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

PRINTED: 09/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185149	A. BUILDING B. WING	08/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF BARDSTOWN	120 LIFE CARE WAY BARDSTOWN, KY 40004

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F 000	INITIAL COMMENTS A standard health survey was conducted 08/24/10 through 08/26/10 and a Life Safety Code Survey was conducted on 08/26/10. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition. This was a Nursing Home Initiative Survey starting on Tuesday at 5:45am. An abbreviated standard survey investigating KY00014948 and KY00015038 was initiated on 08/24/10 and concluded on 08/26/10. KY00014948 and KY00015038 were substantiated and deficiencies were cited at 483.25 Quality of Life, F309 and F325 at a scope and severity of a "D".	F 000	This plan of Correction is submitted under Federal and State regulations and status applicable to long-term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Furthermore, we request this Plan of Correction service as our credible allegation of compliance.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined the facility failed to ensure physician orders were obtained and/or followed for two residents (#15 and #16) of the twenty three (23) sampled residents. Resident #15 utilized oxygen without a physician's order	F 309	**Tag # F309** 1. The physician for Resident #15 was notified on 8/25/10 upon identification of no order for the oxygen that was in use. A physician order was obtained on 8/25/10 for oxygen at 3 liters via nasal cannula. Please note: The resident did not have any adverse event related to using oxygen. The resident has recorded oxygen saturation of 92-97% on the Treatment Administration Record. Oxygen saturations were obtained and recorded by the charge nurses.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
X Jackie Carlin	X Executive Director	9/23/10

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

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F 309	Continued From page 1 and Resident #16 had an order for ultra sound treatments to a pressure area that was not acted on by nursing. The findings include: Review of the facility's policy on Resident Screening dated 11/01/04 revealed referrals to screen are documented using the Resident Screening Referral. Review of the closed record for Resident #16 revealed an admission date of 10/29/09 and diagnoses of Obesity, Failure to Thrive, Heart Failure, Edema, Arterial Insuffiencey Left Lower Leg, Very Large Stasis Ulcer Mid Shaft Lower Leg Stage IV, and Severe Peripheral Vascular Disease. The resident was discharged 06/01/10 to another facility. The Quarterly MDS dated 05/18/10 identified the resident with two Stage IV, one Stage I and one Stage III pressure ulcers. The resident was coded as non-ambulatory and required extensive assist of two persons and a lift for transfers. Review of the Wound Care Center's recommendation dated 04/20/10 revealed the resident was to receive ultrasound treatments to the left lower leg twice a day. The physician telephone orders dated 04/20/10 indicated the resident was to receive ultrasound treatments to the left lower leg twice a day. Review of the therapy treatment records with the Physical Therapy Assistant (PTA) revealed there was no order from nursing regarding ultrasound treatments. Interview with the PTA and Occupational Therapist (OTR/L) Manager on 08/26/10 at 10:10am revealed if nursing obtained or received an order for ultrasound it would have been sent to	F 309	Resident # 16was discharged from this facility on 6/1/10. 2. All residents have the potential to be affected by this practice. A 100% audit was completed by the Nurse Management Team (Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Staff Development Coordinator) on 9/16/10 of all active residents using oxygen to ensure all residents had a physician order for the use of oxygen if necessary. No other residents were identified to not have a physician order for oxygen in use. A 100% audit of all physician orders for the last 90 days was completed by the Nurse Management Team (Director of Nursing, Assistant Director of Nursing, MDS Coordinator, and/or Staff Development Coordinator) by 9/24/10 to ensure nursing had communicated treatment orders to therapy. All treatment orders had been communicated to therapy. 3. An in-service will be completed by 9/24/2010 by the Nurse Management Team for all licensed nurses on the correct	

