Director</p> <p>7/17/13 Resident Rights, Reporting Violations and How to Conduct a Thorough Investigation Presented to: Management Team Presenter: Imelda Phfister, District Ombudsman</p> <p>7/18/13 In-service and Review of the Revised Abuse and Neglect Policy for understanding of its content and how to implement it. Presented to: Management Team and HR Director Presenter: Sue Bennett, RN, BSN, Nurse Educator</p> <p>7/18-22/13 Revised Abuse and Neglect Policy Presented To: All Nursing Home Staff Presented by: DON, SW, Charge Nurses using Read and Sign and Explanantion of the Content.</p>		



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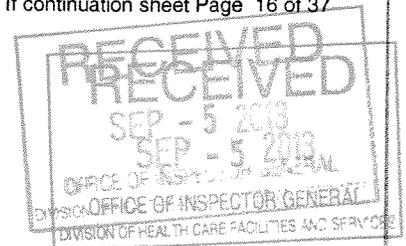
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F 225	<p>Continued From page 14</p> <p>first abuse investigation she had conducted. She revealed Resident #6 told SRNA #4 and #5 that SRNA #3 had kissed her and indicated other sexual actions may have occurred. She confirmed SRNA #4 and the Charge Nurse had called her on 03/08/13 and reported the allegation. The DON stated she immediately started the investigation along with the Social Worker. She stated she called the facility the next day (03/09/13) and told SRNA #3 not to provide direct care for Resident #6. Per interview, she did remove SRNA #3 from all resident care, because she thought the facility's abuse policy stated to remove from direct care of the resident named in the allegation, not all residents. Review of the March 2013 schedule revealed SRNA #3 worked March 9, 10, 12, 13, 14, and 15 providing direct care to residents while the abuse investigation was conducted.</p> <p>Further interview with the DON on 07/10/13 at 2:20 PM, revealed the DON called Licensed Practical Nurse (LPN) #1, on 03/09/13, and told her to put a copy of the abuse policy in the communication binder and for all staff to sign off after they read the policy. However, the DON could not provide evidence where staff had signed they read the abuse policy. She further revealed she had reported the allegation to APS on 03/12/13; however, she had not notified OIG. She stated she had followed the facility's abuse policy and did not know to report to the OIG. She thought maybe the Administrator had reported. The DON stated she concluded the investigation on 03/19/13 and unsubstantiated abuse had occurred.</p> <p>Interview with the Social Worker, on 07/10/13 at</p>	F 225	<p>(See information and summary of corrections made outlined on pages 9-14.</p> <p>The Abuse and Neglect policy was revised on Sept. 1, 2013. The revision includes a "resident to resident" violation in the list of potential kinds of abuse or rights violations.</p> <p>The Administrator, the MDS Nurse, and the Business Office Mgr. made the change after receiving information from the OIG POC reviewer that this kind of abuse was inadvertently omitted from the policy when it was revised earlier in July. The revision was written and included in the policy. The Administrator called the Medical Director, the Chair of the Board of Directors and informed messages informing them of the policy revision. She also called all Dept. Directors and other members of the QA Committee on Sept. 1 and 2 to inform them of the revision in the policy. She placed a revised a copy of the policy in their mailboxes. She placed a copy of the revised policy in the Nursing Policy Manual in the Nursing Home and in the manual in the Personal Care unit. At the same time, a revised copy was placed in the manuals entitled Reporting an ABUSE/NEGLECT violation, also at each Nursing Station. The old policies in these two manuals were also removed and destroyed.</p> <p>A memo was prepared on and placed in the Nursing Station on Sept 1, at 10:00am, next to the shift communication book, asking employees to use the READ and SIGN method for informing all staff of the policy change. The DON and Charge Nurses on each shift will be responsible for verifying that the employees working performed the task.</p> <p>PRN or other employees scheduled off for the next several days, will be asked to READ And SIGN indicating completion of the task BEFORE working their next schedule shift.</p>		



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NAME OF PROVIDER OR SUPPLIER WINDSOR GARDENS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 ISAAC GREER COURT BARDSTOWN, KY 40004		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 15</p> <p>beginning at 2:20 PM who was present during the interview with the DON, revealed she had not reported the allegation to OIG and did not know she was suppose to. She stated she had only been in the Social Worker position for a few months and this was her first abuse investigation.</p> <p>Interview with Administrator, on 07/10/13 at 4:57 PM, revealed the abuse allegation had been reported to her. She stated Resident #6 loved SRNA #3 and didn't want any other staff caring for him/her. The Administrator indicated she had interviewed the resident and the resident told her SRNA #3 had kissed him/her good-night. When she spoke with SRNA #3, he admitted to kissing Resident #6, on the forehead, in a loving way, because he thought of the resident as family. However, the Administrator failed to document either interview and failed to inform the DON and Social Worker, who were conducting the abuse investigation. The Administrator did not report the allegation to the OIG because she thought the DON and Social Worker had already reported.</p> <p>Interview with the APS worker, on 07/11/13 at 1:53 PM, revealed they received the referral on 03/13/13 and went to the nursing facility and met with the resident on 03/15/13. She attempted to interview the resident but the resident was confused and did not recall the allegation and denied SRNA #3 had kissed her. She interviewed SRNA #3 per telephone and he denied the allegations. However, the APS worker had not been told SRNA #3 had admitted he had kissed the resident on the forehead. The APS worker revealed she had not asked SRNA #3 if he had kissed the resident.</p>	F 225	<p>The State Surveyor interviewed the Administrator on July 10, 2013. The conversation with SRNA #3 happened a week or more after the abuse allegation was completed and found to be unsubstantiated by the facility and by APS. There was no reason to document the conversation in the investigation record at that point in time.</p> <p>Protection of Residents In the revised Abuse and Neglect Policy (July 18, 2013) there is a section entitled "Protection." This section states: If an employee is alleged to have abused a resident, that employee will be removed from providing all direct resident care by being suspended from the facility during the pending investigation. If the abuse allegation is resident to resident abuse, or abuse committed by a family member, or a visitor to the facility, the charge nurse on duty, when the incident occurred or when it is reported, will immediately take steps to treat and protect the abused resident. She will alert all staff working on the unit and get assistance to deal with the incident. The charge nurse will call, or ask another staff member to call the DON and the Administrator to inform them of the incident. If needed, the DON and Administrator will come to the unit to assist and/or make recommendation about steps to be taken. A nursing assessment will be performed on the abused resident(s) by the charge nurse or another nurse on duty at the time to determine injury or to give emotional/psychological support. The attending physician or the resident will be notified by the nurse who performed the assessment and orders given by the physician(s) will be followed. The POA/family members of the resident will be notified. Any other residents involved or near the incident will also be assessed by the charge nurse or staff working at the time to determine negative impact and to take whatever steps are necessary to protect all the residents on the unit. The procedure section of the Abuse and Neglect Policy will then be followed beginning with completing Report Form A and taking the steps to report the abuse incident to the agencies and persons listed on the form.</p>		



A Windsor Garden Incident Report will be completed by the charge nurse or other Department Director on duty at the time of the incident. The incident report included the name(s) of the resident(s), and the alleged abuser (whether staff, another professional, family member, other resident or visitor to the facility). The report includes a summary of the incident, what was done to treat or care for the one allegedly abused, who was notified, what treatment was given at the time with what outcome, and what follow-up to that treatment will occur.

The Incident Report on 3/8/13 was completed by the Charge Nurse on duty and was given to the DON on 3/9/13 and included the information listed above.

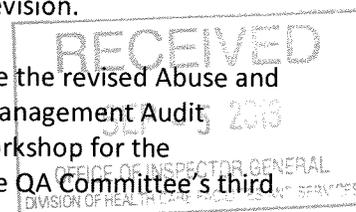
All Windsor Gardens Incident Reports are reviewed and signed by the DON or Department Director within 48 hours of the incident. Incident Reports are reviewed by the Clinical Team at its weekly Care Planning meeting and any follow-up steps that need to be taken and who will take them is determined. The Incident Report Form includes a signature line for the DON, the Administrator and others in attendance at the meeting. The completed forms are kept in a file in the DON's office and summary of the incidents that occur in the preceding quarter is presented by the DON at the quarterly Quality Assurance meeting.

At a called meeting on July 18, 2013, the Quality Assurance Committee reviewed steps taken to remove the IJ from Windsor Gardens. There were three actions implemented in the Windsor system to insure that all employees are aware of the need to protect resident rights. Resident Rights and Abuse and Neglect are two of the yearly required in-services for all employees, the first action is to schedule the District Ombudsman or another qualified professional to present another required in-service on this topic for all employees sometime between August 1, 2013 and December 31, 2013. The Administrator will be responsible for planning this in-service and will report on the completion at the January, 2014 meeting.

The second action is to begin using the CMS Hand in Hand Modules on Abuse and Neglect for all new employees at employee orientations held at Windsor, beginning August 1, 2013. The task was assigned to the Human Resources Director. She will also give each new employ a copy of the The Abuse and Neglect Policy and highlight the importance of safeguarding Resident Rights. The 7 kinds of abuse/neglect, the responsibility of employees to report any suspected incidents of resident abuse/neglect to her, to their Charge Nurse, Department Director or the Administrator, or to call the OIG hotline number to report the incident. The new employee will also be introduced to Report Form A and receive an overview of the investigative process. There is a checklist for items to be covered during new employee orientation and attendance at this in-service and policy review are included on the list. The list becomes a part of the employee's personnel file. The Facility Administrator reviews new employee checklist after each orientation is completed to ensure HR Director utilizes CMS Hand in Hand Modules on Abuse. Administrator will report at Q.A. quarterly meetings - ongoing.

The State Survey Team determined that the Abuse and Neglect policy being used by Windsor's Nursing Home was incomplete. Although the policy in place was followed by the DON, SW and Administrator to determine that the abuse allegation was not substantiated, the policy needed revision.

The main purpose of the QA meeting called on July 18 was to review and approve the revised Abuse and Neglect policy. It was recommended by the Administrator that the yearly Risk Management Audit include a review of the facility's policies and procedures and if need be plan a workshop for the Administrator and Management Team on How To Write and Review Policies. The QA Committee's third



action was to accept the recommendation. The Nurse Consultant was scheduled to come to Windsor on August 19. The Policy and Procedure workshop is scheduled for Tuesday, Sept.11,2 013.

There were two actions and two QA monitors approved by the QA Committee to insure future utilization and compliance with the Abuse and Neglect policy.

- 1) It was determined that the revised policy be distributed that day to the Nursing Policy Manual kept at the Nursing Station in the Nursing Home, that a copy also be placed in the Personal Care Manual kept at the Nursing Station in the Personal Care Unit, and that a copy of the policy be placed in the Assisted Living Manual at the Assisted Living reception desk. The DON was responsible for the action in the Nursing Home, and the Administrator placed the policy in the other two manuals. These manuals are accessible to all employees 24/7. (When placing the revised policy, the "old" policies were removed and destroyed.)
- 2) The Administrator assembled a Manual labeled Abuse & Neglect Reporting. The manual contains a copy of the revised policy on Abuse and Neglect; several Copies of Report Form A, and the Abuse and Neglect Policy Checklist. It also has copies of Questions for a Rights Violation Interview. The QA Committee approved the Administrator's recommendation that this manual be kept at the Nursing Station in the Nursing Home for easy, ready access to all staff, should an abuse allegation be made in the future.

A QA monitor was approved for completing Report Form A and for completing the Abuse and Neglect Policy Checklist. These forms will be completed and signed by the DON, SW, Charge Nurse or other Department Director and submitted to the Administrator on the fifth day of an investigation. The Administrator will check the forms for completeness, and when necessary call the OIG Complaint office to provide and up-date on the progress of the investigation. The Administrator will also summarize the content, and present the summary information to the QA Committee quarterly and to the Chair of the Board of Directors whenever an allegation of resident abuse happens.

Board of Director oversight -

The Administrator meets with the Board of Directors quarterly. A summary report on all action taken each quarter to insure resident safety will be presented as a part of her operational report. Any incidents of abuse and neglect will be reported by the Administrator to the Board Chair immediately.

The Ky State OIG office accepted the Allegation of Compliance on 7/29/2013 and CMS accepted the Allegation of Compliance on 7/30/13.

