

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

PRINTED: 02/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/04/2011
NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey and an Abbreviated Survey investigating AROs KY00015272, KY00015273, KY00015274, K&00275, KY00015276, KY00015622, KY00015670, KY000689, KY00015830, KY000894, and KY00015898 was conducted 02/01-04/11; and, Life Safety Code Survey was conducted 02/02/11. Deficiencies were cited, with the highest scope and severity of an "F". AROs KY00015272, KY00015273, KY00015274, KY00015276, KY000689, KY00015830, and KY000894. were unsubstantiated with no deficiencies cited. ARO KY00015670 was substantiated with no deficiencies. AROs KY00015275 and KY000622 were substantiated with deficiencies cited. ARO KY00015898 was unsubstantiated with deficiencies cited.	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
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 follow the Comprehensive Plans of Care for two (2) of thirty-one (31) sampled residents (Residents #17 and #29). Resident #17's Plan of care included interventions of assist of two (2) staff for turning and repositioning, however this was not observed to have occurred. Resident #29 was care planned for transfer with gait belt device.	F 282	F282 Harrodsburg Health Care Center will care for residents and meet their needs as evidenced in the Comprehensive Plans of Care. Resident #29 no longer resides in facility. Employee #11 no longer employed at facility. Resident # 17 will be turned and repositioned per care plan and SRNA Assignment sheet Facility wide audit was conducted for all in-house residents to validate care plan interventions were implemented. This audit was conducted by Unit Manager/Designees through direct observation on 03/15/11. Any intervention identified as not implemented was immediately corrected.	3/16/11

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Johnson TITLE: Administrator (X5) DATE: 3/10/11

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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F 282	Continued From page 1 The findings include: 1. Review of Resident #17's medical record revealed diagnoses which included Mental Retardation, Psychosis, and Febrile Convulsions. Review of the Minimum Data Set Assessment (MDS), dated 01/19/11, revealed the facility assessed the resident to have impairment in cognitive skills and required extensive to total assistance with most Activities of daily Living (ADL). Review of the Care Area Assessment (CAA) Summary, dated 01/26/11, revealed physical and mental limitations that contributed to his/her dependent functional status for performing ADL's. Review of the Plan of Care dated 01/25/11, revealed the resident was care planned for assist of two (2) staff for turning and repositioning. Observation of Resident #17, on 02/04/11 at 9:50 AM, revealed State Registered Nurse Aide (SRNA) #11, turning the resident without any other assistance while providing care. Interview, on 02/04/11 at 10:20 AM, with SRNA #11 revealed she was not aware the resident was a two (2) person staff assist for turning and bed mobility. She further stated that even though the Nurse Aide flow sheet confirmed the requirement of two (2) + assist, she thought if Resident #17 assisted her, that would substitute for the staff requirement of two (2). Interview on 02/04/11 at 10:10 AM with Licensed Practical Nurse (LPN) #1, revealed two (2) person should assist with turning Resident #17, as care	F 282	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> Re-education to be completed by Staff Development Coordinator/Designee on implementing all care plan interventions, as indicated on the care plan, for all nursing staff by 03/15/11. All new admissions will be reviewed within 24 hours of admit M-F and on Monday for weekend admits by Director of Nursing/Designee for 12 weeks beginning week of 03/07/11 to ensure care plan was updated and SRNA assignment sheet was completed accurately upon admit for all interventions. Audit will be completed weekly for 12 weeks beginning week of 03/07/11 by Unit Manager/Designee. 7 residents per unit will be observed to validate direct care staff following care plan interventions and deficient practice identified will be corrected immediately.	3/16/11	

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F 282	Continued From page 2 planned. LPN #1 stated the staff was educated after a fall on 12/24/10 to utilize two (2) staff when turning Resident #17. 2. Review of Resident #29's medical record revealed diagnoses which included Trochanteric Fracture, Edema, and Osteoporosis. Review of the Minimum Data Set Assessment (MDS), dated 08/06/10 revealed the facility assessed the resident as requiring assistance of staff for physical functioning. Review of the Plan of Care dated 07/30/10 revealed the resident was care planned for use of gait belt device with transfer. Review of medical record Incident Investigation dated 08/06/10 revealed State Registered Nurse Aide (SRNA) #10 failed to use a gait belt on 08/06/10, during transfers of Resident #29. Interview, 02/03/11 at 8:00 PM with SRNA #10 confirmed she failed to use a gait belt during transfers in the facility shower room on 08/06/10. Interview, with Administrator on 02/03/11 at 4:15 PM revealed she had talked to SRNA #10, on 08/06/10 about falling to follow the care plan and the SRNA was suspended until satisfactory skill demonstration was completed during Gait Belt Retraining conducted by Registered Nurse (RN) #2 on 08/10/10.	F 282	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> Administrator will observe 2 staff members weekly per unit for 12 weeks beginning week of 03/07/11 to ensure care plan interventions are being followed. Any deficient practice will be corrected immediately. All audits will be brought to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Director of Nursing Services (DNS), Registered Dietician (RD), Activities Director (AD), Social Service Director (SS), Case Manager (CM), Maintenance Director, Medical Director (MD), MDS Nurses, and the Dietary Manager every month for the next three months. The PIC will determine if further action is needed (All audits will be reviewed by the Committee and plan will be revised based on audit findings beginning month of April 2011	3/16/11	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323	F323 Harrodsburg Health Care Center will continue to ensure that the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents.		

