

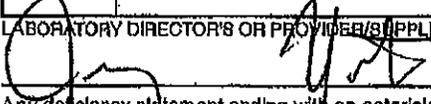
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  188174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/30/2011
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NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8976 BURLINGTON PIKE FLORENCE, KY 41042
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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
F 000	INITIAL COMMENTS	F 000		
F 246 SS=D	<p>A Recertification Survey was conducted 11/28/11 through 11/30/11. Deficiencies were cited, with the highest scope and severity of an "F".</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined the facility failed to ensure resident's food preference were met for one (1) of twenty-four (24) sampled residents, (Resident #9).</p> <p>The findings include:</p> <p>Observation of Resident # 9, on 11/28/11 at 6:10 PM, in the resident's room, revealed the resident was not eating his/her dinner consisting of meat, squash, green beans and carrots.</p> <p>Review on the meal ticket on Resident #9's tray, on 11/28/11 at 6:10 PM, revealed the resident's dislikes were listed as: squash, no seeds or nuts.</p> <p>Interview with Resident #9, on 11/28/11 at 6:10 PM, revealed he/she did not like squash or anything with seeds or nuts. The resident stated</p>	F 246	<p>P246 Reasonable Accommodation of Resident Needs/Preferences A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safe of the individual or other residents would be endangered.</p> <p>1. Resident #9 meal ticket was reviewed by DON and DON met with resident #9 on 11/28/2011 at 650pm interviewed resident related to preferences and dislikes also questioned resident about the meal she had received and offered food replacement resident stated she did not want anything else and she was fine.</p> <p>2. Resident #9 was not impacted by the alleged placement of squash on the resident's tray.</p> <p>3. A facility audit was conducted on 11/30/2011 by the nursing Administration team to ensure all resident's preferences and dislike was listed on meal ticket, were accurate and alternatives were being offered.</p> <p>4. All Registered Nurses, Licensed Practical Nurses, Kentucky Medication Aides, State Registered Nursing Assistants and dietary staff were in-serviced on the protocol for checking meal tickets for preferences and accuracy and food alternatives are being offered. The in-services were conducted on 12/16/2011, 12/17/2011 and 12/19/2011 by the DON. The staff development nurse coordinator or designee will ensure all new hire Register Nurses, Licensed Practical Nurses, Kentucky Medication Aides and State Register Nursing Assistance receive training on the protocol for checking dislikes on the meal ticket and offering food alternatives.</p> <p>5. A QA will be conducted by the DON or designee on 5 residents every week for 12 weeks to ensure the protocol for checking meal tickets for preferences and allergies, ensuring accuracy and offering food alternatives.</p> <p>6. The Administrator will ensure continued compliance.</p>	12/20/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12-19-11
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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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NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8876 BURLINGTON PIKE FLORENCE, KY 41042	
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F 246	Continued From page 1 that he/she did not tell anyone or request anything different.	F 246	F 323 Free of Accident Hazards/Supervision/Devices	
F 323 SS=D	Interview with Registered Nurse (RN) #1, on 11/30/11 at 1:15 PM, revealed the resident's meal preferences were supposed to be honored and he/she should not have had those items on his/her tray.  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 prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the resident environment remained free of accident hazards as evidenced by one (1) of two (2) treatment carts being unlocked and unsupervised by staff on the Memory Unit (A Wing).  The findings include:  Observation, on 11/29/11 at 12:05 PM, revealed an unlocked treatment cart. Observation of the contents of the treatment cart revealed one (1) eight (8) inch long "Phillips Head" screwdriver in the top drawer. The second drawer contained eight (8) AA "Duracell" batteries, loose from the	F 323	The facility must ensure that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  1. The three un-sampled residents were not impacted by the alleged action of the nurse of leaving of the treatment cart unlocked. The other residents on the Memory Care Unit were not impacted by the alleged action of the nurse of leaving of the treatment cart unlocked.  2. LPN #2 immediately ensured the treatment cart was locked on 11/29/2011 at 12:10pm. Nurse #2 was immediately in-serviced along with the other nurses on the unit on ensuring all carts are locked at all times when not in sight by the DON on 11/29/2011.  3. A facility audit was conducted on 11/29/2011 at 12:30pm by the nursing administration team to ensure all treatment and medication carts were locked.	