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F 309	Continued From page 2 therapy on a resident screening referral form. Therapy never received the form for Resident #16 and never provided ultrasound treatments to Resident #16. Interview with a Licensed Practical Nurse (LPN), on 08/26/10 at 10:20am, revealed when an order is received for therapy, a copy of the order or the referral form should be placed under the door to therapy. Therapy then evaluates the resident. The yellow copy is given to Medical Records so the order can be transcribed onto the new Physician's orders. The new order is also placed on the 24 hour report. The facility could not provide evidence of the 24 hour report or that therapy was notified of the order for treatment. Policy review for Admission, Transfer, & Discharge revealed duties of a Charge Nurse include: 1) Notify physician in charge of the admission. Take his/her orders, or verify all orders that do not carry his/her signature. 2) Transcribe all doctors' orders. Record review for Resident #15 revealed an admission date of 08/06/10 with diagnoses of Atrial Fib, Decubitus Ulcer, Cardiac Dysrhythmia, COPD, HTN, Hyperlipidemia, PVD, and Amputation of left foot. The resident was admitted with continuous oxygen at 3 liters per nasal canula in use. Physician orders revealed there were no current orders for oxygen therapy for Resident #15. Review of the Discharge Summary and transfer form from the transferring hospital did not indicate the use of oxygen by Resident #15.	F 309	process for communication of physician orders to therapy. An in-service will be completed by 9/24/2010 by the Nurse Management Team for all licensed nurses on obtaining physician orders for residents requiring oxygen. 4. Nurse Management Team will review all physician orders daily, Monday - Friday to ensure any physician orders requiring needed services and therapy follow up are communicated to the appropriate discipline and residents requiring oxygen physician orders have been obtained. Audits will continue daily Monday through Friday for 1 month, the weekly for 1 month and then monthly for 3 months. Any issues identified in the audits will be reviewed monthly in the Performance Improvement Committee meeting. Revisions will be made as necessary. 5. Date of Compliance 10/01/10.	

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F 309	Continued From page 3 Observation of Resident #15 on 08/25/10 at 11:15am and 3:35pm, and on 08/26/10 at 8:15am revealed the resident was receiving oxygen therapy at 3 liters via nasal canula. Interview on 08/25/10 at 4:50pm with LPN #1, twenty (20) days after the resident's admission, revealed there was no physician's order for oxygen for Resident #15. The LPN indicated that the initial orders are obtained from the Discharge Summary and transfer forms from the hospital. Those orders are written down and the physician called to review those orders and obtain other orders as needed. LPN #1 stated there were no orders for oxygen for Resident #15; however, he would obtain a clarification.	F 309		
F 325 SS=D	483.25(i) 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 by: Based on interview and record review, it was determined the facility failed to address the fluctuation of weight for one resident (Resident #8) of the twenty-three (23) sampled residents. Resident #8 had documented weight fluctuations	F 325	**Tag # F325** 1. Resident # 8 was re-weighed on 8/25/10. It was established that Resident # 8 weight was 315 pounds. Resident was placed on the Nutritional Intervention Program to ensure weight is stable. Weekly weights will be obtained for 4 weeks to ensure accuracy of weights. Please note: Resident # 8 has not had a weight loss. His admission weight on 3/4/10 was 297.7 pounds and his weight on 8/25/10 is 315 pounds.	

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F 325	Continued From page 4 of as much as 52.8 pounds in a two week period; however, there was no documentation that those weight fluctuations were addressed. The findings include: Policy review of the Nutritional at Risk Program (NAR) revealed 1) If a significant weight loss is determined, the Dietary Manager will initiate a weight NAR tracking sheet with the following indicated, Resident's name, room number, physician, date started on program, starting weight, date discharged from the program, weight at the date of discharge, date and year, weekly progress note or lack of progress and actions taken including family and MD notification as indicated. 2) Residents with significant weight loss will be submitted to the interdisciplinary NAR committee comprising of the nursing department, rehab services, social services, food services, activity, administrator and volunteer (optional) following confirmation by re-weighing. Residents with significant weight losses will be placed on weekly weights until stable weight is attained. Rehab staff input will be documented in the attached form along with the recommendation. All forms will become a part of the permanent record. 3) The NAR committee will meet to discuss resident assessment findings, develop a new MDS if indicated, and plan of care to correct undesirable weight change. Record review for Resident #8 revealed the following dates and weights recorded on the Weight Change History form; 03/05/10 - 297.7, 03/14/10 - 253.4, 04/02/10 - 295.6, 05/07/10 - 306.2, 05/21/10 - 253.4, 06/02/10 - 301.2, 07/06/10 - 315.0, 07/16/10 - 253.4, and 08/12/10 - 322.0. Review of Nutritional Progress Notes	F 325	2. A 100% audit of all resident weights for the last 180 days was completed by the Nurse Management Team (Director of Nursing, Assistant Director of Nursing, MDS Coordinator, and/or Staff Development Coordinator) on 9/23/10. The audit was to ensure no other residents had a weight fluctuation that had not been identified and addressed by the Interdisciplinary Team and placed in the Nutritional Intervention program if needed. No other residents were identified to have weight fluctuations. 3. Restorative Aides, who are responsible to obtaining resident weights, will re-in-serviced on procedures for proper weighing or residents by 9/24/10 by the Assistant Director of Nursing. Re-weights will be observed by a nurse manager or Dietary Manager	