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F 323	<p>Continued From page 3 prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one (1) of thirty-one (31) residents, (Resident #29). On 08/06/10, Resident #29 sustained a Hematoma to Right Lower Extremity (RLE) during care/transfers in the facility shower room. The Hematoma required wound care intervention including excision and evacuation of hematoma, dressing soaks and antibiotic therapy.</p> <p>The findings include:</p> <p>Review of Resident #29's medical record revealed diagnoses which included Trochanteric Fracture, Edema, and Osteoporosis. Review of the Minimum Data Set Assessment (MDS) dated 08/06/10, revealed the facility assessed the resident as requiring assistance of staff for physical functioning.</p> <p>Review of the August Physician Orders revealed the resident was on Coumadin, (a blood-thinner for anticoagulation).</p> <p>Review of Resident #29's medical record revealed diagnoses which included Trochanteric Fracture, Edema, and Osteoporosis. Review of the Minimum Data Set Assessment (MDS), dated 08/06/10 revealed the facility assessed the resident as requiring assistance of staff for</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Resident #29 no longer resides in facility</p> <p>Employee #10 is no longer employed at facility</p> <p>Facility wide audit was conducted for all in-house residents to validate care plan interventions were implemented to include supervision and/or assistive devices. This audit was conducted by Unit Manager/Designees through direct observation on 03/15/11. Any identified concern related to supervision, assistive devices or accident hazards was corrected immediately.</p> <p>Gait belt retraining was conducted with employee #10 at time of incident on 08/06/10. Employee was required to attend one on one training before returning to work.</p> <p>Gait belt retraining will be completed by Staff Development/Designee for all direct care staff to ensure proper usage by 03/15/11.</p> <p>In addition, the Staff Development Coordinator conducted education with all facility staff regarding providing an environment that is free of accident hazards to include, but not limited to, restraints, equipment, nonslip surfaces, appliances, cleaning supplies, side rails, hand rails and water temperatures.</p>	3/16/11

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F 323	Continued From page 4 physical functioning. Review of the Plan of Care dated 07/30/10, revealed the resident was care planned for use of gait belt device with transfer. Review of medical record Incident Investigation dated 08/06/10, revealed State Registered Nurse Aide (SRNA) #10 failed to use a gait belt on 08/06/10 during transfers of Resident #29. Interview, 02/03/11 at 8:00 PM with SRNA #10 confirmed she failed to use a gait belt during transfers in the facility shower room on 08/06/10. Interview, with Administrator on 02/03/11 at 4:15 PM revealed she had talked to SRNA #10, on 08/06/10 about failing to follow the care plan and the SRNA was suspended until satisfactory skill demonstration was completed during Gait Belt Retraining conducted by Registered Nurse (RN) #2 on 08/10/10.	F 323	All new admissions will be reviewed within 24 hours of admit M-F and on Monday for weekend admits by Director of Nursing/Designee for 12 weeks beginning week of 03/07/11 to ensure care plan was updated and SRNA assignment sheet was completed accurately upon admit for care plan interventions. Unit Manager/Designee will monitor 7 residents per unit weekly for 12 weeks beginning week of 03/07/11 to ensure direct care staff is following care plan and following all interventions. Any deficient practice will be corrected immediately. All audits will be brought to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Director of Nursing Services (DNS), Registered Dietician (RD), Activities Director (AD), Social Service Director (SS), Case Manager (CM), Maintenance Director, Medical Director (MD), MDS Nurses, and the Dietary Manager every month for the next three months. Review to begin April 2011. The PIC will determine if further action is needed.	3/16/11
F 325 SS=G	489.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced	F 325	F325 The facility did not fail to maintain the nutritional status for resident #5. The facility discussed residents #5 nutritional status with her surviving children/health care surrogate on numerous occasions.	

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F 325	<p>Continued From page 6 for 120 milliliters of the house nutritional supplement three (3) times per day ordered on 12/29/10.</p> <p>Review of the first eight (8) days of January 2011 Meal Intake form revealed an average meal intake of 14.8 percent. Review of the Individual Resident Weight History revealed Resident #5 weighed 101.3 pounds on 01/08/11. The weight loss from 12/06/10, at 112.2 pounds, through January 01/08/11, at 101.3 pounds, is a 9.7% weight loss in one month which is a severe weight loss.</p> <p>Record review further revealed Resident #5 was hospitalized from 01/08/11 to 01/14/11. Review of the physician's order dated 01/14/11 revealed the physician had determined Resident #5 as Incapable of making his/her own health decisions. Review of the last seventeen (17) days of the January 2011 meal intake form revealed an average meal intake of 12.7%.</p> <p>Review of a referral to rehabilitation services for Resident #5, dated 01/22/11, revealed Resident #5 had a recent change in activities of daily living, a change in eating behavior including decreased oral intake, drooling, coughing while eating or drinking and weight loss. The referral continued to elaborate the resident was eating eleven (11) percent on average and had significant weight loss. The Speech Pathologist documented she had spoken with the resident's family, not the designated Health Care Surrogates, Family Members #1 and #2, who indicated they felt the resident's poor nutrition intake was related to advanced dementia and was comfortable with him/her primarily getting hydration orally. She further indicated the resident was unable to</p>	F 325	<p>All residents with significant weight loss per protocol and who has the potential to be affected by weight loss will be reviewed by the Interdisciplinary team (Director of Nursing, Activities Director, Unit Managers, Case manager and Dietician) per weight loss protocol of 2% or more in one week; 5% or more in one month.</p> <p>The Interdisciplinary Team will provide education to the health care surrogate and will validate understanding of the information/education through questioning the health care surrogate. In addition, the facility will ensure appropriate documentation of the education/information and the demonstrated understanding of the health care surrogate regarding alternate means of nutrition and interventions, if indicated, for weight loss are present by 03/15/11.</p> <p>Social Services/Designee will monitor all new admits with 48 hours of admit to determine if living will is present and face sheet has appropriate health care surrogate listed for next 12 weeks beginning 03/07/11. Any areas of deficient practice will be corrected immediately.</p>	3/16/11	