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F 323	Continued From page 2 packaging. The third drawer contained one (1) pair of "Needle Nose" pliers. The bottom drawer of the cart contained numerous topical lotions and creams. Also observed in the bottom drawer were loose plastic single-dose vials of Albuterol "mini-neb" used in respiratory breathing treatments.  Further observation of the unlocked cart revealed it was in the resident common area with no staff member attending the cart for a minimum of five (5) minutes. Three (3) unsampled, unsupervised residents came within arms reach of the cart during the five (5) minute observation period.  Interview with Licensed Practical Nurse (LPN) #2/Unit Manager of the A Wing, on 11/29/11 at 12:20 PM, revealed that per facility policy the treatment carts were to remain locked when unattended by staff. The Unit Manager further revealed that the observed objects within the treatment cart posed a potential hazard to the residents.	F 323	4. All Registered Nurses and Licensed Practical Nurses where in-serviced on the facility protocol to ensure all treatment carts are locked at all times when not in sight by the DON. These in-services were conducted on 12/16/2011, 12/17/2011 and 12/19/2011. The staff development coordinator or designee will ensure new hire Registered Nurses and Licensed Practical Nurses receive training on the protocol of ensuring all treatment and medication carts are locked at all times when not in sight.	
F 371 SS=F	489.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced	F 371	5. A QA will be conducted by the DON or designee ensuring that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents and the medication and treatment carts are locked at all times 2 x week for 12 weeks. The Unit Managers will monitor compliance each day Monday through Friday and the supervisor on Saturday and Sunday with walking rounds. 6. The Administrator will ensure continued compliance.	12/20/11

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F 371	<p>Continued From page 3 by: Based on observation, interview and review of facility's policy and procedures it was determined the facility failed to prepare and distribute food in a sanitary manner. Dietary staff failed to wash hands and change gloves when changing tasks. Additionally, staff did not have their hair contained inside hair coverings. The facility's failure had the potential to effect 132 of 138 residents.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Review of the facility's policy "Glove Use", dated 09/27/11, revealed gloves shall be used by dietary staff to separate hands and food and food-contact surfaces.</li> </ol> <p>Review of the facility's policy "Personnel Standards - Hand-washing and Hair Restraints", dated 09/27/11, revealed hands must be washed before putting on gloves, after removing gloves and after touching a resident, etc. The policy did not detail hands were to be washed when moving from one task to another.</p> <p>Observations, on 11/30/11 during the lunch meal from 11:30 AM until 1:20 PM, revealed the cook asked a dietary aide to get a potpie from the freezer. Dietary Aide #1 exited the kitchen and return a moment later with a potpie in the box. Dietary Aide #1 passed the potpie to Cook #1. Cook #1 opened the box and placed the potpie into the microwave. Then the Cook #1 resumed preparing trays for residents. Cook #1 did not change her gloves or wash her hands. After the potpie had finished cooking Cook #1 removed the potpie from the oven, checked the temperature and served the potpie. Then Cook #1 resumed</p>	F 371	<p>F 371 483.35 Food Procure, Store/Prepare/Serve-Sanitary</p> <p>The facility must procure food from sources approved or considered satisfactory by federal, state or local authorities and store, prepare, distribute and serve food under sanitary conditions.</p> <ol style="list-style-type: none"> <li>There were no negative outcomes to any residents due to the dietary staff failing to change gloves or wash their hands between glove changing.</li> <li>In-service conducted for all dietary staff on 12/17/11 in regard to proper glove usage and hand washing.</li> <li>Dietary Director or designee to complete QA's to monitor hand-hygiene/glove-changes are performed correctly and as required to ensure sanitary conditions are maintained. These QA's will be performed for one meal three times per week during meal preparation and service for one month, and then once weekly for three months to ensure that food is stored, prepared, distributed and served under sanitary conditions.</li> <li>Administrator will ensure compliance.</li> </ol>	