7/23/2013 - Date the IJ was removed

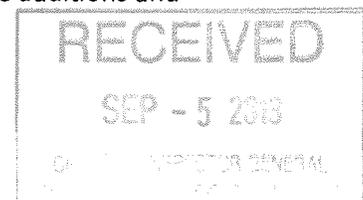
3/9/2013 - Immediate Jeopardy determined to exist. The revisit to the facility occurred on 8/1/13 and the facility was found to be in compliance.

Steps taken in the Allegation of Compliance follow:

How IJ has been addressed:

The Abuse and Neglect Policy was analyzed and several revisions were made. The additions and language revisions in the new policy follow:

1. **Definition Section** – A definition section has been added to the policy.



2. **Reporting/Notification Section** – The obligation to report any suspected incident of abuse/neglect is clearly stated. The incident is to be reported to the facility management (Administrator, DON, Charge Nurse, or other Department Director) and to the OIG, to APS and to the Long Term Care Ombudsman. A clear statement of who is to be notified has been added that includes the oversight agencies listed (b), as well as the Administrator, the Medical Director, the Attending Physician. **A Reporting Form Guide** will be used to cover all the steps of the reporting process included in a thorough investigation. This guide consists of two parts: **First Report Form (A)** and **Reporting Form Guide (B)**
3. **Protection Section**
4. **Investigation Section** including Abuse and Neglect Policy and Procedure Checklist
5. **Monitoring Section** includes Abuse and Neglect Tracking Form
6. **Employee Counseling Section**

TIMELINE OF ACTIONS

3/11/13 - Son of alleged abused resident was called by SW

3/12/13 - SW called APS

3/19/13 - Investigation by APS was conducted on (Case# 1001524)

7/11/13 - Administrator called and left message for Medical Director

7/11/13 - Administrator call three members of the Board of Directors who were told of the IJ citation and read the summary statement immediately after the Survey Team exited the building. A copy of the OIG Immediate Jeopardy Notification was placed in the corporate mailbox for next day pick up. The current Board member contact for the facility has been in daily communication with the Administrator for status updates, guidance and support.

7/12/13 - Medical Director called Administrator and was informed and IJ citation summary was read to him.

7/12/13 - In-service Hand-in-Hand Abuse & Neglect Module Presented to: Nursing Home Staff working day (6A-6P) & evening (6P-6A) shifts on the unit.

Presenter: HR Director The Human Services Director has developed a new plan for employee orientation that includes Modules 2, 3 and 5 of the CMS Hand-in-Hand Series as a part of the in-service/education program.

7/15/13 - Medical Dir. updated on progress of the AOC

7/17/13 - Medical Dir. updated on progress of AOC

7/17/13 - In-service on Resident Rights, Reporting Violations and How to Conduct a Thorough Investigation Presented to: Management Team

7/18/13 - Emergency QA meeting held at 3:00 p.m.

7/18/13 - In-service and Review of the Revised Abuse and Neglect Policy for understanding of its content and how to implement it.

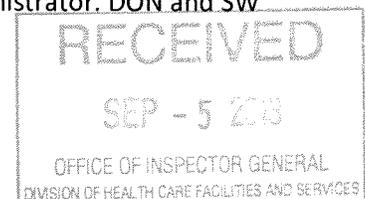
Presented to: Management Team and HR Director

7/18-22/13 In-services on Revised Abuse & Neglect Policy

Presented To: All Nursing Home Staff

7/18/13 - Revised Abuse & Neglect Policy placed in PC/Memory Unit, Nursing Facility, and Assisted Living to be accessible to staff 24/7. Old copies of policy were shredded. The policy will be used for every new employee orientation.

7/22/13 - Investigation questions for Resident Rights Violation compiled by Administrator, DON and SW in-serviced on questions.



What resident/patients are impacted by the IJ? A total of 35 residents of the unit were potentially at risk since the abuse allegation of March 8, 2013. (This number represents the number of unit residents on March 8 through July 22, 2013.) BIMS scores were obtained from MDS 3.0 on each resident potentially impacted. Based on the patient's BIMS score, one of the two other assessments (Interviews and Skin Assessments) were conducted by the SW, DON, MDS Nurse or Charge Nurse.

What staff are involved in the IJ?

The Administrator, DON, Social Service/Activity Director, reporting CNA, alleged CNA, and potentially all management who had not implemented an effective policy and procedure review annually, including shredding old policies.

What areas of the facility are impacted by the IJ?

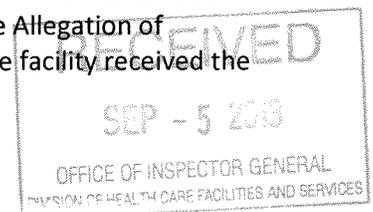
The Nursing Center.

How will the IJ be prevented from recurring to other residents/patients? A thorough investigative procedure is included in the revised Abuse and Neglect Policy:

Investigative Process Steps:

- To protect residents from harm during the investigation, the individual(s) alleged to be involved in the abuse will be removed from providing direct resident care by being suspended from the facility during the pending investigation by their Dept. Manager, Administrator, SW, HR Manager or Manager on Call.
 - A BIMS (Brief Interview for Mental Status) will be performed with resident involved immediately (or within 24 hours) of incident. This will be performed by the Social Services Director or other qualified staff.
 - Interviews with at least 3-5 other residents on the unit of incident location will be conducted by the DON, Administrator, Social Service Director or Charge Nurse.
- All Staff working on the unit at the time of the incident will be interviewed following the report of the incident by the Director of Nursing, Social Service Director or Charge Nurse.
- Separate interviews will be conducted with the accused person and the victim by the Director of Nursing, Social Service Director or Charge Nurse. Questions should be addressed in a YES and NO manner due to the topic. Open ended questions for clarification will also be utilized by the investigator as necessary.
 - If there are substantial findings, the Administrator or DON will report to the State Nurse Aide Registry and applicable licensing authorities any knowledge it has of any action by a court of law which would indicate an employee is in violation of their professional practice act.
 - The employee will be counseled and such counseling will be documented with a Windsor Gardens Employee Counseling Form. Counseling will be conducted by the Director of Nursing, Administrator, Social Service Dir. or Charge Nurse and will be accompanied by the HR Director.
 - The Administrator, DON or SW will perform a five-day follow-up of the incident documenting and reporting to Office of Inspector General, Adult Protective Services/Child Protective Services, the Ombudsman and the facility Medical Director of the findings.

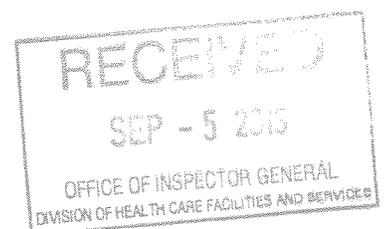
The Administrator meets with the Medical Director of the facility once each month. He was called on July 11, 2013 when the IJ was issued and has been updated three times while the Allegation of Compliance was being written and approved by both the OIG and CMS. When the facility received the



Statement of Deficiencies from the OIG, a copy was sent to him. He met with the Administrator and DON to review the deficiencies and gave input and encouragement.

The date for the Emergency Quality Assurance Committee meeting was set around the Medical Director's schedule. He gave input and was a part of the QA Committee that voted to approve the revised Abuse and Neglect Policy and the actions and monitors set up to ensure that the policy would be implemented effectively. He and the Administrator will work effectively with the Quality Assurance Committee to follow up on the specifics outlined in the Plan of Correction by being sure the actions to be taken and monitors set up are completed.

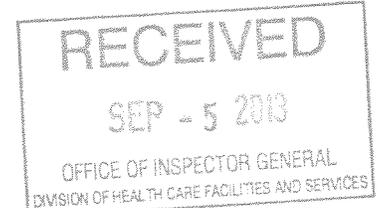
On August 19, 2013, the Medical Director met with the Administrator and the Management Team to review the Plan of Correction developed to correct the deficiencies listed in the Statement of Deficiencies resulting from the State Licensing Survey.



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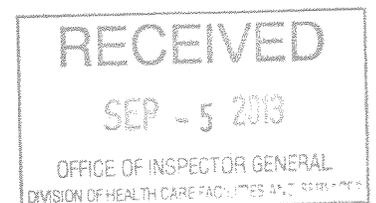
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F 225	Continued From page 16 Additional interview with the Administrator, on 07/11/13 at 3:38 PM, revealed she recalled a conversation with the DON and Social Worker about the abuse investigation and the Social Worker told the Administrator she had called APS. The Administrator told the Social Worker they needed to call the OIG and she assumed this had been done. However, the Administrator revealed she had not followed up on that directive to ensure reporting was done. The Administrator acknowledged she had not provided guidance and oversight to the DON and Social Worker during the investigation and had not reviewed the abuse investigation.	F 225			
F 226 SS=J	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, review of the facility's investigation, and review of the facility's policy and procedures, it was determined the facility failed to have an effective system to ensure development and implementation of written policies and procedures that prohibit abuse for one (1) of thirteen (13) sampled residents (Resident #6). The facility's Abuse and Neglect policy did not contain all seven components as required. The policy did not include the	F 226	F226.483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC. POLICIES Completion Date: A revised Abuse and Neglect policy approved by the Quality Assurance Committee on 7/18/13 is an integral part of the Allegation of Compliance and Plan of Correction. The Allegation of Compliance Plan was accepted by the OIG on July 29, 2013. Immedicate Jeopardy was removed from the facility on July 23, 2013.	9/01/2013	



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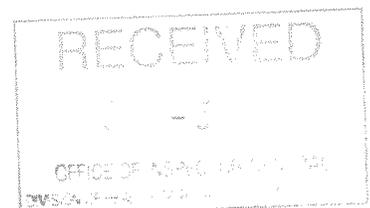
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F 226	<p>Continued From page 17</p> <p>investigation component and gave no guidance on how to investigate an allegation of abuse. The facility also failed to ensure protection of residents after an allegation of abuse was reported, failed to report the allegation to the appropriate state agencies promptly, and failed to conduct a thorough investigation.</p> <p>On 03/08/13, the facility received an allegation of abuse from Resident #6, who reported State Registered Nurse Aide (SRNA) #3 had kissed and hugged him/her like a lover. The resident had reported the allegation to SRNA #4 and SRNA #5 and the allegation was reported to the Director of Nursing (DON). The DON called the facility and spoke with SRNA #3 on 03/09/13 and informed him not to provide direct care for Resident #6; however, SRNA #3 continued to care for other residents during the abuse investigation.</p> <p>Interview and review of the facility's investigation revealed the facility did not report the allegation of abuse to Adult Protection Services (APS) until 03/12/13, five days after receiving the allegation, and failed to report the allegation to the Division of Long Term Care, Office of Inspector General (OIG) per facility policy. (Refer to F225)</p> <p>The facility's failure to develop and implement policy and procedures related to abuse has caused, or is likely to cause, serious injury, harm, impairment, or death to Resident #6 and other residents in the facility.</p> <p>Immediate Jeopardy was identified on 07/11/13 and is ongoing in 42 CFR 483.13 Resident Behavior & Facility Practice, F226 at a S/S"J", with Substandard Quality of Care (SQC) identified</p>	F 226	<p>In the revised Abuse and Neglect Policy (July 18, 2013) there is a section entitled "Protection." This section states: If an employee is alleged to have abused a resident, that employee will be removed from providing all direct resident care by being suspended from the facility during the pending investigation. If the abuse allegation is resident to resident abuse, or abuse committed by a family member, or a visitor to the facility, the charge nurse on duty, when the incident occurred or when it is reported, will immediately take steps to treat and protect the abused resident. She will alert all staff working on the unit and get assistance to deal with the incident.</p> <p>The Charge nurse will call, or ask another staff member to call the DON and the Administrator to inform them of the incident. If needed, the DON and Administrator will come to the unit to assist and/or make recommendation about steps to be taken. A nursing assessment will be performed on the abused resident(s) by the charge nurse or another nurse on duty at the time to determine injury or to give emotional/psychological support. The attending physician of the resident will be notified by the nurse who performed the assessment and orders given by the physician(s) will be followed. The POA/family members of the resident will be notified. Any other residents involved or near the incident will also be assessed by the Charge nurse or staff working at the time to determine negative impact and to take whatever steps are necessary to protect all the residents on the unit. The procedure Section of the Abuse and Neglect Policy will then be followed beginning with completing Report Form A and taking the steps to report the abuse incident to the Agencies and persons listed on the form.</p> <p>The Incident Report on 3/8/13 was completed by the Charge Nurse on duty and was given to the DON on 3/9/13.</p>		