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F 325	<p>Continued From page 7</p> <p>participate in the evaluation secondary to cognitive status.</p> <p>Review of the Individual Resident Weight History revealed Resident #5 weighed 102.6 pounds on 01/31/11. Review of the Individual Resident Meal Intake form also revealed at no time was an alternative accepted during these three (3) months and on most days snacks were refused during these three (3) months.</p> <p>Review of Nursing notes revealed consistent documentation of decreased appetite and/or poor food intake, fluids being ordered and the resident's skin being described as dry November 2010 through February 2011.</p> <p>Record review further revealed a restart physician's order was noted for the date of 02/02/11 for 120 milliliters of the house nutritional supplement three (3) times per day.</p> <p>Observation on 02/03/11 at 11:30 AM revealed a nutritional supplement sitting on the resident's bedside unopened. Observation of the temperature taken revealed the supplement, which was milk based was seventy-seven (77) degrees Fahrenheit.</p> <p>Observation, on 02/04/11 at 11:55 AM, revealed CNA #1 was feeding the resident during the lunch meal time. CNA #1 was noted to pour milk into a plastic cup and offer the resident a drink which the resident accepted and appeared to swallow. Resident #5 was noted to lean his/her head forward and the aide attempted to offer the resident ice cream on a spoon, rubbed the ice cream on the resident's lips. The resident was noted to purse lips together and make a face. The</p>	F 325	<p>Executive Director will audit 5 charts weekly for 12 weeks beginning 03/07/11 to validate IDT team has reviewed weight loss and appropriate interventions are in place.</p> <p>DON to audit 5 weight losses weekly beginning week of 03/07/11 x 12 weeks to ensure that all weight loss is addressed per policy and family and Md notified of recommendation and that resident family wishes are followed.</p> <p>All audits will be brought to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Director of Nursing Services (DNS), Registered Dietician (RD), Activities Director (AD), Social Service Director (SS), Case Manager (CM), Maintenance Director, Medical Director (MD), MDS Nurses, and the Dietary Manager every month for the next three months. The PIC will determine if further action is needed</p>	3/16/11	

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F 325	<p>Continued From page 8</p> <p>aide offered the resident another drink of milk, the resident accepts, but did not appear to swallow; the aide attempted to offer another sip of milk to the resident and noticed milk was running out of the resident's mouth and down his/her chin. The aide waited approximately forty-five (45) seconds and attempted to offer another drink of milk which the resident accepted and appeared to swallow. The aide stated she was afraid to feed the resident anymore because she was concerned about the resident choking. The Resident was noted to begin coughing after the aide laid the bed back down from a ninety (90) degree angle to a thirty (30) degree angle.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, 02/03/11 at 12:30 PM revealed the resident did not eat or drink and indicated he/she would let food come back out of his/her mouth before being sent to the hospital on 01/08/11. She further indicated the resident's Power of Attorney (POA) had stated he had difficulty encouraging the resident to eat. Interview with CNA #2 on 02/03/11 at 12:50 PM revealed the nutritional shake the family, not the designated health care surrogates, said they had gotten the resident to drink was all over him/her. The CNA indicated the resident did not open his/her eyes to voice stimulation. She further stated it took fifteen (15) minutes to feed the resident to eat two (2) small bites of ice cream. She states she will try for thirty (30) minutes to feed the resident and if she was unable to feed the resident she asked other staff to try and ninety (90) percent of the time the other staff would have no success feeding the resident.</p> <p>Interview with CNA #2 on 02/04/11 at 9:55 AM revealed she was unable to state how long the resident had decreased responsiveness and</p>	F 325			

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F 325	<p>Continued From page 9</p> <p>indicated it may have been over one (1) month. She further indicated if she worked four (4) days maybe one (1) of the four (4) days the resident would open his/her eyes. She further indicated Resident #5 had a previous episode of decreased responsiveness in November but had "come back to himself/herself." Interview with CNA #3 on 02/04/11 at 10:05 AM revealed the resident had a "dramatic" change in cognition after returning from the hospital and was less alert. The CNA stated before the last hospital admit staff could get the resident to drink a whole milk, a bowl of ice cream and maybe eat some of the entree from a meal.</p> <p>Interview with LPN #4 on 02/04/11 at 11:20 AM revealed the resident had decreased responsiveness for the past month and before this time he/she had good days and bad days. LPN #4 further indicated the resident would eat some days and not on other days. She indicated the family was able to get the resident to eat better than staff. She further stated the Physician believed it was time to place a gastrostomy tube (feeding tube) or let the resident go because he/she was old and tired.</p> <p>Interview with Registered Nurse (RN) #4, on 02/03/11 at 2:15 PM, revealed Resident #5 was more alert and able to feed until approximately two (2) months ago.</p> <p>Interview with the Registered Dietitian (RD) on 02/03/11 at 11:45 AM revealed the resident weighed 112.2 pounds on 12/29/10 and on 12/27/10 the resident's Peractin (an appetite stimulant) had been discontinued and Megace (an appetite stimulant) had been ordered. She also noted, the resident refused snacks. The</p>	F 325		