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F 371	<p>Continued From page 4</p> <p>serving trays without changing her gloves and washing her hands. Additional observation revealed the Cook #1 received a hamburger patty from the Dietary Manager. The hamburger patty was in a plastic bag and the Dietary Manager was not wearing gloves. Cook #1 shook the hamburger patty onto a saucer and placed it into the microwave. Cook # resumed preparing trays without changing her gloves and washing her hands. After the hamburger had cooked the Cook #1 removed it from the microwave tested the temperature and resumed preparing trays. Cook #1 did not wash her hands or change her gloves. Additionally, during observation of the tray line Cook #1 obtained hot water from the coffee maker twice. The first time she obtained hot water to thin pureed food. The second time she obtained hot water to make a bowl of quick oats. Cook #1 did not change her gloves or wash her hands prior to returning to the serving line and preparing residents' trays.</p> <p>Interview with Cook #1, on 11/30/11 at 1:32 PM, revealed she should have changed her gloves and washed her hands when she put the potpie and hamburger into the microwave and prior to returning to the tray line.</p> <p>Interview, on 11/30/11 at 3:14 PM, with the Dietary Manager revealed staff should change gloves and wash hands when changing from one task to another.</p> <p>2. Review of the facility's policy "Personnel Standards - Hand-washing and Hair Restraints", dated 09/27/11, revealed hair-nets or hats that effectively restrain head and facial hair must be worn at all times in food preparation areas.</p>	F 371	<ol style="list-style-type: none"> <li>There were no negative outcomes to any residents due to the dietary staff not wearing beardnets/hairnets.</li> <li>In-service conducted for all dietary staff on 12/17/11 in regard to proper hairnet/beardnet use.</li> <li>Dietary Director or designee to complete QA's to monitor hairnet/beard guard use required to ensure sanitary conditions are maintained. These QA's will be performed for one meal three times per week during meal preparation and service for one month, and then once weekly for three months to ensure that food is stored, prepared, distributed and served under sanitary conditions.</li> <li>Administrator will ensure compliance.</li> </ol>	12/20/11	

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F 371	<p>Continued From page 5</p> <p>Additionally, the policy detailed beard must be covered by a hair net or beard-guard.</p> <p>Observations, on 11/30/11 during the lunch meal from 11:30 AM until 1:20 PM, revealed Cook #1 had hair sticking out from under the hair-net on the right side of her face while preparing trays and food for residents. Additionally, Dietary Aide #6's hair-net was worn in a manner that allowed her hair to be exposed all the way around her head. The hair-net covered less than fifty (50) percent of her hair as she performed a variety of tasks within the food preparation areas. Furthermore, Dietary Aide #5 had a beard that was not covered by a hair-net or beard-guard. Dietary Aide #5 sliced ham and prepared grilled cheese sandwiches as needed during the observation of the tray line.</p> <p>Interview with Cook #1, on 11/30/11 at 1:32 PM, revealed the hair-net was to cover the whole head. The cook was not aware her hair was sticking out from under the hair-net.</p> <p>In interview, on 11/30/11 at 1:35 PM, Dietary Aide #6 stated the hair-net should cover all the hair. She stated the hair-net often slides around on her head.</p> <p>Interview, on 11/30/11 at 1:37 PM, with Dietary Aide #5 revealed facial hair was to be kept clean and covered.</p> <p>Interview, on 11/30/11 at 3:14 PM, with the Dietary Manager revealed hair-nets should be worn to restrain the hair covering all the hair on their head and beards.</p>	F 371		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 98=E	<p>Continued From page 6 SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>F 441 Infection, Prevent the Spread</p> <p>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.</p> <ol style="list-style-type: none"> <li>Resident #5, 6, 9, 10, and 13 did not have a negative impact by the alleged practice of not changing gloves.</li> <li>Resident # 13 did not have a negative impact by the alleged improper storage of the suction machine. Resident #13 was not using the suction machine. DON interviewed resident #13 on 11/28/2011. Resident #13 revealed that the suction machine was not in use and has not been needed "in a long time".</li> <li>Residents in room 214, 215, 216, 218, 219 and 220 did not have a negative impact from alleged improper storage of bed pans, urinals, or urine graduates.</li> <li>LPN # 1 and LPN # 5 were immediately educated and in serviced by the DON on 11/29/2011 at 2:00pm on performing skin assessments and changing of gloves.</li> </ol>	