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F 226	<p>Continued From page 18 at 42 CFR 483.13. The Immediate Jeopardy was determined to exist on 03/09/13. The facility was notified of the Immediate Jeopardy on 07/11/13.</p> <p>The findings include:</p> <p>Review of the facility's Abuse and Neglect policy, revised 01/06/06, revealed the abuse policy contained definitions of abuse, but did not contain all seven components as required. The policy did not include the investigation component and gave no guidance on how to investigate an allegation of abuse. According to the abuse policy, the facility would immediately report the allegation to APS and the Division of Long Term Care (OIG). A five (5) day follow-up of the incident would be performed and reported to the above state agencies. Further review of the policy revealed to protect residents from harm during the investigation, the individual (s) alleged to be involved in the abuse would be removed from providing direct resident care during the pending investigation.</p> <p>Review of the facility's investigation of the allegation of abuse revealed an incident report was completed on 03/08/13 at 7:30 PM. The DON was notified. The next day, on 03/09/13, SRNA #3 reported to work and was told by the DON (per telephone) not to give direct care to Resident #6. However, interview with SRNA#3 and the DON revealed he was allowed to care for other residents. The investigative report revealed the Administrator was informed of the allegation on 03/09/13. Written statements of SRNA #4 and #5 were obtained; however, no other staff or residents were interviewed. Further review of the investigation revealed the resident was not</p>	F 226	<p>A Windsor Garden Incident Report will be completed by the Charge Nurse or other Department Director on duty at the time of the incident. The incident report includes the name(s) of the resident(s), and the alleged abuser (whether staff, another professional, family member or visitor to the facility). The report includes a summary of the incident, what was done to treat or care for the one abused, who was notified, what treatment was given at the time with what outcome, and what follow-up to that treatment will occur.</p> <p>All Windsor Incident Reports are reviewed and signed by the DON or Department Director within 48 hours of the incident. Incident Reports are reviewed by the Clinical Team at its weekly Care Planning meeting and any follow-up steps that need to be taken and who will take them is determined. The Incident Report Form includes a signature line for the DON, the Administrator and others in attendance at the meeting. The completed forms are kept in a file in the DON's office and a summary of the incidents that occur in the preceding quarter is presented by the DON at the quarterly Quality Assurance meeting. Should an abuse allegation or Rights Violation occur in the future, the Charge Nurse will call the DON and the Administrator to determine the right/best kind of assessment tool or action(s) to take to protect residents. The three checklists included in the Abuse and Neglect policy are to be used on ALL Resident Rights violations and Allegations of Abuse. A nursing assessment performed by the Charge nurse or another nurse on duty is always the first step taken. Other assessment tools that might be used are: resident BIMS Scores, Interviews with resident(s), family members, and other staff, and a Skin Screening. (A list of possible questions to be used in interviews was developed as a part of the Plan of Correction. The list titled Questions for Rights Violation Interviews is a part of the Abuse and Neglect policy. Questions on the list are geared to different kinds of abuse, like verbal abuse, theft, intimidation, etc.)</p>	



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F 226	<p>Continued From page 19 assessed for possible signs of abuse.</p> <p>Continued review of the facility's investigation revealed the Social Worker documented she had interviewed Resident #6 on 03/11/13 regarding the allegation and SRNA #3 on 03/12/13. APS was notified on 03/12/13, five (5) days after the facility received the abuse allegation. There was no documented evidence the abuse allegation had been reported to the OIG.</p> <p>Interview with the DON, on 07/10/13 at 2:20 PM with the Social Worker present, revealed she had reported the allegation to APS on 03/12/13. When asked if she had notified the OIG of the allegation, she replied, she had followed the facility's abuse policy and did not know to report to the OIG. She thought maybe the Administrator had reported. The Social Worker stated she had not reported the allegation to the OIG. Even though the facility's policy stated the facility would immediately report "the incident to Adult Protective Services and the Division of Long-Term Care".</p> <p>Further interview with the DON, on 07/10/13 at 2:20 PM, revealed this was her first abuse investigation so she tried to follow the abuse policy closely. She confirmed the abuse policy she utilized during the investigation was the revised 2006 policy. She stated she had misunderstood the protection piece of the abuse policy and thought the policy said to remove the individual from direct care of the resident making the allegation. However, review of the facility's policy and procedures revealed "to protect residents from harm during an investigation, the individual(s) alleged to be involved in the abuse</p>	F 226	The Social Worker and DON have attended all in-services on Abuse and Neglect, Resident Rights, Reporting and Investigating held at the facility between 7/17-22/2013.		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 226	<p>Continued From page 20</p> <p>is/are removed from providing direct resident care during the pending investigation". Per interview, the DON allowed SRNA #3 to continue to provide direct care to other residents other than Resident #6 during the investigation. She did not assign another staff to accompany SRNA #3 when providing care to other residents.</p> <p>Interview with Administrator, on 07/10/13 at 4:57 PM, revealed the abuse allegation had been reported to her. The Administrator indicated she had interviewed the resident and SRNA #3 and both confirmed SRNA #3 would kiss Resident #6 good-night. However, she failed to document either interview and failed to inform the DON and Social Worker, who were conducting the abuse investigation. In addition, interview with the Administrator revealed she did not report the allegation to the OIG because she thought the DON and Social Worker had already reported.</p> <p>Additional interview with the Administrator, on 07/11/13 at 3:38 PM, revealed she recalled telling the Social Worker to call the OIG; however, she did not follow-up on that directive to ensure reporting was done. Further interview revealed the Administrator thought the abuse policy for residents protection had been followed; even though the alleged perpetrator was allowed to provide direct resident care after the allegation of potential abuse was reported.</p> <p>Interview with the Administrator, during the extended survey on 07/17/13 at 10:30 AM, revealed the DON and Social Worker had used the 2006 version of the abuse policy during the March investigation and this was the wrong abuse policy. She stated the policy had been revised</p>	F 226	<p>The DON and SW called the Abuse Hotline on March 12, 2013. The Administrator did not follow-up because she thought the abuse allegation was reported.</p> <p>The Administrator meets with the Medical Director of the facility once each month. He was called on July 11, 2013 when the IJ was issued and has been updated three times while the Allegatio of Compliance was being written and approved by both the OIG and CMS. When the facility received the Statement of Deficiencies from the OIG, a copy was sent ot him. He met with the Administrator and DON to review the deficiencies and gave input and encouragement.</p> <p>The date for the Emergency Quality Assurance Committee meeting was set around the Medical Director's schedule. He gave input and was a part of the QA Committee that voted to approve the revised Abuse and Neglect Policy and the actions and monitors set up to insure that the policy would be implemented effectively. He and the Administrator will work effectively with the Quality Assurance Committee to follow up on the specifics outlined in the Plan of Correction by being sure the acitons to be taken and monitors set up are completed.</p>		



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F 226	Continued From page 21 and included the investigation component. However, review of the facility's policy provided during the survey revealed the investigation component was not included in the policy.	F 226			
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to conduct a Significant Change in Status Assessment when one (1) of thirteen (13) sampled residents (Resident #3), who experienced a major decline in functional status that impacted one or more areas of the resident's health status. The facility assessed Resident #3 with a decline in ambulation, bed mobility, transfers, toilet use, dressing, and personal hygiene from supervision only to extensive to total assist with his/her Activities of Daily Living (ADL).	F 274	F274 COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE Significant change that prior MDS Coord. failed to complete was in 9/2012; however, quarterly and comprehensive MDS assessments have been completed since then to reflect resident's decline. Measures put into place to correct the violation - The facility has recently begun using PointClickCare MDS software (6/1/13). This new software offers alerts to the user when a significant change in status occurs and MDS Nurse will know to complete the assessment at that time. To ensure that the violation will not recur: MDS Nurse completed the following: * Webex MDS 3.0 Entry on 5/30/13. * Homework for MDS 3.0 Entry completed on 6/4/13. * Webex MDS 3.0 Mgt. & Submission on 6/7/13. * Homework for MDS 3.0 Mgt. & Submisison completed on 6/13/13. * Coaching calls with Stephanie Beck, from PointClickCare on 6/4/13 and 6/13/13 * PointClickCare Webex trainers were Christine Dart and Colleen Green. Copy of coaching calls/homework with PointClickCare provided. MDS Nurse monitors 72 hr report sheet of any significant change daily and a new change of condition form was created (see attached) for all floor nurses to complete. The completed form will be given to the MDS Nurse so MDS Nurse will know of all significant changes on any residents and update changes promptly.		

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F 274	<p>Continued From page 22</p> <p>In addition, the resident was no longer able to ambulate.</p> <p>The findings include:</p> <p>The facility did not provide a specific policy for Significant Change in Status Assessment. The facility utilized the Center for Medicare and Medicaid (CMS), Resident Assessment Instrument (RAI) User Manual, version 3.0.</p> <p>Review of the CMS RAI Manual version 3.0 Chapter 2, Page 2-20 and 2-21, revealed a significant change was a decline or improvement in a resident's status that would not normally resolve without interventions by staff and was not self-limiting, impacted more than one area of the resident's health status and required interdisciplinary review/revision of the care plan.</p> <p>Review of the clinical record revealed the facility admitted Resident #3 on 07/09/12 with diagnoses of Dementia with Behavioral Disturbance, Alzheimer's Disease, Abnormal Gait, Scoliosis, Muscle Weakness, Osteoarthritis, and Atypical Psychosis. Review of the Admission Minimum Data Set (MDS) assessment, dated 07/16/12, revealed the facility assessed the resident with a cognitive impairment with mood and behaviors noted. The facility assessed the resident's functional status as supervision with one person assist with bed mobility, transfers, ambulation, locomotion, dressing, personal hygiene, and toilet use. The facility assessed the resident as occasionally incontinent of bowel and bladder.</p> <p>Continued review of the clinical record revealed the resident had a hospital stay from September</p>	F 274	<p>All staff were in-serviced on 8/9/13 on this new change of condition form by DON. Documentation is on file.</p> <p>All residents who have had changes in conditions are at risk of the same alleged deficient practice. MDS Nurse will complete audit of all residents with an identified change of condition during the past 90 days to verify the appropriate significant change to be completed by 9/1/13.</p> <p>The MDS Nurse will review completed audit quarterly with Q.A. for further follow-up with recommendations or continuation as indicated.</p> <p>Completion Date:</p>	9/1/13	



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F 274	<p>Continued From page 23</p> <p>4-18, 2012. Review of the Quarterly MDS assessment, dated 10/14/12, revealed the facility determined the resident had a major decline in his/her functional status that did not resolve. That assessment revealed the resident required the extensive assist of one person for bed mobility, transfers, locomotion, ambulation, dressing, personal hygiene, and toilet use. Continued review revealed another Quarterly MDS was completed on 01/14/13, and on 04/10/13. The most recent Quarterly assessment, dated 04/10/13, revealed the resident was no longer able to ambulate with assistance and had declined further to need total assistance with locomotion, personal hygiene and bathing. The facility assessed the resident as requiring the assistance of two (2) persons for bed mobility, transfers, and bathing.</p> <p>Interview with the MDS Coordinator, on 07/11/13 at 3:00 PM, revealed she would have completed a Significant Change in Status Assessment upon the resident's return from the hospital. She stated she had not been working at the facility when the resident returned from the hospital and the decline in functional status was noted. She reviewed Resident #3's MDS assessments and stated a Significant Change in Status Assessment should have been done instead of a Quarterly assessment on 10/14/12. She stated it appeared the decline occurred when the resident returned from a hospital stay and did not return to her/his previous functional status. She revealed the facility's old computer MDS software would not flag and alert the user when a significant change in status occurred. The nursing facility had since purchased a different MDS software that would alert the user to consider a Significant Change in</p>	F 274		