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F 325	<p>Continued From page 10</p> <p>resident's average meal intake was thirteen (13) percent (based on a seven (7) day review of meal intake), she had recommended to liberalize the diet from no added salt mechanical soft to regular mechanical soft diet, 120 milliliters of the house nutritional supplement three (3) times a day. The order was obtained for a regular mechanical soft diet and 120 milliliters of the house nutritional supplement on 12/29/10. She further indicated on 01/28/11 she had reviewed Resident #5's medical record and determined the resident was eating eleven (11) percent of meals on average based on seven (7) days of meal intake. The RD also stated on 01/28/11, she again recommended 120 milliliters of the house nutritional supplement three (3) times each day because it had not been restarted when the resident returned from the hospital on 01/14/11 and also recommended a Speech therapy evaluation. The RD further noted in the resident's chart there was a nursing note which read the Speech Pathologist had discussed placement of a feeding tube on 02/02/11.</p> <p>Interview with the Speech Pathologist on 02/03/11 at 7:55 PM revealed she had screened the resident because nursing called regarding difficulty getting the resident to eat. She further indicated she had spoken with a family member and they stated the family was able to get the resident to eat; and, as long as they could get him/her to drink they were pretty happy. She further stated she discussed with the family member what she does as a Speech Pathologist and did not discuss tube feeding because she would not feel comfortable discussing this without having completed an evaluation first and the resident was not alert enough to do an evaluation.</p> <p>Interview with the resident's Physician on 02/2/11</p>	F 325		

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F 325	<p>Continued From page 11</p> <p>at 4:58 PM revealed he had been notified of the resident's weight loss. The Physician further stated he had ordered fluids when the family expressed concern because Resident #5 was not eating or drinking; however, supervision was needed secondary to the resident's Congestive Heart Failure. He further indicated he had not discussed tube feeding with the family.</p> <p>Phone interview with one of the Health Care Surrogates #1, on 02/04/11 at 10:15 AM, revealed they had not spoken with the Speech Pathologist about tube feeding placement. She indicated it may have been another family member and provided contact information for the family member. The family member further indicated they were unable to visit often and was unaware of all details of the resident's condition.</p> <p>Phone interview with a member of the resident's family (who was not designated as one of the two primary Health Care Surrogates), on 02/04/11 at 10:55 AM, revealed someone may have mentioned a feeding tube in passing. She stated she believed someone from the facility staff stated the resident needed a feeding tube because the resident had not eaten much at the time. The family member did not recall when this was or who had made the statement.</p> <p>Phone interview with another family member, not the Health Care Surrogates, on 02/04/11 at 12:50 PM revealed he noticed a change in the resident's cognition approximately three (3) weeks ago. He further indicated the resident "quit eating and now acts like he/she cannot drink." He further stated it seemed like the resident will hold drinks in his/her mouth, will swallow hard or blow out of his/her mouth when trying to offer him/her a drink. He</p>	F 325			

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F 325	Continued From page 12 stated staff will tell him the resident was giving up, "things you don't want to hear". This family member revealed the facility had not discussed the option of a feeding tube for Resident #5. Interview with Resident #5's Physician on 02/04/11 at 5:30 PM, revealed he believed his/her status was steadily decreasing and it had been an ongoing issue of how the resident will "clamp" his/her mouth closed. He further stated with staff feeding the resident it may take thirty (30) minutes to feed one bite so the facility did encourage family to feed the resident because it was not feasible for staff. While the facility had taken steps to improve Resident #5's weight and implemented a nutrition supplement, changing the resident's diet, involving the family to assist in feeding the resident, there was no documented evidence, nor interview to confirm or validate that the facility notified the Health Care Surrogates in order to determine a course of action related to the resident's weight loss and the consideration of a feeding tube in order to prevent further severe weight loss.	F 325		03/16/11	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 All residents with the exception of those who receive nutrition solely by alternative means have the potential to be affected by this deficiency. Employee #10, 11,12 will receive one on one training regarding deficient practice identified during state survey by dietician by 03/15/11.		

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F 371	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to follow policy and procedure for hand sanitation during meal service. The findings include: Observation during the lunch meal service on 02/02/11 at 11:30 AM and at 11:35 AM, revealed Cook #10 opened the refrigerator door obtained sausage patties from the refrigerator, opened the microwave door to place the sausage patties inside and did not wash his hands before returning to the trayline to plate residents' food. Observation on 02/02/11 at 11:50 AM revealed Dietary Aide #11 opened the refrigerator door and did not wash hands prior to returning to trayline. Observation on 02/02/11 at 11:55 AM revealed Cook #10 opened the oven and did not wash hands before returning to trayline. It was also noted he took chicken patties from the oven and plated them for residents without having taken the temperatures prior. Observation on 02/02/11 at 12:00 PM revealed Dietary Aide #11 opened the milk cooler and did not wash his hands before returning to trayline. Observation on 02/02/11 at 12:05 PM revealed Dietary Aide #11 opened the refrigerator and did	F 371	All dietary staff will be re-educated by licensed dietician on proper food storage and handling, proper hand washing and infection control by 03/15/11. Sanitation rounds are conducted daily by the Registered Dietician/ Nutrition Services Manager or designee Dietary Manager/Dietician will observe daily for 12 weeks proper food handling, storage and infection control to ensure compliance. Administrator will conduct weekly dietary rounds to review for proper food storage and handling and infection control.	3/16/11