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F 325	Continued From page 5 revealed a quarterly review by the dietary manager completed on 01/23/10 and 07/16/10. There was no documented quarterly dietary review in April 2010. There were no other notes on the Nutritional Progress Notes for 2010. The weight fluctuation of 40-50 pounds was not addressed on the Dietary quarterly assessments. Interview with Resident #8 on 08/25/10 at 9:30am revealed knowledge of the weight fluctuations; however, the resident could not provide any explanations as to what the facility had done to assist in maintaining the current weight. Interview with the Regional Director of Clinical Services (RDCS) on 08/26/10 at 9:00am revealed the process for monitoring weights entails weights to be obtained by the Restorative CNA and then placed into the computer by the Dietary Manager. The weights are then reviewed by the Assistant Director of Nursing (ADON) and Dietary Manager. Review of Resident #8's weight change history form by the RDCS revealed it looked like someone had entered some numbers without actually weighing the resident, since the weight of 253.4 had been entered three different times and all other weights were fairly consistent. The RDCS stated those weight variations should have been picked up during the weekly Nutrition Intervention Program (NIP) and discussed at that time. Interview with the Dietary Manager (DM) on 08/26/10 at 10:30am revealed the process for monitoring weights are as follows; he receives weights from the Restorative CNA and he inputs the weights into the computer. The Restorative CNA would not know if there had been a decrease or increase in weight. The DM stated if	F 325	An in-service will be completed by 9/24/2010 by the Nurse Management Team (Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Staff Development Coordinator) for the Interdisciplinary Team (Dietary Manager, Nursing (MDS), Rehab Services Manager, Social Service Director, Activity Director) in regard to the nutritional intervention program as it relates to weight fluctuations. 4. The Dietary Manager will review all resident weights to ensure weight changes are identified and reported timely to the Interdisciplinary Team for placement on the Nutritional Intervention Program, weekly for 2 months, then monthly for 3 months. The Executive Director will audit to ensure compliance weekly for 2 months, then monthly for 3 months.	

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F 325	Continued From page 6 there is a significant change in weights he would ask the CNA to reweigh the resident. If there is a significant weight loss or gain he would evaluate the resident's diet for appropriateness. The facility holds weekly Nutrition Intervention Program meetings to address significant changes and record significant issues on the dietary note. Interview with the Restorative CNA on 08/26/10 at 11:00am revealed the weights were obtained on Resident #8 by taking the scales into the resident's room, the scale is zeroed out, the resident is weighed and the weight is recorded and turned in to the dietary manager. The CNA is provided a list of resident names only and no prior weight to compare. Interview with the Registered Dietician on 08/26/10 at 2:30pm revealed significant weight changes are reviewed in the NIP meeting every week and necessary dietary adjustments are made at that time. She considers a significant weight change to be 5% in 30 days or 10% in 180 days. However, she could not explain why the reported weight changes for Resident #8 were not addressed. She thinks there was some kind of mistake with those weights, but stated they should have been addressed.	F 325	Any issues identified in the audits will be reviewed monthly or as needed in the Performance Improvement Committee meeting. Revisions will be made to the Nutritional Intervention Program as indicated. 5. Date of Compliance 10/01/10. **Tag # F371** 1. No residents were found to be affected by this practice.	
F 371 SS=D	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	Please note: All unpasteurized eggs were disposed on 8/24/10. Unpasteurized eggs will no longer be an item that can be purchased at this facility. Only pasteurized eggs will be available for purchase by the company utilized by the dietary department for product purchasing.	