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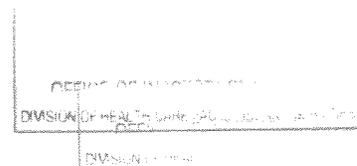
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F 274	Continued From page 24 Status Assessment. The MDS Coordinator conducted a further search that revealed the resident's decline was reflected on the Prospective Payment System (PPS) assessment dated 09/24/12; however, the facility failed to identify those changes on the Quarterly assessment dated 10/14/12. Observation of Resident #3, on 07/09/13 at 9:27 AM, 11:44 AM, 1:24 PM; and, at 4:20 PM, revealed the resident sitting in a wheelchair or recliner. The resident was unable to converse with the surveyor. Interview with the private sitter, on 07/09/13 at 9:27 AM, revealed she stayed with the resident from 7:00 AM-5:00 PM and has worked for the resident for over six (6) months. She stated the resident was unable to ambulate and required extensive assist from staff for most ADLs.	F 274			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure staff followed the care plan for two (2) of thirteen (13) sampled residents (Residents #4 and #5). The facility failed to ensure staff removed the lap buddy restraint during meals for	F 282	F282 483.20(K)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN To correct the violation the facility has in-serviced all staff to remove restraint of Resident #4 every 2 hours when under direct supervision by staff/family and all on meals on 8/9/13 by DON. Resident #4 Plan of Care Kardex updated on 8/9/13 to indicate use of lap buddy and removal every 2 hours under direct supervision and during all meals. MDS Nurse to update Plan of Care Kardex with a Care Plan update monthly and PRN. On 7/15/13 a new restraint release record form was put in place for nurses to complete with reminder to monitor CNA as well for completion. (In-service documentation on file - 8/9/13)		



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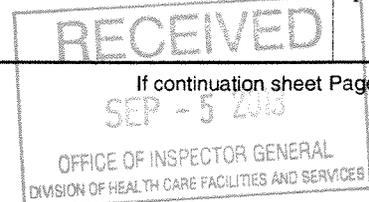
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F 282	<p>Continued From page 25</p> <p>Resident #4 and failed to ensure staff ambulated Resident #5 to and from the dining room for meals.</p> <p>The findings include:</p> <p>Interview, on 07/11/13 at 2:30 PM, with the Director of Nursing (DON) revealed the facility used the Resident Assessment Instrument (RAI) for developing and implementing the care plan.</p> <p>1. Observation of Resident #4 on 07/09/13 at 12:15 PM and 5:10 PM; and, on 07/10/13 at 8:45 AM and 12:10 PM found the resident sitting at the dining room table in a wheelchair. Staff was observed to be feeding the resident. The lap buddy restraint was not removed.</p> <p>Review of Resident #4's clinical record revealed the facility admitted the resident on 02/26/11 with diagnoses which included Chronic Respiratory Failure, Dysphagia, Alzheimer's, Diabetes, Anxiety, and Pain. The facility initiated the lap buddy on 04/04/12 related to a significant history of falls. Review of the Quarterly Minimum Data Set Assessment completed on 06/13/13, revealed the facility assessed Resident #4's cognition as short term and long term memory problems.</p> <p>Review of the Care Plan for Resident #4 revealed interventions put in place for use of the lap buddy included to remove the restraint when under direct supervision by staff or family and release every two (2) hours. Review of the State Registered Nursing Assistant (SRNA) report revised on 07/04/13 revealed to remove the lap buddy during meals and release every two (2) hours. Review of the Plan of Care Kardex for</p>	F 282	<p>Care Plan audit will be completed on all Care Plans to assure accuracy and that all care plans match CNA Plan of Care Kardex. This is to be completed by 9/1/13.</p> <p>Charge Nurse or DON will randomly select a meal daily x 12 weeks to audit for completion beginning on 8/12/13.</p> <p>The DON will review the completed audit with Q.A. Committee quarterly for further follow-up and recommendations or continuation as indicated. Next Q.A. meeting scheduled for October 2013.</p> <p>Completion Date:</p>	9/1/13	



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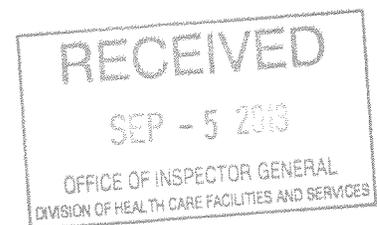
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F 282	<p>Continued From page 26</p> <p>July 2013 for Resident #4 revealed no indication of the use of the lap buddy.</p> <p>Interview with SRNA #3, on 07/10/13 at 4:50 PM, revealed Resident #4 did have a lap buddy and it should have been removed every two (2) hours for fifteen (15) minutes and taken off at meals. He stated the resident could take it off him/herself. The SRNA went over and asked the resident to take it off, but the resident was not able to take the lap buddy off on command.</p> <p>Interview with SRNA #2, on 07/10/13 at 4:57 PM, revealed Resident #4's lap buddy should have been removed at meals. She stated it was an opportunity to remove the restraint and it was also a dignity issue.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/11/13 at 9:35 AM, revealed the nurses monitor the dining room to ensure residents are getting the correct diet, and for safety. She stated the lap buddy should have been removed at meals for Resident #4. LPN#1 stated she was monitoring the dining room on 07/09/13 and it just slipped her mind. She stated the purpose of removing the restraint was to allow the resident to get closer to the table, and not be confined and enjoy their meal.</p> <p>2. Observation, on 07/09/13 at 12:15 PM at 5:10 PM and on 07/10/13 at 12:00 PM, revealed staff brought Resident #5 to the dining room in the wheelchair and did not ambulate the resident.</p> <p>Review of the clinical record for Resident #5 revealed the facility admitted the resident on 04/17/11 with diagnoses which included</p>	F 282	<p>To correct violation, the DON has in-serviced all staff on 8/9/13 to ambulate Resident #5 to and from all meals with walker x2 assist.</p> <p>To ensure violation will not recur: Therapy began services on Resident #5 on 7/24/13 - 7/31/13 for one week to evaluate resident's ambulation. On 7/24/13, the Therapy Manager in-serviced staff on how to ambulate resident, the importance of ambulation, what to do if resident refuses, how to document if resident completes task.</p>		



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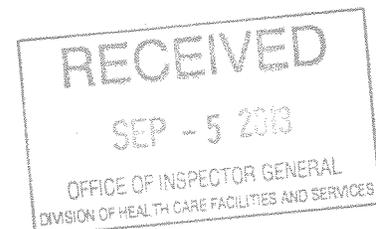
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F 282	<p>Continued From page 27</p> <p>Hypertension, Hypothyroidism, Insomnia, Hearing Loss, and Dementia. Review of the Minimum Data Set (MDS) Assessment completed on 06/16/13 for the Quarterly assessment; and, on 03/13/13 for the Annual review revealed the facility assessed the resident's cognitive Basic Interview for Mental Status (BIMS) score at a three (3) indicating the resident was severely impaired. The facility assessed the resident's ability to walk in the room for both assessments as requiring extensive assistance of two (2) staff. The facility documented a change on the Quarterly Assessment completed on 06/06/13 related to "walks in the corridor" from extensive assistance of two (2) to Activities of Daily living activity did not occur.</p> <p>Review of the Comprehensive Care Plan revealed the facility developed a care plan for Resident #5 on 02/13/13 including Restorative to ambulate with assist of two (2) and walk to and from all meals. Review of the Plan of Care Kardex for May 2013, June 2013, and July 13 revealed documentation of Restorative to ambulate resident to and from meals with a walker and two (2) assist.</p> <p>Interview with SRNA #3, on 07/10/13 at 4:50 PM, revealed Resident #5 could not ambulate to the dining room. SRNA #3 stated he had reported this information to the nurses.</p> <p>Interview with SRNA #2, on 07/10/13 at 4:57 PM, revealed Resident #5 would refuse to walk or the resident's legs would give out. The SRNA stated she did not know if the resident's refusal to ambulate had been reported to the nurses.</p>	F 282	<p>On 7/24/13, a reminder was added to CNA book. In-service documetation is on file.</p> <p>The Charge Nurse or DON will randomly select a meal daily x12 weeks to audit completion beginning on 8/12/13. The DON will review the completed audit with Q. A. Committee quarterly for further follow-up and recommendations or continuation as indicated. The next Q.A. meeting is scheduled for October 2013.</p> <p>Completion Date:</p>	9/1/13	



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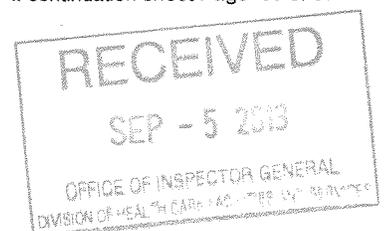
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F 282	<p>Continued From page 28</p> <p>Interview with LPN #1, on 07/11/13 at 9:25 AM, revealed staff had reported to her, on occasion, Resident #5's refusal to ambulate at times. She stated if the SRNAs were signing the SRNA Kardex with the care needs listed she assumed the care was being provided.</p> <p>Observation, on 07/11/13 at 11:35 AM, revealed two (2) staff ambulated Resident #5 to the bathroom in the resident's room and to the dining room without difficulty.</p> <p>Interview with the Minimum Data Set Coordinator, on 07/11/13 at 1:40 PM, revealed during care plan meetings the staff discussed any change in the resident's status. She stated Resident #5 had not had a decline. She stated she had asked staff why the resident was not being ambulated, but no one would give a reason. She stated Resident #5 could do it and did refuse at times, but the resident could ambulate.</p> <p>Interview with the Director of Nursing, on 07/11/13 at 1:50 PM, revealed everybody was responsible to ensure care needs were provided for the residents. She stated she was unaware the restraint lap buddy was not being removed for Resident #4 during meals or that Resident #5 was not being ambulated to meals and back. She stated the nurses were responsible for the oversight of the SRNAs to ensure care was being provided as indicated on the care plan.</p>	F 282		
F 323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives</p>	F 323		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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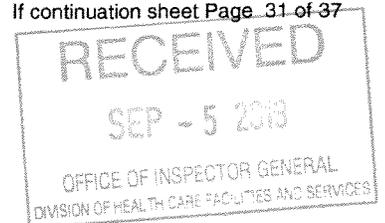
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F 323	Continued From page 29 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to provide an environment free of hazards by ensuring harmful chemicals were stored securely. The facility staff left cleaning supplies and chemicals stored in an unlocked cabinet with the door open on two (2) of two (2) halls (B and C Hall). Cognitively impaired residents, who wandered resided on these halls. The findings include: The facility did not provide a policy regarding the storage of chemicals and hazardous materials. Review of the facility's resident roster revealed four (4) residents on the B Hall were assessed with a cognitive impairment. Continued review revealed two (2) residents were identified to exhibit behaviors of wandering. Observation, on initial tour, of the B Hall shower room, on 07/09/13 at 8:10 AM, revealed the door to the shower room was open. The shower room had a thirty-two (32) oz bottle of H2Orange2 cleaner sitting on top of the sink. The cleaner could cause skin and eye irritation, irritation if inhaled, and if ingested could cause stomach	F 323	F323 483.25(h) FREE OF ACCIDENT HAZARDS/ SUPERVISION/DEVICES A total of 13 residents could have been affected by this deficiency. A new policy was developed on 8/4/13 to address this issue. Policy Title: Storage of Chemicals and Solutions (see attached). Measures put in place to correct the violaton: Keypad lock will be installed to the shower room door no later than 8/31/13. Locked door audit checks will be conducted 3 x wk for 12 weeks randomly by Housekeeping Supervisor and/or Charge Nurses beginning 8/12/13. The Housekeeping Supervisor will review the completed audit with Q.A. Committee for further follow-up and recommendations or continuation as indicated. The next quarterly Q.A. meeting is scheduled for October 2013. The Therapy Dept. will keep all chemical solutions such as BioFreeze in a locked closet adjacent to the Therapy room when not treating residents. The Rehab Manager will be responsible for completing a daily checkoff list to ensure compliance beginning 8/12/13. On 8/19/13, the DON will in-service staff on the new chemical storage policy and locked chemicals. Completion Date:	9/1/13	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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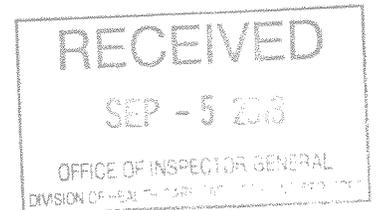
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F 323	<p>Continued From page 30</p> <p>upset, vomiting and nausea. An unlocked cabinet in the shower room contained four (4) shaving creams, nine (9) deodorants, nine (9) perineal wash, nine (9) body wash, nine (9) lotions, and one (1) skin barrier cream. The barrier cream label stated if swallowed get medical help.</p> <p>Observation, during the initial tour, of the C Hall revealed a bathroom between the shower room and the therapy bathroom; the bathroom was unlocked. Further observation revealed the bathroom had an unlocked storage cabinet that contained a spray bottle of antibacterial all purpose cleaner and bottle of rubbing alcohol. The label on the cleaner stated it was harmful to humans and animals.</p> <p>Review of the Material Safety Data Sheet (MSDS) for the Antibacterial All Purpose Cleaner, dated 04/08/09, revealed the cleaner was harmful if absorbed through the skin or swallowed. The cleaner was corrosive to the eyes and skin, severely irritating to the respiratory system, and caused burns to the mouth, throat, and stomach. First aid would be required and seek medical attention immediately.</p> <p>Observation, on 07/09/13 at 9:47 AM; and, on 07/11/13 at 2:35 PM, revealed a gallon sized jug full of chemical and a bottle of germicidal wipes sitting on top of the sink in the Therapy Department on the C Hall. The bathroom adjoining to the therapy room, which also had access from the unlocked shower room, had a storage cabinet with a spray bottle of antibacterial all purpose cleaner which stated Danger, causes digestive tract, eye and skin burns, causes respiratory tract irritation, harmful if absorbed</p>	F 323			