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F 371	<p>Continued From page 14 not wash his hands.</p> <p>Observation on 02/02/11 at 12:05 PM revealed Cook #10 opened the walk-in refrigerator door and did not wash their hands prior to returning to trayline. It was noted the Cook returned to the walk-in refrigerator a second time and did not wash his hands prior to returning to trayline.</p> <p>Observation on 02/02/11 at 12:10 PM revealed Cook #10 opened the oven to obtain a chicken patty and did not wash hands prior to returning to trayline.</p> <p>Observation on 02/02/11 at 12:12 PM revealed Dietary Aide #12 opened the walk-in freezer to obtain an ice cream and did not wash his hands prior to returning to trayline.</p> <p>Observation on 02/02/11 at 12:18 PM revealed Cook #10 touched his/her nose with the back of their hand and did not wash their hands prior to returning to resident trayline to serve food.</p> <p>Interview with Cook #10, Dietary Aide #11 and #12 on 02/2/11 at 12:20 PM revealed they should have washed their hands before returning to the trayline after performing other tasks such as using the microwave or opening the refrigerator/freezer.</p> <p>Interview with the Dietary Manager on 02/02/11 at 12:55 PM revealed Cook #10 had told her he had</p>	F 371	<p>All audits will be brought to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Director of Nursing Services (DNS), Registered Dietician (RD), Activities Director (AD), Social Service Director (SS), Case Manager (CM), Maintenance Director, Medical Director (MD), MDS Nurses, and the Dietary Manager every month for the next three months. The PIC will determine if further action is needed</p>	3/16/11

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F 371	Continued From page 15 taken the temperature of the chicken patties while cooking, however had not taken the temperature while holding them in the oven.	F 371			
F 441 SS=D	Review of the facility's policy titled "Handwashing," dated 04/28/07, revealed hands should be washed after touching bare parts of the body other than clean hands and clean, exposed portions of arms. Further review revealed hands should be washed after handling soiled equipment or utensils. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	F441 LPN # 2 no longer employed at facility. Infection control and wound dressing check off was completed immediately with nurse # 2 on 02/04/11 prior to OIG exit. All residents with orders for wound dressings were observed during dressing changes to ensure appropriate infection control techniques were implemented. Any concern identified was corrected immediately. Skills check off and observation will be completed by Staff development Coordinator/ designee for all licensed staff to ensure that proper wound care dressing is completed, appropriate hand washing and protective equipment is present when indicated by 03/15/11. All areas of infection control policy will be reviewed in staff education by 03/15/11.	3/16/11	

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F 441	<p>Continued From page 16</p> <p>direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to have an effective system to prevent the spread of infection. Facility staff failed to follow infection control guidelines related to use of gowns, gloves, and hand washing during a dressing change for one (1) of thirty-one (31) sampled residents (Resident #2).</p> <p>The findings include:</p> <p>Review of the facility's policy "Infection Control and Prevention Program" revealed infected residents are isolated only to the degree needed to isolate the infecting organism. Residents with multiple drug resistant organism will be placed in a room with residents at low risk for infection. Review of the document provided by the facility, as the guidelines staff were to follow related to infections, revealed staff would use contract precautions while caring for residents with multiple organisms, such as Methicillin Resistant</p>	F 441	<p>In-servicing to be completed with licensed staff by Staff Development coordinator/designee on wound dressing changes and infection control policy by 03/15/11</p> <p>Unit manager/designee will conduct weekly audit on one licensed nurse, to include direct observation, of licensed staff completing wound dressing changes for 12 weeks to ensure compliance.</p> <p>In addition, the Director of Nursing, Staff Development Coordinator or the Unit Manager will conduct one observation of each unit per week to validate that appropriate infection control techniques are implemented in all care areas. Any concerns identified will be corrected immediately.</p> <p>Director of Nursing/Designee will review audits completed by Unit managers/Designee monthly to ensure compliance beginning April 1, 2011.</p>	3/16/11	

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F 441	<p>Continued From page 17</p> <p>Staphylococcus Aureus (MRSA). Per the guidelines, staff should use gloves if touching infectious material and gowns if soiling is likely.</p> <p>Review of the facility's "Pressure Ulcer Care" policy revealed staff were to treat all pressure ulcers as contaminated. Additionally, staff were to use the appropriate personal protective equipment (PPE). The PPE could include but was not limited to gloves, gowns, face shields, and face masks. Clean technique was to be used when performing treatments to pressure ulcers.</p> <p>Review of the clinical record for Resident #2 revealed he/she was admitted to the facility with pressure ulcers to the right buttock and bilateral lower extremities. Additionally, the wounds were infected with MRSA.</p> <p>Interviews, on 02/03/11 at 11:06 AM, with the Infection control nurse, Registered Nurse (RN) #2 revealed staff were to wear gloves when providing treatment to Resident #2 due to the risk of contamination. Additionally, RN #2 stated when performing wound care, gloves should be changed and hands washed after removing the old dressing, after cleaning the wounds, and after completion of the treatment.</p> <p>Interviews, on 02/02/11 at 10:15 AM, with the Unit Manager and RN #1 revealed staff should wear gowns when caring for Resident #2's wound due to a risk of contamination. Additionally, the two (2) nurses stated when performing wound care gloves should be changed and hands washed after removing the old dressing, after cleaning the wound, and after completion of the treatment.</p> <p>Observation, on 02/01/11 at 4:16 PM, revealed</p>	F 441	<p>All audits will be brought to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Director of Nursing Services (DNS) Registered Dietician (RD), Activities Director (AD), Social Service Director (SS), Case Manager (CM), Maintenance Director, Medical Director (MD), MDS Nurses, and the Dietary Manager every month for the next three months. The PIC will determine if further action is needed</p>	03/16/11	