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F 371	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide and prepare pasteurized eggs for eight (8) residents requesting partially cooked eggs. The findings include: The facility had no policy regarding the purchasing of pasteurized eggs. Observation on 08/24/10 at 6:10am revealed there were two (2) boxes of non-pasteurized eggs in the refrigerator. In an interview with the dietary cook at 6:25am on 08/24/10 she stated, eight (8) residents request eggs daily that are fried with cooked egg whites and runny yolks. An interview with the dietary manager at 8:25am on 08/24/10 revealed he had knowledge of the non-pasteurized eggs being purchased and stated all eggs are completely cooked. Further, he stated that he was unaware that the facility needed to purchase pasteurized eggs.	F 371	2. All residents had the potential to be affected. 3. An in-service was completed by the Executive Director on 8/30/10 for the Dietary Manager on the facility policy regarding the use of pasteurized eggs only. The Dietary Manager in-serviced the dietary staff on 9/1/10 on the facility policy regarding the use of pasteurized eggs only. 4. The Dietary Manager will perform audits to ensure eggs received by the dietary department are pasteurized. Audits will be completed weekly for 2 months, then monthly for 3 months. Executive Director will review audits to ensure compliance weekly for 2 months and then monthly for 3 months Any issues identified in the audits will be reviewed monthly in the Performance Improvement Committee meeting. Revisions will be made to the policy as indicated. 5. Date of Compliance 10/01/10.	
F 441 SS=E	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.	F 441		

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F 441	Continued From page 8 (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 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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to maintain an infection control program to provide a safe, sanitary environment and prevent the spread of disease and infection for six (6) out of the twenty-three (23) sampled residents	F 441	**Tag # F441** 1. Residents #7, 14, 19, and 20 indwelling catheter tubing, drainage bags and privacy bags were replaced with new ones. Residents #13 and 15 dressing changes were completed on 8/27/10 using aseptic wound dressing technique. Both residents' wounds are free of signs and symptoms of infection. 2. All residents requiring indwelling catheters have the potential to be affected by this practice. All residents with a wound have the potential to be affected by this practice. No residents were found to be affected by this practice. 3. Nurse # 5 and the Assistant Director of Nursing were educated by 9/24/10 by the Regional Director of Clinical Services regarding wound care, infection control, hand washing, and proper use of gloves.	

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F 441	Continued From page 9 (Residents #7, #13, #14, #15, #19, and #20). Residents #7, #14, #19 and #20 had indwelling catheter tubing and drainage bags in direct contact with the floor. In addition, the facility failed to follow aseptic technique during dressing change for Residents #13 and #15 when performing wound care by not hand washing per the facility policy. The findings include: Review of the Daily Catheter Care Policy (undated) stated to make sure the catheter tubing and drainage bag are kept off the floor. Observation of Resident #7 on 08/24/10 at 8:30am and 08/26/10 at 11:05am revealed the resident had the indwelling catheter tubing and drainage bag on the floor. Observation of Resident #14, on 08/24/10, at 11:53am, 12:06pm, and 2:30pm and on 08/25/10 from 12:20pm to 12:24pm revealed four (4) staff members in proximity of the resident who had the catheter tubing on the floor but the staff did not assist with removing the tubing from the floor. Observation of Resident #19 on 08/24/10 at 2:30pm, 08/25/10 at 12:15pm and 08/26/10 at 9:10am revealed the resident had their indwelling catheter tubing and drainage bag on the floor. Observation of Resident #20, on 08/24/10 at 8:55am, revealed the resident had their indwelling catheter tubing and drainage bag on the floor and this was not acknowledged by three (3) staff working in the area. Interview with Nurse Aide #4 on 08/25/10 at	F 441	The Executive Director initially in-serviced all staff on 8/27/10 regarding the infection control practice keeping indwelling catheter tubing, drainage bags, and privacy bags up off the floor. The Regional Director of Clinical Services conducted an in-service and competency with the Nurse Management Team (Director of Nursing, Assistant Director of Nursing, MDS Coordinator, and/or Staff Development Coordinator) on 9/21/10 (train the trainer) regarding infection control, hand washing, wound care, peri-care, indwelling catheter care, and tubing, drainage bags, and privacy bags not touching the floor. An in-service will be completed by 9/24/10 by the Nurse Management Team (Director of Nursing, Assistant Director of Nursing, MDS Coordinator, and/or Staff Development Coordinator) for nursing staff regarding infection control, hand washing, wound care, peri-care, indwelling catheter care, and tubing, drainage bag, and privacy bags not touching the floor.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185149		08/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF BARDSTOWN	120 LIFE CARE WAY BARDSTOWN, KY 40004