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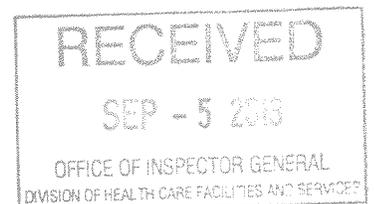
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F 323	<p>Continued From page 31 through skin or if swallowed.</p> <p>Review of the MSDS for the germicidal wipes, dated 12/14/07, revealed the wipes contained two (2) hazardous ingredients. If ingested, the wipes could irritate the throat, stomach and gastrointestinal (GI) tract which could lead to nausea and diarrhea. The wipes may cause irritation to the eyes and skin if in contact. If the wipes were ingested then seek medical attention. If skin or eye contact, then flush with water for fifteen (15) minutes and seek medical attention.</p> <p>On 07/17/13 at 3:05 PM, observation of the B Hall shower room revealed the shower room was unlocked and the cabinet in the shower room was also unlocked with chemicals inside.</p> <p>On 07/18/13 at 9:00 AM, observation of the B Hall shower room revealed a bottle of H2Orange2 on top of the sink in the shower room. The door to the shower room was open.</p> <p>Review of the MSDS for H2Orange2 Concentrate 117, dated 10/27/11, revealed the chemical was hazardous and contained hydrogen peroxide. The cleaner could cause skin and eye irritation, irritation if inhaled, and if ingested could cause stomach upset, vomiting and nausea. First aide measures for eyes and skin included flushing and to seek further treatment advice from a poison control center or doctor. If ingested, poison control or a doctor should be called immediately for treatment.</p> <p>Interview with the Rehab Technician (RT), on 07/11/13 at 2:42 PM, revealed the cleaners and chemicals should be locked in the bathroom</p>	F 323			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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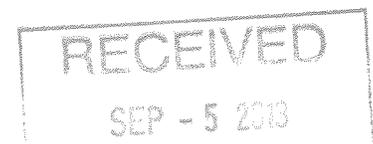
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F 323	Continued From page 32 cabinet. She stated residents use the therapy bathroom at times and it was possible for residents to have access to the chemicals. The RT stated there were confused residents in the facility and with the chemicals within reach, the residents could eat or drink them, which would be hazardous to the residents. Interview with the Rehab Manager, on 07/11/13 at 3:30 PM, revealed the cleaning supplies and chemicals should not be stored on the sink in the therapy room or in the unlocked cabinet in the therapy bathroom. She stated the cleaners and chemicals should be locked in the cabinet in the shower room. The Rehab Manager stated residents use the therapy bathroom if needed during therapy. She stated there was a risk of residents swallowing the chemicals or skin coming into contact could be harmful. The Rehab Manager stated she was responsible to monitor the supplies to ensure they were secure and out of residents' reach. She stated she did not keep a written log of audits of chemicals safely stored. Interview with Licensed Practical Nurse (LPN) #1, on /7/09/13 at 8:10 AM and 07/18/13 at 9:05 AM, revealed she was responsible to ensure the chemicals were locked and out of residents' reach. She stated chemicals should not be in resident reach, the cabinet in the shower room should be kept locked, and the door to the shower room should be locked when the staff left the room. The LPN stated residents could drink the chemicals or spray it in their eyes, and it would be harmful to the residents.	F 323			
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	F 490			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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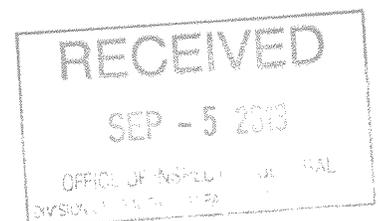
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F 490	Continued From page 33 A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's abuse policy and investigation, it was determined the facility's Administration failed to ensure the facility was administered in a manner which enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychological well-being for one (1) of thirteen (13) sampled residents (Resident #6). The facility's Administration failed to have an effective system to ensure policy and procedures were developed and implemented to protect residents from abuse; failed to ensure staff was knowledgeable of the facility's policy and procedures related to abuse; and failed to provide guidance and oversight during an abuse investigation. (Refer to F225 and F226). The Administration's failure to ensure facility policies/procedures related to abuse prevention were developed and implemented caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. The Immediate Jeopardy was determined to exist on 03/09/13 and is ongoing at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226 at a S/S of a "J") and 42 CFR 483.75	F 490	F490 483.75 EFFECTIVE ADMINISTRATION/ RESIDENT WELL-BEING Completed Date: 9/2/2013 The Administrator is responsible for providing oversight to the facility operation and enabling the facility to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. With the alleged abuse allegation March 8, 2013, there are indications that the Administrator complied with this tag. SRNA #4 and #5 reported what they thought was inappropriate behavior on the part of SRN #6; Report of the allegation when to the Charge Nurse and to the DON; the DON reported the allegation to the Administrator. The DON protected the resident by removing SRNA #6 from direct care of Resident #6 and instructed SRNA #6 to have another staff accompany him when he was delivering care to other residents on the unit; the Administrator told the DON and SW to report the incident to the OIG and to APS; the DON and SW called the reporting hotline number listed on the policy they used and reported the incident; an investigation was conducted by the DON and SW and it was substantiated that abuse did not occur; APS came to investigate and the findings reported to the DON, SW and Administrator was that abuse could not be substantiated. The IJ A issued to the facility on July 11, 2013 was responded to in good faith. In-services were planned by the Administrator and DON and implemented by knowledgeable presenters. The information was used to revise the Abuse and Neglect policy. The Administrator and Management Staff in the facility were in-serviced on the policy on July 18, 2013. Later, that same day, an emergency Quality Assurance meeting was held. The Medical Director and members of the QA committee approved the policy and developed an implementation	9/2/2013	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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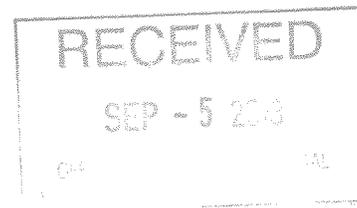
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F 490	Continued From page 34 Administration (F490 at a S/S of a "J"), with Substandard Quality of Care at 42 CFR 483.13 Resident Behavior and Facility Practices. The facility was notified of the Immediate Jeopardy on 07/11/13. The findings include: Review of the facility's Abuse and Neglect policy, revised 01/06/06, revealed the abuse policy did not contain all seven components as required. The policy did not include the investigation component and gave no guidance on how to investigate an allegation of abuse. According to the abuse policy, the Administrator or Director of Nursing (DON) will immediately initiate follow-up corrective action along with immediate notification of the incident to Adult Protective Services (APS) and the Division of Long Term Care. A five (5) day follow-up of the incident would be performed and reported to the above state agencies. Further review of the policy revealed to protect residents from harm during the investigation, the individual (s) alleged to be involved in the abuse would be removed from providing direct resident care during the pending investigation. On 03/08/13, the facility received an allegation of abuse from Resident #6, who reported State Registered Nurse Aide (SRNA) #3 had kissed and hugged her/him like a lover would. The resident had reported the allegation to SRNA #4 and SRNA #5 and they reported to the Director of Nursing (DON). The DON called the facility and spoke with SRNA #3 on 03/09/13 and informed him not to provide direct care for Resident #6; however, SRNA #3 continued to care for other residents for six (6) days during the abuse	F 490	plan to place the policy in a manual in the Nursing Home at the desk where it could be accessed by staff 24/7. In-service on the new policy was planned and delivered to all Nursing Home staff by the DON, SW and charge nurses. All tasks required to remove the IJ from Windsor Gardens were overseen by the Administrator and the IJ was removed from the facility by July 23, 2013. The Administrator will include information on any Rights Violation investigated in the facility in her report at the next scheduled Quality Assurance meeting and Board of Directors meeting. Both of these meetings are scheduled quarterly. The Administrator will be held accountable by the Board of Directors of Windsor Gardens to insure that the revised policy is accessible to all Management staff and employees and that it is used to insure that Resident Rights are communicated to residents and their families. The CHFS Resident Rights summary sheet is a part of the Admission Packet given to any resident admitted to any program at Windsor Gardens. There is signature required by the resident and POA to indicate receipt. A summary of Resident Rights is included in every Resident Council meeting held at Windsor Gardens. The Administrator recommended to the QA Committee at its July 18 meeting that a summary review of the Abuse and Neglect policy be presented at each new employee orientation, beginning Aug. 1, 2013. The HR Director will include the policy review immediately following completion of the OIG Hand in Hand module on Abuse and Neglect. The law requiring reporting right's violation of any vulnerable adult and child will be shared and a summary on how to report a suspected violation will be given.		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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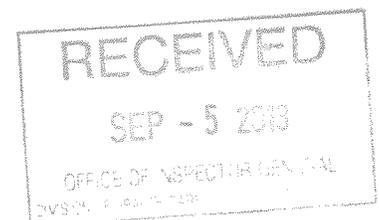
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F 490	<p>Continued From page 35 investigation.</p> <p>Review of the facility's investigation revealed the facility did not report the allegation to APS until 03/12/13 and did not report to the OIG at all per the facility's policy. Interview with the DON and Social Worker revealed this was their first abuse investigation and they did not know they were suppose to report to the OIG. In addition, the DON revealed she had interpreted the abuse policy wrong and thought she was protecting residents when she removed SRNA #3 from direct care of Resident #6, who was the alleged victim.</p> <p>Interview with the Social Worker, on 07/17/13 at 8:40 AM, revealed she had requested training many times for the Social Service position; however, she had not received any training. She did not know the Long Term Care regulations and had never conducted an abuse investigation before. She stated she tried to follow the facility's abuse policy but had interpreted the policy wrong and did not know to report the allegation to the OIG. She stated she did not receive guidance or oversight from the Administrator during the investigation.</p> <p>Interview with the Administrator, on 07/11/13 at 3:38 PM, revealed she recalled a conversation with the DON and Social Worker about the abuse investigation and she told the Social Worker they needed to call the OIG and she assumed this had been done. However, the Administrator revealed she did not follow-up on that directive to ensure reporting was done. She was aware that all allegations of abuse were supposed to be reported to the Office of Inspector General and</p>	F 490	<p>The Administrator also recommended that a workshop on How to Write and Revise Policies be scheduled for the Management Team at Windsor Gardens. This date has been set for August 19. The workshop will be presented by an RN Nurse Consultant with Risk Management Solutions. This company has performed a risk management audit scheduled at Windsor the past 4 years. The QA Committee approved a plan suggested by the Administrator to have a designated department present new policies or polices for review as a part of each QA meeting.</p> <p>The Administrator includes an operational summary of Windsor at each quarterly Board meeting. A summary of all issues and actions taken by the Quality Assurance Committee will be added to her Board report.</p> <p>The Board of Directors met on 7/29/13 and accepted the Administrator's recommendations.</p> <p>The State Survey Team determined that the Abuse and Neglect policy being used by Windsor's Nursing Home on March 8, 2013, was incomplete. Although the policy in place was followed by the DON, SW and the Administrator to determine that the abuse allegation was not substantiated, the policy needed revision.</p> <p>The main purpose of the QA meeting called on July 18 was to review and approve the revised Abuse and Neglect policy. It was recommended by the Administrator that the yearly Risk Management Audit include a review of the facility's policies and procedures and if need be plan a workshop for the Administrator and Management Team on How To Write and Review Policies. The QA Committee's third action was to accept the recommendation. The Nurse Consultant was scheduled to come to Windsor on August 19. The Policy and Procedure workshop is scheduled for Tuesday, Sept. 11, 2013.</p>		