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F 441	Continued From page 18 Licensed Practical Nurse (LPN) #2 preformed a dressing change on Resident #2. The LPN offered a gown to the surveyor prior to beginning the treatment. LPN #2 and the State Registered Nurse Aide (SRNA) assisting her did not wear a gown during the treatment. Additionally, the LPN removed the old dressing, and changed her gloves without washing her hands. She then cleaned the wound and applied the new dressing without changing her gloves. After completing the dressing change to Resident #2 buttocks, LPN #2 verified the treatment orders for the bilateral lower extremity. After verifying the orders, the LPN returned to Resident #2's room to perform the treatments to the bilateral lower extremities. The LPN placed a towel under the resident's left foot and began the treatment. LPN #2 removed the soiled dressing wrapped around the resident's foot. The LPN removed her gloves and exited the room without washing her hands. The LPN returned to the room put on clean gloves and proceeded to remove the adhesive dressing from the heel and clean the wound to the left heel. After cleaning the wound, the LPN applied ointment to the new adhesive dressing and placed the dressing over the resident's wound. The LPN did not change her gloves and wash her hands prior to applying the new dressing. After wrapping the resident's foot with a gauze dressing the LPN removed her gloves and washed her hands. LPN #2 put on clean gloves and moved the towel from under Resident #2's left foot and placed the towel under the resident's right foot. She removed the soiled dressing and removed her gloves, but did not wash her hands. The LPN obtained the new dressing supplies and opened the supplies. After putting on clean gloves the LPN cleaned the wound to the right ankle and applied a new dressing without changing gloves.	F 441		

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F 441	Continued From page 19 Once the new dressing was in place LPN #2 removed her gloves and applied tape to the dressing. LPN #2 then proceeded to put on new gloves and placed the towel used during the dressing change into a plastic bag. After placing the towel in the bag, the LPN used her gloved hand to remove the charge stickers from the supplies used during the dressing changes. Interview, on 02/04/11 at 10:45 AM, with LPN #2 revealed she was not aware of the lack of glove changes and hand washing. The LPN stated she should have changed her gloves and washed her hands between each step of the dressing change. Additionally, LPN #2 stated it was her option as to whether or not to wear the gown during the dressing change. The LPN explained with contact precautions she would not wear a gown.	F 441		
F 514 SS=D	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was	F 514	F514 Harrodsburg Health care will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented, readily accessible; and systematically organized. Resident #4 code status is correct per care plan, physician orders and chart. All documents are in chart. A chart audit of all in-house residents was completed by MDS coordinator on 02/07/11 to ensure all components of code status are present in chart. Review included physicians order, chart spine and care plan. Any concerns identified were corrected immediately. All new admissions will be reviewed by MDS Coordinator/Social Services/Designee within 24 hours of admit to ensure appropriate documentation is present for DNR status for the next 12 weeks beginning week of 03/07/11.	