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F 441	Continued From page 7  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility's policy and procedures it was determined the facility failed to have an effective system in place to prevent the development and transmission of disease and infection, for five (5) of twenty-four (24) sampled residents (Residents #5, 6, 9, 10 and 13). Staff failed to change gloves and wash their hands during skin assessments for the five (5) residents. Further, the facility failed to ensure resident equipment such as bedpans, urine graduates and suction machines were stored in a manner to prevent infection or contamination.  The findings include:  1. Review of the facility's policy "Standard Precautions (Gloves)", not dated, revealed gloves should be changed between tasks and procedures on the same resident after contact with material that may have a high concentration of microorganisms.  Review of the facility's policy "Skin Assessment", not dated, revealed gloves were to be worn during skin assessments. Additionally the policy detailed the skin assessment was to be complete from head to toe and front to back. Furthermore, the policy stated gloves were to be changed between task and procedures on the same resident after contact with material that may contain a number of microorganisms.  Observation, on 11/29/11 at 11:00 AM, revealed	F 441	5. The suction machine belonging to resident #13 was immediately placed in a plastic bag, removed from room, sanitized and returned to central on 11/28/2011 by DON.  6. The bed pans, urinals and/or urine graduates in rooms 214, 215, 216, 218, 219 and 220 were discarded and replaced by with new items labeled with the resident's name on 11/28/2011 by DON.  7. A facility audit was conducted on 12/01/2011 by the Nursing Administration team to ensure proper protocol being followed for performing skin assessments, changing gloves and proper storage of medical equipment.	

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F 441	<p>Continued From page 8</p> <p>Licensed Practical Nurse (LPN) #5 completed a skin assessment for Resident #6. The LPN started at the resident's toes and proceeded up the body to the head. The nurse did not change her gloves and wash her hands after assessing Resident #6's perineal area. After assessing the perineal area LPN #5 assessed the resident from the waist to the head.</p> <p>Observation, on 11/29/11 at 11:15 AM, revealed LPN #5 completed a skin assessment on Resident #13. The LPN assessed the resident's perineal area and did not change her gloves and wash her hands before she proceeded to the assess the resident from the waist up, ending at the head. Record review revealed Resident #13 was on contact precautions due to an Urinary Tract Infection with Escherichia Coli Extended-Spectrum Beta-Lactamases (ESBLs). ESBLs organisms produce enzymes which reduce the effectiveness of Third Generation Cephalosporins (antibiotics).</p> <p>During an observation of a skin assessment on Resident #10, on 11/29/11 at 11:30 AM, LPN #5 stated she needed to collect a stool specimen for Clostridium Difficile (an infectious organism). The LPN collected the specimen and proceeded to assess the resident from the waist to the head. The nurse did not change her gloves or wash her hands after collecting the stool specimen.</p> <p>Interview, on 11/29/11 at 5:00 PM, with LPN #5 revealed she started at the feet and worked up to the head. In further interview LPN #5 stated she should have changed her gloves after she collected the stool specimen.</p>	F 441	<p>8. All Registered Nurses, Licensed Practical Nurses and State Registered Nursing Assistants were in-serviced on the protocol for performing skin assessments, changing gloves, and proper storage of medical equipment, and maintaining safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The in-services were conducted on 12/16/2011, 12/17/2011 and 12/19/2011 by the DON. The staff development nurse coordinator or designee will ensure all new hire Register Nurses, Licensed Practical Nurses and State Registered Nursing Assistants receive training on performing skin assessments, changing gloves and proper storage of medical equipment and maintaining safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>9. A QA will be conducted by the DON or designee of 5 residents every week for 12 weeks to ensure the protocol for to ensure the protocol for performing skin assessments, changing gloves and proper storage of medical equipment and maintaining a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection is implemented.</p> <p>10. The Administrator will ensure continued compliance.</p>	12/20/11	