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F 490	<p>Continued From page 36</p> <p>had reported verbal abuse, sexual abuse and misappropriation of funds in the past, stating "I understand the requirements." The Administrator thought the abuse policy for residents protection had been followed. "Evidently, it got over looked." The Administrator continued to state she had delegated the responsibility to investigate the abuse allegation to the Social Worker and DON and acknowledged she had not provided guidance and oversight to the DON and Social Worker during the investigation and did not ensure the abuse policy was followed. She revealed she had not reviewed the abuse investigation, stating "I assumed those things had been completed."</p> <p>Interview with the Administrator, during the extended survey on 07/17/13 at approximately 10:30 AM, revealed the Social Worker had requested training related to social services but she was unable to find a training program for the Social Worker to attend. She further stated the wrong abuse policy had been followed during this abuse investigation. She stated there had been a revised abuse policy since the 2006 version but the DON and Social Worker had used the 2006 version. However, the 2006 version of the abuse policy was what the facility provided the surveyor during Task 5-G, and this policy did not contain the investigation component.</p>	F 490	<p>There were two actions and two QA monitors approved by the QA Committee to ensure future utilization and compliance with the Abuse and Neglect policy.</p> <p>1) It was determined that the revised policy be distributed that day to the Nursing Policy Manual kept at the Nursing Station in the Nursing Home, that a copy also be placed in the Personal Care Manual kept at the Nursing Station in the Personal Care Unit, and that a copy of the policy be placed in the Assisted Living Manual at the Assisted Living reception desk. The DON was responsible for the action in the Nursing Home, and the Administrator placed the policy in the other two manuals. These manuals are accessible to all employees 24/7. (When placing the revised policy, the "old" policies were removed and destroyed.)</p> <p>2) The Administrator put together a Manual labeled Abuse & Neglect Reporting. The manual contains a copy of the revised policy on Abuse and Neglect; several copies of Report Form A, and the Abuse and Neglect Policy Checklist. It also has copies of Questions for a Rights Violation Interview. The QA Committee approved the Administrator's recommendation that this manual be kept at the Nursing Station in the Nursing Home for easy, ready access to all staff should an abuse allegation be made in the future.</p> <p>When the Abuse and Neglect Policy was revised on 9/1/13 to include resident to resident abuse and the need to immediately determine actions to take to protect residents when this occurs, the Administrator called the Quality Assurance Committee members to get their approval of the policy revision. She also set up and implemented a plan to in-service the DON, Dept. Directors and all Nursing Home Staff on the policy revisions.</p>		



A QA monitor was approved for completing Report Form A and for completing the Abuse and Neglect Policy Checklist. These forms will be completed and signed by the DON, SW, Charge Nurse or other Department Director and submitted to the Administrator on the fifth day of an investigation. The Administrator will check the forms for completeness, and when necessary call the OIG Complaint office to provide and up-date on the progress of the investigation. The Administrator will also summarize the content, and present the summary information to the QA Committee quarterly and to the Chair of the Board of Directors whenever an allegation of resident abuse happens.

Board of Director Oversight

The Administrator meets with the Board of Directors quarterly. A summary report on all action taken each quarter to insure resident safety will be presented as a part of her operational report. Any incidents of abuse and neglect will be reported by the Administrator to the Board Chair immediately when they occur. The Board of Directors will include a review of resident safety and the facility policy and procedure update(s) in the Administrator's new annual performance evaluation.

Continuing Education

The Administrator is a five year member of KAHCA and of ACHCA and attends Ky. chapter meetings when they are scheduled. She also attends a national conference at least once yearly. She has completed the required number of CEU's yearly and attends all employee in-services scheduled at Windsor Gardens.

The Ky State OIG office accepted the Allegation of Compliance on 7/29/2013 and CMS accepted the Allegation of Compliance on 7/30/13.

7/23/2013 - Date the IJ was removed

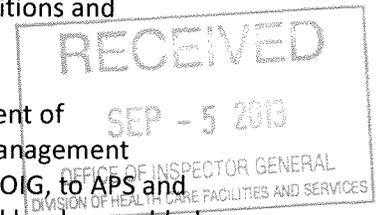
3/9/2013 - Immediate Jeopardy determined to exist. The revisit to the facility occurred on 8/1/13 and the facility was found to be in compliance.

Steps taken in the Allegation of Compliance follow:

How IJ has been addressed:

The Abuse and Neglect Policy was analyzed and several revisions were made. The additions and language revisions in the new policy follow:

1. **Definition Section** – A definition section has been added to the policy.
2. **Reporting/Notification Section** – The obligation to report any suspected incident of abuse/neglect is clearly stated. The incident is to be reported to the facility management (Administrator, DON, Charge Nurse, or other Department Director) and to the OIG, to APS and to the Long Term Care Ombudsman. A clear statement of who is to be notified has been added



that includes the oversight agencies listed (b), as well as the Administrator, the Medical Director, the Attending Physician. **A Reporting Form Guide** will be used to cover all the steps of the reporting process included in a thorough investigation. This guide consists of two parts:

First Report Form (A) and Reporting Form Guide (B)

3. **Protection Section**
4. **Investigation Section** including Abuse and Neglect Policy and Procedure Checklist
5. **Monitoring Section** includes Abuse and Neglect Tracking Form
6. **Employee Counseling Section**

TIMELINE OF ACTIONS

3/11/13 - Son of alleged abused resident was called by SW

3/12/13 - SW called APS

3/19/13 - Investigation by APS was conducted on (Case# 1001524)

7/11/13 - Administrator called and left message for Medical Director

7/11/13 - Administrator call three members of the Board of Directors who were told of the IJ citation and read the summary statement immediately after the Survey Team exited the building. A copy of the OIG Immediate Jeopardy Notification was placed in the corporate mailbox for next day pick up. The current Board member contact for the facility has been in daily communication with the Administrator for status updates, guidance and support.

7/12/13 - Medical Director called Administrator and was informed and IJ citation summary was read to him.

7/12/13 - In-service Hand-in-Hand Abuse & Neglect Module Presented to: Nursing Home Staff working day (6A-6P) & evening (6P-6A) shifts on the unit.

Presenter: HR Director The Human Services Director has developed a new plan for employee orientation that includes Modules 2, 3 and 5 of the CMS Hand-in-Hand Series as a part of the in-service/education program.

7/15/13 - Medical Dir. updated on progress of the AOC

7/17/13 - Medical Dir. updated on progress of AOC

7/17/13 - In-service on Resident Rights, Reporting Violations and How to Conduct a Thorough Investigation Presented to: Management Team

7/18/13 - Emergency QA meeting held at 3:00 p.m.

7/18/13 - In-service and Review of the Revised Abuse and Neglect Policy for understanding of its content and how to implement it.

Presented to: Management Team and HR Director

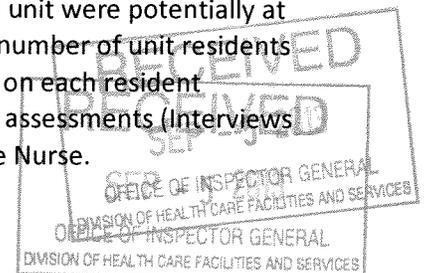
7/18-22/13 In-services on Revised Abuse & Neglect Policy

Presented To: All Nursing Home Staff

7/18/13 - Revised Abuse & Neglect Policy placed in PC/Memory Unit, Nursing Facility, and Assisted Living to be accessible to staff 24/7. Old copies of policy were shredded. The policy will be used for every new employee orientation.

7/22/13 - Investigation questions for Resident Rights Violation compiled by Administrator. DON and SW in-serviced on questions.

What resident/patients are impacted by the IJ? A total of 35 residents of the unit were potentially at risk since the abuse allegation of March 8, 2013. (This number represents the number of unit residents on March 8 through July 22, 2013.) BIMS scores were obtained from MDS 3.0 on each resident potentially impacted. Based on the patient's BIMS score, one of the two other assessments (Interviews and Skin Assessments) were conducted by the SW, DON, MDS Nurse or Charge Nurse.



What staff are involved in the IJ?

The Administrator, DON, Social Service/Activity Director, reporting CNA, alleged CNA, and potentially all management who had not implemented an effective policy and procedure review annually, including shredding old policies.

What areas of the facility are impacted by the IJ?

The Nursing Center.

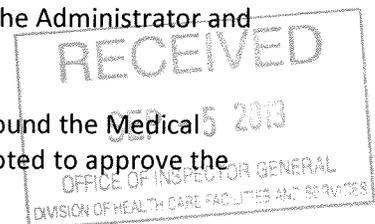
How will the IJ be prevented from recurring to other residents/patients? A thorough investigative procedure is included in the revised Abuse and Neglect Policy:

Investigative Process Steps:

- To protect residents from harm during the investigation, the individual(s) alleged to be involved in the abuse will be removed from providing direct resident care by being suspended from the facility during the pending investigation by their Dept. Manager, Administrator, SW, HR Manager or Manager on Call.
 - A BIMS (Brief Interview for Mental Status) will be performed with resident involved immediately (or within 24 hours) of incident. This will be performed by the Social Services Director or other qualified staff.
 - Interviews with at least 3-5 other residents on the unit of incident location will be conducted by the DON, Administrator, Social Service Director or Charge Nurse.
- All Staff working on the unit at the time of the incident will be interviewed following the report of the incident by the Director of Nursing, Social Service Director or Charge Nurse.
- Separate interviews will be conducted with the accused person and the victim by the Director of Nursing, Social Service Director or Charge Nurse. Questions should be addressed in a YES and NO manner due to the topic. Open ended questions for clarification will also be utilized by the investigator as necessary.
 - If there are substantial findings, the Administrator or DON will report to the State Nurse Aide Registry and applicable licensing authorities any knowledge it has of any action by a court of law which would indicate an employee is in violation of their professional practice act.
 - The employee will be counseled and such counseling will be documented with a Windsor Gardens Employee Counseling Form. Counseling will be conducted by the Director of Nursing, Administrator, Social Service Dir. or Charge Nurse and will be accompanied by the HR Director.
 - The Administrator, DON or SW will perform a five-day follow-up of the incident documenting and reporting to Office of Inspector General, Adult Protective Services/Child Protective Services, the Ombudsman and the facility Medical Director of the findings.

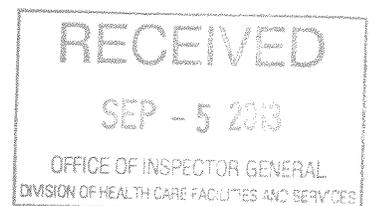
The Administrator meets with the Medical Director of the facility once each month. He was called on July 11, 2013 when the IJ was issued and has been updated three times while the Allegation of Compliance was being written and approved by both the OIG and CMS. When the facility received the Statement of Deficiencies from the OIG, a copy was sent to him. He met with the Administrator and DON to review the deficiencies and gave input and encouragement.

The date for the Emergency Quality Assurance Committee meeting was set around the Medical Director's schedule. He gave input and was a part of the QA Committee that voted to approve the



revised Abuse and Neglect Policy and the actions and monitors set up to ensure that the policy would be implemented effectively. He and the Administrator will work effectively with the Quality Assurance Committee to follow up on the specifics outlined in the Plan of Correction by being sure the actions to be taken and monitors set up ~~are~~ completed.

On August 19, 2013, the Medical Director met with the Administrator and the Management Team to review the Plan of Correction developed to correct the deficiencies listed in the Statement of Deficiencies resulting from the State Licensing Survey.