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F 514	<p>Continued From page 20</p> <p>determined the facility failed to maintain accurate clinical record information related to code status for one (1) of thirty one (31) sampled residents (Resident #4).</p> <p>Resident #4 was a Full Code Status; however, the Comprehensive Plan of Care noted the Resident Code Status to be Do Not Resuscitate (DNR).</p> <p>The findings include:</p> <p>Review of the Comprehensive Plan of Care, dated 01/26/11, revealed Resident #4's code status was DNR. However, review of the Advance Directives revealed the resident was a full code status. Observation of the resident's medical chart revealed the resident's status was also designated by the sticker on the front of the medical chart as " full code".</p> <p>Review of the Resident Progress Notes, dated 01/26/11 referenced a phone conference with Resident #4's Power of Attorney (POA) which confirmed his/her "Full Code" Status. Continued review revealed Social Services would send the POA the required documents to complete to initiate the change from Full Code to DNR for Resident #4.</p> <p>Interview with Social Services Director on 02/03/11 at 4:00 PM , revealed that during a Care Plan Phone Conference with the POA on 01/26/11, the facility informed him/her of additional paperwork (Kentucky Emergency Medical Transportation Form) the facility needed signed to initiate the request for a physician's order to make a resident DNR. Further interview revealed on 01/28/11, she mailed the forms to the POA with instructions for the process of changing</p>	F 514	<p>Social Services and MDS coordinator will continue to monitor code status and update with each care plan meeting and/or annual assessment whichever is first. Admissions Coordinator will ensure all appropriate documentation is presented upon admission per clinical record standards. Social Services/Designee will follow up with chart review for all new residents within 48 hours of admission to ensure all information is present. Any areas of concern will be immediately addressed and items retrieved.</p> <p>Medical Records Clerk will complete audit quarterly to ensure that all items are present. Any deficient practice will be corrected immediately.</p> <p>Re-education will be completed by Staff Development Coordinator/Designee on maintaining clinical record and DNR status and appropriate steps by 03/15/11</p> <p>Administrator to monitor compliance of admission audit weekly beginning week of 03/07/11 for 12 weeks to ensure clinical record is being maintained in accordance to F514.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/04/2011
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NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330
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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)	(X6) COMPLETION DATE
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F 614	Continued From page 21 Resident #4's Full Code status to DNR.	F 514		
F 520 SS=D	<p>Interview with the MDS Coordinator on 02/03/11 at 4:15 PM, revealed she had incorrectly changed the status on the Comprehensive Plan of Care to DNR before all the required documents were completed. She stated she would make the correction immediately to accurately reflect Full Code Status for Resident #4.</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 520	<p>All audits will be brought to the Performance Improvement Committee (PIC) which includes the Executive Director (ED Director of Nursing Services (DNS), Registered Dietician (RD), Activities Director (AD), Social Service Director (SS), Case Manager (CM), Maintenance Director, Medical Director (MD), MDS Nurses, and the Dietary Manager every month for the next three months. The PIC will determine if further action is needed</p> <p>F520</p> <p>Employee #2 demonstrated competencies in sterile dressing change on 02/15/10; demonstrated competency in hand washing on 03/23/10; received education on the plan of correction to include infection control from the 04/01/10 annual survey on 05/11/2010; Received education on infection control precautions and hand washing on 11/01/10; and again demonstrated competency of sterile dressing change on 02/4/11</p> <p>Employee nurse # 2 no longer employed at facility.</p> <p>Staff Development/Designee will validate competencies for all licensed nurses for return demonstration on Infection control practices to include hand washing precautions, dressing changes, PPE and Infection Control Policy by 03/15/11. All areas of concern will be addressed during return demonstration to ensure no deficient practice.</p> <p>Unit manager/designee will conduct weekly audit on 1 license employee to include direct observations of licensed staff completing wound dressing changes and following infection control protocol techniques for care provided for 12 weeks beginning 03/14/11</p>	03/16/2011

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NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 520	<p>Continued From page 22</p> <p>by: Based on observation and interview it was determined the facility failed to have an effective quality assurance program related to infection control.</p> <p>The findings include:</p> <p>Review of the facility's history of deficient practice revealed the facility was cited for infection control problems, on the 04/01/10 (annual survey) and on 10/30/09 (abbreviated/complaint survey). On 04/01/10, the facility was cited related to licensed nurses placing test strips soiled with blood into the trash and removing soiled glucose test strips from the glucometer with ungloved hands. On 10/30/09, the facility was cited for infection control breaches after nursing assistants failed to clean residents' buttocks after incontinent episodes and failed to perform hand hygiene between incontinent care and oral care.</p> <p>Observation, on 02/01/11 at 4:16 PM, revealed Licensed Practical Nurse (LPN) #2 performed wound care on Resident #2. During the observation the LPN failed to change gloves and perform hand hygiene to prevent the possible spread of infection. Additionally, the LPN failed to wear the appropriate Personal Protective Equipment (PPE) during the wound care. (Cross Reference F441).</p> <p>Interview, on 02/04/11 at 10:45 AM, with LPN #2 revealed she was not aware of her breaches in infection control.</p> <p>Interview, on 02/02/11 at 10:15 AM, with the Unit Manager revealed she had not observed LPN #2 during wound care. The Unit Manager stated she</p>	F 520	<p>the week of 03/14/11 to validate that appropriate infection control techniques are implemented in all care areas. Any concerns identified will be corrected immediately and skills check off will be completed one on one for employee to validate competencies and infection control.</p> <p>Director of Nursing will monitor wound changes audit supplied by Unit Manager/Designee monthly for 3 months beginning 04/01/11 to ensure compliance.</p> <p>The Executive Director will validate audits are conducted in accordance with the Plan of Correction through direct review.</p> <p>Skills checks off competencies are completed yearly and infection control re-education will be completed quarterly. Observation will be completed by Unit Manager/Designee on an ongoing basis to ensure infection control policy is being followed. One on one education will occur should deficient practice be identified.</p> <p>Areas of concern will be brought to Director of Nursing and then to Executive Director. All areas of concerns will be reviewed by Performance improvement committee to complete an action plan to eliminate infection control deficient practices.</p>	03/16/2011