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NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8978 BURLINGTON PIKE FLORENCE, KY 41042		
(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 441	<p>Continued From page 9</p> <p>Observation, on 11/29/11 at 3:30 PM, revealed LPN #1 conducted a skin assessment on Resident #5. The nurse conducted the skin assessment from toe to head. The nurse did not change her gloves or wash her hands after she removed the resident's brief and assessed the perineal area LPN #1 then proceeded to complete the assessment and examination of the face, ears and head.</p> <p>Observation, on 11/29/11 at 4:36, revealed LPN #1 completed a skin assessment on Resident #9. LPN #1 did not change her gloves and wash her hands after assessing the perineal area of Resident #9. After she assessed the perineal area the nurse proceeded to complete the assessment from the waist to the head.</p> <p>Interview, on 11/29/11 at 5:16 PM, with LPN #1 revealed she was not aware she had not changed her gloves and washed hands after assessing the resident's perineal area and prior to assessing the upper body. She state the perineal area should be assessed last because it is not clean.</p> <p>Interview, on 11/29/11 at 5:16 PM, with Registered Nurse (RN) #4 revealed skin assessments were to be conducted from head to toe and gloves were to be changed after assessing the perineal area before proceeding to other parts of the body.</p> <p>Interview, on 11/30/11 at 2:56 PM, with RN #1 revealed gloves should be changed after assessing the perineal area to prevent contamination of other body parts.</p> <p>Interview, on 11/30/11 at 3:30 PM, with the</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042
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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
F 441	<p>Continued From page 10</p> <p>Director of Nursing (DON) revealed gloves were to be changed after assessing the perineal area and before proceeding to other body parts.</p> <p>2. Observation, on 11/28/11 at 3:20 PM, during initial tour, revealed a suction machine on the toilet room floor of Resident #12's room. The equipment was not bagged, tagged or sitting on any type of barrier.</p> <p>Interview with Resident #12, on 11/28/11 at 6:12 PM, in the resident's room, revealed the suction machine was for him/her and that it had not been used in a long time.</p> <p>Interview with RN #1, on 11/30/11 at 1:05 PM, revealed the suction machine should have been bagged and tagged and placed in the dirty utility room, not in the resident's bathroom floor because it was an infection control issue.</p> <p>3. Observation during the initial tour of the facility, on 11/28/11 between 3:20 PM and 5:00 PM, revealed the following:</p> <p>Room #214- a bedpan with brown material in it was lying in the floor of a shared bathroom, not bagged or labeled.</p> <p>Room #215- a bedpan was wedged between the handrail and the wall of a shared bathroom, not labeled or bagged.</p> <p>Room #216- a bedpan was lying on the floor of a shared bathroom, not bagged or labeled.</p> <p>Room #218- a bath basin was sitting on the floor of a shared bathroom, not bagged or labeled.</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6078 BURLINGTON PIKE FLORENCE, KY 41042	
(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 441	<p>Continued From page 11</p> <p>Room #219- two (2) bedpans were lying in the floor of the shared bathroom, one (1) bedpan had brown material in it, neither were labeled or bagged.</p> <p>Room #220- a graduate used for emptying urine from a urinary drainage bag was sitting on the sink of a shared bathroom, not labeled or bagged.</p> <p>Interview with LPN #3, on 11/28/11 at 6:20 PM, at the nursing station, revealed bedpans, bath basins, and urine graduates were suppose to be in bags and labeled with that resident's name for infection control measures.</p> <p>Interview with RN #1, on 11/30/11 at 1:06 PM, in the conference room, revealed bedpans, urine graduates and bath basins should be labeled with the resident's name and bagged for infection control measures and to prevent cross contamination.</p>	F 441		