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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185457	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - WINDSOR GARDENS B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2013
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NAME OF PROVIDER OR SUPPLIER WINDSOR GARDENS	STREET ADDRESS, CITY, STATE, ZIP CODE 101 ISAAC GREER COURT BARDSTOWN, KY 40004
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 2005

SURVEY UNDER: 2000 New

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: one (1) story, Type III (111)

SMOKE COMPARTMENTS: Two (2) smoke compartment

FIRE ALARM: Complete fire alarm system with heat and smoke detectors

SPRINKLER SYSTEM: Complete automatic dry sprinkler system.

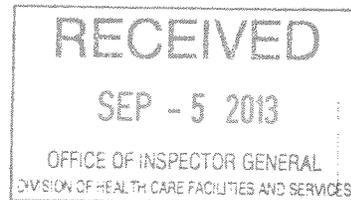
GENERATOR: Type II generator. Fuel source is diesel.

A standard Life Safety Code survey was conducted on 07/09/13. Windsor Gardens was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility has thirty (30) certified beds with a census of thirteen (13) on the day of the survey.

The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)

K 000 K000 INITIAL COMMENTS

This Plan of Correction is prepared and submitted as required by law. By submitting the Plan of Correction, Windsor Gardens does not admit that the deficiencies listed on this form exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies and/or any statements, facts, and conclusions that form the basis of the alleged deficiencies.



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Suzanne Reasbeck</i>	TITLE <i>X Administrator</i>	(X6) DATE <i>X 9/05/2013</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 025 Continued From page 2

K025

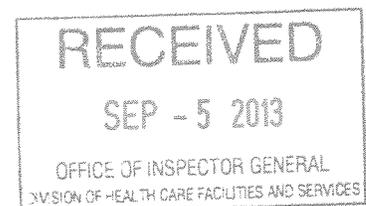
claiming that the construction assembly forming the bottom of the interstitial (attic) space provides resistance to the passage of smoke equal to that provided by the smoke barrier. However, further observation revealed the drywall on the ceiling was only one (1) layer of 5/8 inch thick, and not all light fixtures throughout the facility were able to provide a one (1) hour fire resistive rating or resist the passage of smoke. Two layers of 5/8 inch thick drywall are required to equal a one (1) hour rating and light fixtures are to be rated to use this exception. Further observation revealed the draft stop located in the attic above the cross corridor doors was covered in plywood and would not provide the required one (1) hour rating required. The facility has greater than 22,500 square feet, and is required to form two (2) smoke compartments.

Interview, on 07/09/13 at 10:30 AM, with the Maintenance Director confirmed the observation that the ceiling was only one layer of 5/8 inch drywall, and light fixtures would not resist the passage of smoke. Further interview revealed he had not been aware of the ceiling being only one (1) layer of 5/8 inch drywall, but was aware the facility had greater than 22,500 square feet, and two smoke compartments were required.

Reference: NFPA 101 (2000 Edition).

18.3.7.3

Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1 hour.
Exception No. 1: Where an atrium is used,



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K 025 Continued From page 3
smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor.
Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems.

K025

8.3 SMOKE BARRIERS

8.3.1* General.

Where required by Chapters 12 through 42, smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke.

8.3.2* Continuity.

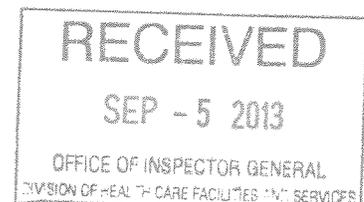
Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.

Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.

18.3.7* Subdivision of Building Spaces.

18.3.7.1

Buildings containing health care facilities shall be



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K 025 Continued From page 4

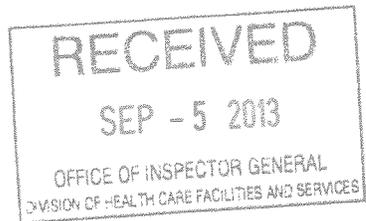
K025

subdivided by smoke barriers as follows:

- (1) To divide every story used by inpatients for sleeping or treatment into not less than two smoke compartments
- (2) To divide every story having an occupant load of 50 or more persons, regardless of use, into not less than two smoke compartments
- (3) To limit the size of each smoke compartment required by (1) and (2) to an area not exceeding 22,500 ft² (2100 m²)
Exception: The area of an atrium separated in accordance with 8.2.5.6 shall not be limited in size.
- (4) To limit the travel distance from any point to reach a door in the required smoke barrier to a distance not exceeding 200ft (60 m).
Exception No. 1: Stories that do not contain a health care occupancy, located totally above the health care occupancy.
Exception No. 2: Areas that do not contain a health care occupancy and that are separated from the health care occupancy by a fire barrier complying with 7.2.4.3.
Exception No. 3: Stories that do not contain health care occupancies and that are more than one story below the health care occupancy.
Exception No. 4: Open-air parking structures protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.

8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:

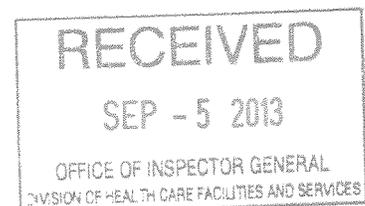
- (a) The space between the penetrating item and



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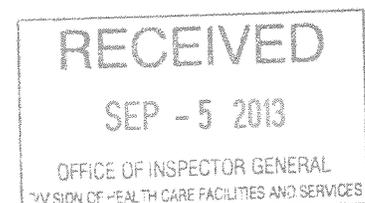
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K 025	Continued From page 5 the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025	
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6	K 051	



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K 051	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building fire alarm system was installed as required by NFPA standards. The deficient practice has the potential to affect two (2) of two (2) smoke compartments, staff, and the residents. The facility is certified for thirty (30) beds with a census of thirteen (13) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/09/13 at 10:00 AM with the Maintenance Director revealed the Fire Alarm Control Panel (FACP) had been hit by lightning on 06/26/13 and was out of service. The facility had been on Fire Watch since 06/26/13.</p> <p>Interview, on 07/09/13 at 10:00 AM with the Maintenance Director revealed the FACP had been out of service since 06/26/13. Further interview revealed the facility had a contractor look at the damage to the FACP caused by the lightning and was waiting for a bid to fix or replace the FACP. The facility did not have a signed contract in place to repair or replace the FACP.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>18.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6.</p> <p>9.6 FIRE DETECTION, ALARM, AND COMMUNICATIONS SYSTEMS</p>	K 051	<p>K051 - Fire Alarm</p> <p>The fire alarm system throughout the facility was knocked out by a lightning strike just before midnight on 6/26/2013. The system was inspected by the Maintenance Director that night and found to be out of service. A fire watch was initiated immediately (about 1 hour after system was knocked out) and continued until the system was restored on 8/23/2013. Fire watch was conducted once every 60 minutes as per policy and documented by charge nurse on duty. Maintenance Director reviewed fire watch requirements with each staff member on each shift and verified that fire watch policy was understood and was being followed. Separate AC powered smoke alarms with battery backup are present in each resident room. They have been tested and are in good working order. The outage was reported to the KY OIG the next day, June 27th. The fire alarm service company was also called on June 27th and the technician found the main panel was completely out of service. The fire alarm contractor, Siemens, was called that day but did not arrive at the facility until July 15th. Siemens determined that the system was not repairable and would have to be replaced. Due to lack of response by Siemens, another contractor, Interstate Security Systems, was chosen to replace the system and work was completed on 8/23/2013. See attached contract dated 8/1/2013. Fire alarm system has been in service and monitored 24/7 by Interstate Security Systems since around 5 p.m. on 8/23/2013.</p> <p>Quality Assurance Committee oversees the Fire Watch Policy by having 24/7 access to Fire Watch Logs and reviewing reports by Maint. Dir. at quarterly Q.A. meetings. Q.A. Committee was and is informed on a continuous basis of Fire Alarm status - Meetings were held July 10 and 18, 2013 and August 19, 2013. The next regularly scheduled meeting is October 2013.</p> <p>Completion date: 8/24/2013</p>



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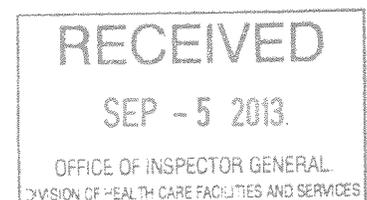
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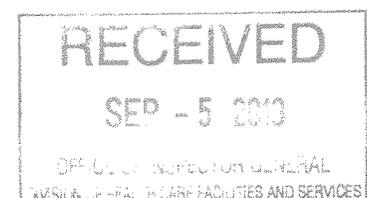
K 051	<p>Continued From page 7</p> <p>9.6.1 General.</p> <p>9.6.1.1</p> <p>The provisions of Section 9.6 shall apply only where specifically required by another section of this Code.</p> <p>9.6.1.2</p> <p>Fire detection, alarm, and communications systems installed to make use of an alternative allowed by this Code shall be considered required systems and shall meet the provisions of this Code applicable to required systems.</p> <p>9.6.1.3*</p> <p>The provisions of Section 9.6 cover the basic functions of a complete fire alarm system, including fire detection, alarm, and communications. These systems are primarily intended to provide the indication and warning of abnormal conditions, the summoning of appropriate aid, and the control of occupancy facilities to enhance protection of life.</p> <p>9.6.1.4</p> <p>A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code, unless an existing installation, which shall be permitted to be continued in use, subject to the approval of the authority having jurisdiction.</p> <p>9.6.1.5</p> <p>All systems and components shall be approved for the purpose for which they are installed.</p> <p>9.6.1.6</p> <p>Fire alarm system installation wiring or other transmission paths shall be monitored for integrity in accordance with 9.6.1.4.</p> <p>9.6.1.7*</p> <p>To ensure operational integrity, the fire alarm</p>	K 051		
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185457	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - WINDSOR GARDENS B. WING _____		(X3) DATE SURVEY COMPLETED 07/09/2013
NAME OF PROVIDER OR SUPPLIER WINDSOR GARDENS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 ISAAC GREER COURT BARDSTOWN, KY 40004		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 051	Continued From page 8 system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.	K 051			
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system installed, in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for thirty (30) beds with a census of thirteen (13) on the day of the survey. The facility failed to ensure the facility had complete sprinkler coverage. The findings include:	K 056	K056 – Sprinkler head placement (#1) As a fire safety concern this deficiency has the potential to affect all residents, staff and visitors. Sprinkler heads are as installed and have passed inspection in 2005, 2006, 2007, 2008, 2009, 2010, 2011 and 2012. No new light fixtures or fire alarm devices have been installed since construction was completed in 2005. (#1, #2) All light fixtures listed by surveyor and any other fixtures found to be too close to a sprinkler head (see attached) have been moved to a distance that will meet or exceed specifications of NFPA 25 and 13. One smoke detector was relocated. The work was supervised by the Maintenance Director and documented as completed. (#3) Any fixtures installed in the future will be located as per code requirements. (#4) No fixtures are moved or installed without oversight of the Maintenance Director. All fixtures will be inspected monthly for next 3 months by Maint. Director. If there are problems they will be fixed immediately. The Maint. Dir. will report any problems with the Sprinkler system or light spacing at the next scheduled Quality Assurance quarterly meeting. Work supervised by the Maintenance Director is reported to the Administrator on an ongoing basis. (#5) Work began on 8/20/2013 and was completed 8/23/2013. See attached list. Completion date: 8/24/2013		



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

PRINTED: 07/22/2013
FORM APPROVED
OM8 NO 0938-0391

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K 056 Continued From page 9

K056

Observation, on 07/09/13 between 10:00 AM and 3:00 PM, with the Maintenance Director revealed light fixtures or other objects installed within twelve (12) inches of a sprinkler head located in room #C06, C12, COS, 807, 808, 801, 803, 805, 812, 806, eye wash station, exam room C Hall, smoke detector #42 by the nurses' station, whirlpool room, 8 Hall, Mechanical Room A Hall, Food Prep Room, Supply Room A Hall, Soiled Linen Room, and Clean Linen Room.

Interview, on 07/09/13 between 10:00 AM and 3:00PM, with the Maintenance Director revealed he was not aware of the sprinkler head requirement.

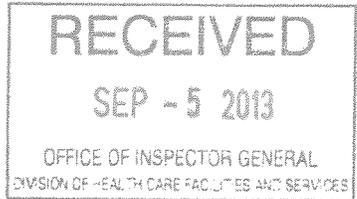
Reference: NFPA 13 (1999 Edition) 5-13 8.1

Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.

Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.

Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.

Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:



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

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K 056 Continued From page 10

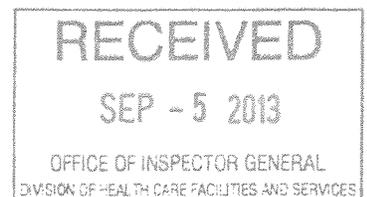
K056

- (1) Sprinklers installed throughout the premises
- (2) Sprinklers located so as not to exceed maximum protection area per sprinkler
- (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.

Reference: NFPA 13 (1999 ed.)
5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures.
Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)

Distance from Sprinklers to above Bottom of Side of Obstruction (A) (8)	Maximum Allowable Distance of Deflector Obstruction (in.)
Less than 1 ft	0
1 ft to less than 1 ft 6 in.	2 1/2
1 ft 6 in. to less than 2 ft	3 1/2
2 ft to less than 2 ft 6 in.	5 1/2
2 ft 6 in. to less than 3 ft	7 1/2
3 ft to less than 3 ft 6 in.	9 1/2
3 ft 6 in. to less than 4ft	12
4 ft to less than 4 ft 6 in.	14
4 ft 6 in. to less than 5 ft	16 1/2
5 ft and greater	18

For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m.



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

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K 056 Continued From page 11
Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).
Reference: NFPA 13 (1999 ed.)
5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.

K 068 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D
Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure combustion air and ventilation for boilers, incinerators, fuel fired HVAC, and water heater rooms were installed in accordance with NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for thirty (30) beds with a census of thirteen (13) on the day of the survey.

The findings include:

Observation, on 07/09/13 at 11:00 AM, with the Maintenance Director revealed the fresh air and exhaust vents serving the HVAC Unit located in the Mechanical Room next to the Nurses' Station had a three foot piece of pipe cut out of each pipe and left open to the attic.

Interview, on 07/09/13 at 11:00 AM with the Maintenance Director revealed an HVAC technician had recently cut the pipes to see if they were blocked causing low manifold pressure.

K 056

K068 – HVAC ventilation

K 068

(#1) As an environmental hazard this deficiency could affect all residents, staff and visitors. Fresh air intake pipes for two HVAC systems were found to have been cut and left open in the attic above B hall during the survey of 7/9/2013. No exhaust pipes were cut. (#2) Both intake pipes were subsequently repaired by the Maintenance Director and all other HVAC system intake and exhaust pipes were inspected and found to be intact on 7/16/13. (#3) All HVAC piping will be inspected immediately after work has been completed. (#4) Attic space cannot be accessed without knowledge of Maintenance Director. Completion of the work on this project was reported to the Administrator and the Board of Directors. If future problems occur, they will be reported immediately to the Administrator. Inspection on HVAC will be included in the Maintenance Director's quarterly report to the Quality Assurance Committee. Next scheduled meeting is October 2013. (#5) Work was completed 7/18/2013.
Completion date: 8/2/2013



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K 068 Continued From page 12
Further interview revealed the Maintenance Director was not aware the pipes had not been re-connected.

K 068

Reference: NFPA 101 Life Safety Code (2000 edition)

18.5.2 Heating, Ventilating, and Air Conditioning.
18.5.2.1

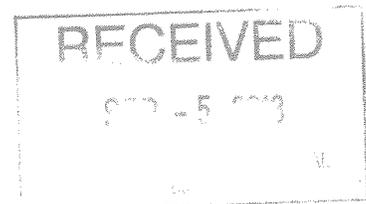
Heating, ventilating, and air conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer's specifications.

Exception: As modified in 18.5.2.2.

18.5.2.2*

Any heating device other than a central heating plant shall be designed and installed so that combustible material will not be ignited by the device or its appurtenances. If fuel-fired, such heating devices shall be chimney connected or vent connected, shall take air for combustion directly from outside, and shall be designed and installed to provide for complete separation of the combustion system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperatures or ignition failure.
Exception No. 1: Approved, suspended unit heaters shall be permitted in locations other than means of egress and patient sleeping areas, provided that such heaters are located high enough to be out of the reach of persons using the area and are equipped with the safety features required by 18.5.2.2.

Exception No. 2: Fireplaces shall be permitted and used only in areas other than patient sleeping



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K 068 Continued From page 13

K068

areas, provided that such areas are separated from patient sleeping spaces by construction having not less than a 1-hour fire resistance rating and that such fireplaces comply with the provisions of 9.2.2. In addition, the fireplace shall be equipped with a hearth that shall be raised not less than 4 in. (10.2 cm) and a fireplace enclosure guaranteed against breakage up to a temperature of 650°F (343°C) and constructed of heat-tempered glass or other approved material. If, in the opinion of the authority having jurisdiction, special hazards are present, a lock on the enclosure and other safety precautions shall be permitted to be required.

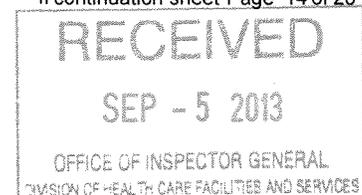
9.2 HEATING, VENTILATING, AND AIR CONDITIONING

9.2.1 Air Conditioning, Heating, Ventilating Ductwork, and Related Equipment.

Air conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 908, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.

9.2.2 Ventilating or Heat-Producing Equipment.

Ventilating or heat-producing equipment shall be in accordance with NFPA 91, Standard for Exhaust Systems for Air Conveying of Vapors, Gases, Mists, and Noncombustible Particulate Solids; NFPA211, Standard for Chimneys, Fireplaces, Vents, and Solid Fuel-Burning Appliances; NFPA 31, Standard for the



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K 068 Continued From page 14
Installation of Oil-Burning Equipment; NFPA 54, National Fuel Gas Code; or NFPA 70, National Electrical Code, as applicable, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.

K 076 SS=D
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, 18.3.2.4

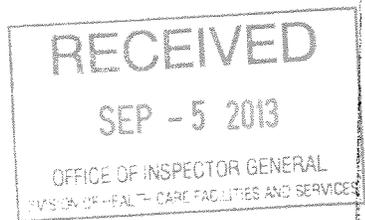
This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for thirty (30) beds with a census of thirteen (13) on the day of the survey. The facility failed to ensure oxygen storage over 300 cu ft. was stored in a room with an ignition source not located below five (5) feet from the floor.

The findings include:

Observation, on 07/09/13 at 2:47 PM, with the

K 068

K 076 K076 - Oxygen storage
(#1) As a potential fire safety hazard this deficiency has the potential to affect all residents, staff and visitors. Oxygen tanks with a total capacity in excess of 300 ft3 were found stored in the Vendor Supply room. (#2) Vendor has removed excess empty tanks and (#3) has agreed to ensure that no more than 12 tanks (empty or full) are left in vendor storage so that the 300 ft3 rule is met. A sign has been posted on the wall. (#4) Maintenance Director, Director of Nursing, and Medical Supply Coord. will monitor 2 x weekly for 2 months, and pending compliance, keep monitoring if necessary. To ensure compliance, the Maintenance Director will present results of monitor at quarterly Quality Assurance Committee meetings for review. (#5) Tanks were removed by 7/13/2013.
Completion Date: **7/31/2013**



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 076 Continued From page 15

K 076

Maintenance Director revealed oxygen storage in excess of 300 ft³ located in the Oxygen Storage Room had a light switch and a receptacle installed below five (5) feet from the floor. There were seventeen (17) E cylinders in storage at the time of the observation.

Interview, on 07/09/13 at 2:47PM, with the Maintenance Director revealed he was not aware the light switch and receptacle could not be below five feet from the floor if the oxygen storage was greater than 300 ft³.

Reference:

NFPA 101 (2000 edition)

8-3.1.11.2

Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³)

(a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry.

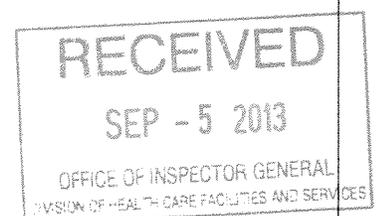
(b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor.

(c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following:

(1) A minimum distance of 6.1 m (20ft)

(2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems

(3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of Y2 hour. An approved flammable liquid



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 076 Continued From page 16 K076

storage cabinet shall be permitted to be used for cylinder storage.

(d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4.

(e) Cylinder and container storage locations shall meet 4-3.1.1.2(a) 11e with respect to temperature limitations.

(f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d.

(g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13.

(h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27.

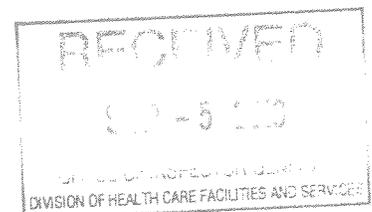
(i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20ft (6.1 m) of outside storage locations.

U) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.

K 147 NFPA 101 LIFE SAFETY CODE STANDARD K147
SS=E

Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff, and visitors. The facility is certified for thirty (30) beds with a census of thirteen (13) on the day of the survey. The facility failed to maintain proper use of power strips and multi-plug adaptors.



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K 147 Continued From page 17

The findings include:

Observations, on 07/09/13 between 10:00 AM and 3:00 PM, with the Maintenance Director revealed an oxygen concentrator was plugged into a power strip located in room #C-11. Further observation revealed a bed was plugged into a multi-plug adaptor located in room #B-10.

Interview, on 07/09/13 between 10:00 AM and 3:00 PM, with the Maintenance Director revealed it was a constant battle to monitor the misuse of power strips and multi-plug adaptors.

Reference: NFPA 99 (1999 edition)

3-3.2.1.2 D

Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.

Reference: NFPA 101 (2000 Edition)

9.1.2 Electric.

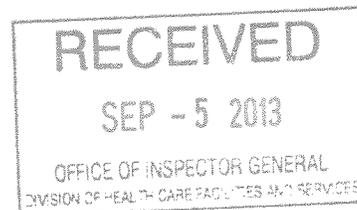
Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.

110-26. Spaces

K 147 **K147 – Power strips/extension cords**

This deficiency has the potential to affect all residents, staff and visitors. All findings of improper use of extension cords, multi-plug adaptors and power strips were remedied immediately on date of survey. A subsequent room by room inspection performed by the Maintenance Director on July 31st, found no further violations. A policy regarding extension cords, multi-plug adaptors, and power strips was written and put into effect in December 2012. Policy remains in effect and inspections are conducted and logged monthly. Logs are then submitted to QA for review at quarterly meetings. The Maintenance Director has reviewed NFPA 70, articles 400 (flexible cords) and 517 (health care facilities), on 8/12/13 under supervision of the Executive Director. NFPA code does not explicitly ban use of extension cords in health care facilities. It dictates only that they be used properly (i.e. not used as a substitute for building wiring and not overloaded). Windsor Gardens written policy banning the use of extension cords and multi-plug adaptors allows management and staff to monitor the use of these devices and prevent misuse by simply banning them. The Maintenance Director is responsible for conducting monthly checks of every room in the SNF for violations of the extension cord policy. Any violations are removed immediately. Residents, staff and family members are regularly reminded of the restrictions. Extension cord/ power strip policy has been made part of the admission procedure. Monthly inspections are logged and results are presented as a part of the Maint. Director's report to the Quality Assurance Committee quarterly meetings. Work was completed July 31, 2013.

Completion date: 8/13/2013



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

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FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185457	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - WINDSOR GARDENS B. WING	(X3) DATE SURVEY COMPLETED 07/09/2013
NAME OF PROVIDER OR SUPPLIER WINDSOR GARDENS		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 SAAC GREER COURT BARDSTOWN, KY 40004	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

K 147 Continued From page 18

K 147

About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.

Reference: NFPA 70 (1999 edition)

Reference: NFPA 70 (1999 edition)

370.28(c) Covers.

All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.

Reference: NFPA 101 (2000 Edition)

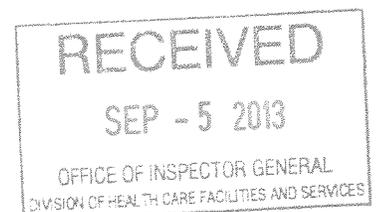
9.1.2 Electric.

Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.

Reference: NFPA 70 400-8

(Extensions Cords) Uses Not Permitted.

Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the



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K 147	Continued From page 19 following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147		
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