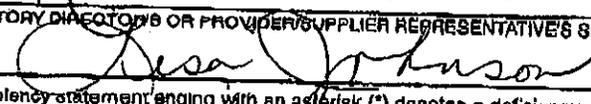
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NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330		
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F 520	<p>Continued From page 23</p> <p>tried to observe nurses during wound care to ensure they followed proper procedures.</p> <p>Interview, on 02/04/11 at 11:06 AM, with the Infection Control Nurse revealed she maintained documentation on infections in the building. The Infection Control Nurse stated she also observed staff as they performed care to ensure they used proper infection control measure. The nurse stated she used the information she gathered to make a monthly report to the Quality Assurance Committee. During the interview, the Infection Control Nurse stated she had not observed nurses perform wound care. She explained she had been focused on the nursing assistance, since she assumed the roll of the Infection control Nurse in July/August the past year.</p> <p>Based on the above interviews it was determined the facility failed to identify infection control issues which would need to be reviewed by the Quality Assurance Committee.</p>	F 520	<p>All audits will be brought to the Performance Improvement Committee (PIC) which includes the Executive Director (ED), Director of Nursing Services (DNS), Registered Dietician (RD), Activities Director (AD), Social Service Director (SS), Case Manager (CM), Maintenance Director, Medical Director (MD), MDS Nurses, and the Dietary Manager every month for the next three months. The PIC will determine if further action is needed</p> <p>In addition, the PIC met on 03/9/11 to evaluate the Performance Improvement / Quality Assurance Process in the facility. There were no areas identified by the PIC that would require changes of the Performance Improvement / Quality Assurance process. The Medical Director was notified of the PIC meeting and outcomes.</p> <p>The Executive Director will continue to facilitate the Performance Improvement Committee and will continue to validate that ongoing monitoring of all process areas is being conducted; that areas of concern are being identified; and that action plans are developed and implemented for areas of identified concern.</p> <p>The Medical Director will continue to attend the PIC on a quarterly basis.</p>	03/16/2011	

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NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330	
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K 000	INITIAL COMMENTS	K 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
K 018 SS-E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/2 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p>	K 018	<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>K018</p> <p>Resident room #105, 106 and 401 that were identified during survey that did not latch appropriately were corrected prior to survey exit on 02/04/11</p> <p>Garbage cans sitting in doorway in rooms 204 and 206 were removed from exit way.</p> <p>All resident room doors through out facility will be checked to ensure they latch appropriately. All rooms will be observed to ensure no trash cans or other items are in exit by 03/15/11 by Maintenance Director/Designee</p> <p>Maintenance Director/Designee will complete weekly audits for 12 weeks on all resident room doors to ensure they are latching properly and that room entry ways are kept clear from trash cans and other hazards.</p> <p>Executive Director will observe through direct observation auditing tools weekly for 12 weeks to ensure compliance</p> <p>All audits will be brought to the Performance Improvement Committee (Executive Director, Director of Nursing, Dietician, Social Services Director, Maintenance Director, MDS Nurse, Case Manager and Dietary Manager) every month for next three months. PIC will determine if further action is needed.</p>	03/16/2011
LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
 Lisa Johnson		Administrator		3/16/2011

RECEIVED
MAR 3 - 2011

RECEIVED
MAR 8 - 2011

This STANDARD is not met as evidenced by:
Based on observation and interviews, it was determined the facility failed to ensure resident room doors were maintained according to NFPA standards. The deficiency affected three (3) smoke compartments, ten (10) residents, staff

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185297	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/02/2011
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NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 659 LEXINGTON ROAD HARRODSBURG, KY 40330
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K 018	<p>Continued From page 1 and visitors.</p> <p>The findings include:</p> <p>Observation on 02/02/2011 at 1:40 PM, revealed resident room doors #105, 106, and 401 did not latch when pulled shut. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 02/02/2011 at 1:40 PM, with the Maintenance Director, revealed he was unaware of the doors not latching properly.</p> <p>Observation on 02/02/2011 at 2:00 PM, revealed trash cans were sitting in front of resident room doors #204 and 206. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 02/02/2011 at 2:00 PM, with the Maintenance Director, revealed he was unaware that trash cans were positioned in front of the doors.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors</p>	K 018		

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NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 653 LEXINGTON ROAD HARRODSBURG, KY 40330
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<p>K 018</p> <p>K 062 88-F</p>	<p>Continued From page 2 shall be constructed to resist the passage of smoke.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the sprinkler system was maintained according to NFPA standards. The deficiency has the potential to affect all smoke compartments, residents, staff and visitors.</p> <p>The findings include:</p> <p>Record review of the sprinkler system maintenance logs on 02/02/2011 at 2:45 PM, with the Maintenance Director, revealed no documented evidence the facility checked the valves located in the sprinkler system.</p> <p>Interview on 02/02/2011 at 2:45 PM, with the Maintenance Director, revealed he did not document monthly checks of valves located in the sprinkler system.</p> <p>Reference: NFPA 25 (1998 edition) 9-3.3.1 All valves shall be inspected weekly. Exception No. 1: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected</p>	<p>K 018</p> <p>K 062</p>	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>All Valves for sprinkler system will be inspected weekly except for the secured valves that may be checked monthly.</p> <p>Sprinkler system valve was checked to ensure in working condition prior to state exit on 02/04/11.</p> <p>Preventative maintenance form implemented to check sprinkler system valve weekly. This audit will be completed ongoing.</p> <p>Executive Director will monitor monthly to ensure sprinkler system valve is checked weekly for next 3 months.</p> <p>All audits will be brought to the Performance Improvement Committee (Executive Director, Director of Nursing, Dietician, Social Services Director, Maintenance Director, MDS Nurse, Case Manager and Dietary Manager) every month for next three months. PIC will determine if further action is needed.</p>	<p>03/16/2011</p>
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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)	(X6) COMPLETION DATE
K 062	Continued From page 3 monthly. Exception No. 2: After any alterations or repairs, an inspection shall be made by the owner to ensure that the system is in service and all valves are in the normal position and properly sealed, locked, or electrically supervised. 9-3.3.2* The valve inspection shall verify that the valves are in the following condition: (a) In the normal open or closed position (b) *Properly sealed, locked, or supervised (c) Accessible (d) Provided with appropriate wrenches (e) Free from external leaks (f) Provided with appropriate identification	K 062		