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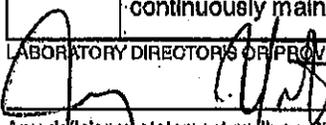
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  11/29/2011
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NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6678 BURLINGTON PIKE FLORENCE, KY 41042
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type V (000)</p> <p>Smoke Compartment: Eleven (11)</p> <p>Fire Alarm: Fire alarm with single station smokes in resident rooms</p> <p>Sprinkler System: Complete sprinkler system (wet and dry)</p> <p>Generator: Type II. Diesel Installed 1999</p> <p>A standard Life Safety Code survey was conducted on 11/29/11. Florence Park Care Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was one hundred thirty seven (137). The facility is licensed for one hundred fifty (150).</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating</p>	K 000		
K 062 SS=E		K 062	<p>This plan of correction shall operate as Florence Park Care Center's written credible allegation of compliance. This plan of correction is not meant to establish any standard of care, contact, obligation, or position and Florence Park Care Center reserves the rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12-19-11
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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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NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042	
(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	<p>Continued From page 1 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 observation and interview, it was determined the facility failed to ensure the sprinkler system was maintained according to National Fire Protection Association (NFPA) standards. Sprinklers must be maintained to ensure their reliability during a fire. The deficiency had the potential to affect three (3) of eleven (11) smoke compartments, fifty two (52) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation, on 11/29/11 at 11:10 AM, revealed the sprinkler piping located above the drop ceiling of the C Wing Hall was being used to support various wires. The observation was confirmed with the Maintenance Director.</p> <p>Interview, on 11/29/11 at 11:10 AM, with the Maintenance Director, revealed he was not aware of the sprinkler piping being used to support the various wires.</p> <p>Reference: NFPA 25 (1998) 2-2.2* Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, corrosion, and misalignment. Sprinkler piping</p>	K 062	<p>K 062 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> <ol style="list-style-type: none"> <li>1. There were no negative outcomes to any residents due to the sprinkler piping supporting various wires.</li> <li>2. In-service was conducted on 12/15/11 by the Administrator with the maintenance director with regard to keeping wires off of the sprinkler piping.</li> <li>3. Maintenance Director began removing wires from the sprinkler piping on 12/16/11.</li> </ol>	12/30/11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  11/29/2011
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6978 BURLINGTON PIKE FLORENCE, KY 41042		
(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)	(X4) COMPLETION DATE	
K 062	Continued From page 2 shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. Exception No. 1:* Pipe and fittings installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Pipe installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062			
K 130 SS=F	NFPA 101 MISCELLANEOUS  OTHER LSC DEFICIENCY NOT ON 2786  This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure single station smoke detectors were maintained according to National Fire Protection Association (NFPA) standards. Single station smoke detectors must be maintained according to NFPA and the manufactures requirements to ensure their reliability to detecting smoke. The deficiency had the potential to affect eleven (11) of eleven (11) smoke compartments, one hundred fifty (150) residents, staff and visitors.  The findings include:  Record review of the facility's smoke detector inspection reports, on 11/29/11 at 12:04 PM,	K 130	K 130 NFPA 101 Miscellaneous  1. There were no negative outcomes to any residents due to the absence of documentation of maintenance to the smoke detectors. 2. In-service was conducted on 12/15/11 by the Administrator with the maintenance director with regard to conducting monthly checks on all smoke detectors. 3. Developed a documenting procedure on 12/15/11 and all checks will be documented monthly and kept in the maintenance log.	12/15/11	



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K 144	<p>Continued From page 4</p> <p>Based on observation and interview, it was determined the facility failed to ensure the emergency generator was maintained according to National Fire Protection Association (NFPA) standards. Emergency generators must be maintained to ensure their reliability in an emergency. The deficiency had the potential to affect eleven (11) of eleven (11) smoke compartments, one hundred fifty (150) residents, staff and visitors.</p> <p>The findings include:</p> <p>Record review of the facility maintenance records for the emergency generator, on 11/29/11 at 12:39 PM, revealed the facility did not document weekly inspections for the generator. The observation was confirmed with the Maintenance Director.</p> <p>Interview, on 11/29/11 at 12:39 PM, with the Maintenance Director, revealed he inspected the generator weekly but did not document his findings.</p> <p>Reference: NFPA 110 (1999 edition) 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. Exception: If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded.</p>	K 144	<p>K 144 NFPA 101 Life Safety Code Standard</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1</p> <ol style="list-style-type: none"> <li>1. There were no negative outcomes to any residents due to the absence of documentation of weekly checks for the generator.</li> <li>2. In-service was conducted on 12/15/11 by the Administrator with the maintenance director with regard to documenting weekly checks for the generator.</li> <li>3. Developed a documenting procedure on 12/15/11 and all checks will be documented weekly and kept in the maintenance log.</li> </ol>	12/15/11

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