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F 441	Continued From page 10 4:00pm revealed no one had ever told the Nurse Aide the privacy bag could not touch the floor. Review of the facility policy on treatment of pressure sores stated that gloves should be removed and hands should be washed, or antiseptic hand cleanser used, after removing old dressing. Gloves should be removed and hands washed again after cleansing the wound and clean gloves applied before securing the new dressing. Review of the facility policy on personal hygiene of the female resident states to always proceed from the least contaminated area to the most contaminated area wiping the area from front to back. If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches. Observation of the wound care/dressing change of the pressure ulcer on the coccyx of Resident #13, on 08/25/10 at 3:05pm, revealed LPN #5 failed to wash their hands and apply clean gloves between suctioning the resident's tracheostomy, turning the resident, and changing the pressure ulcer dressing. Soiled draw sheets were pushed under the resident and not removed before the wound was cleaned and a new dressing applied. Observation of perineal care/indwelling catheter care of resident #13 on 08/25/10 at 3:25pm revealed CNA #7 washed the resident's perineal area from back to front at times and did not clean the indwelling catheter underneath, or hold from the base and clean away from the resident. Interview with CNA #7 on 08/25/10 at 3:35pm revealed knowledge of the errors committed	F 441	The Nurse Management Team (Director of Nursing, Assistant Director of Nursing, MDS Coordinator, and/or Staff Development Coordinator) will complete Competencies by 9/24/10 for all C.N.A.'s/Restorative aides for hand washing, peri-care (male and female), indwelling catheter care (male and female), infection control, and not allowing catheter tubing, drainage bags, and privacy bags not touching the floor. Nurse Management Team will complete competencies by 9/24/10 for all licensed staff for hand washing, aseptic wound care dressing changes, proper handling of soiled linen to avoid contamination, peri-care (male and female), indwelling catheter care (male and female), infection control, and not allowing catheter tubing, drainage bags, and privacy bags not touching the floor. 4. The Nurse Management Team (Director of Nursing, Assistant Director of Nursing, MDS Coordinator, and/or Staff Development Coordinator) will be conducting facility rounds to ensure residents requiring indwelling catheters do not	

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	

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F 441	Continued From page 11 during perineal care/indwelling catheter care of Resident #13. CNA #7 stated that she did the care backwards. She stated she should have cleaned the perineal area from front to back and should have stabilized the catheter at the base while cleaning the catheter from base, away from resident as she had been taught. CNA #7 gave no explanation for the lack of infection control practices during perineal care/indwelling catheter care; however, she did acknowledge that the lack of infection control practices could result in potential harm to the resident by introducing bacteria into the urethra by cross contamination. Interview with LPN #5 on 08/25/10 at 3:40pm revealed knowledge of errors committed during wound care/dressing change. LPN #5 stated that hands should be washed after removing gloves. She also stated the soiled draw sheet should be removed completely before cleaning and dressing the wound to avoid cross contamination. LPN #5 gave no explanation for the lack of infection control practices during wound care. However, she did acknowledge that the lack of infection control practices could result in potential harm to the resident by introducing bacteria into the wound through cross contamination. Observation on 08/26/10 at 9:25am during Resident #15's wound care revealed the Assistant Director of Nursing (ADON) completed the dressing change for the resident. The ADON stated she did not normally do the wound care, but the resident had diarrhea this morning, the wound nurse was busy and the ADON wanted to clean the wound and change the dressing as soon as possible. A soiled pad was left on the bed and covered with a towel. The ADON rested her left forearm on the soiled pad during the	F 441	have catheter tubing, drainage bags, or privacy bags touching the floor. These rounds will be conducted daily, Monday – Friday, for 4 weeks, then weekly for 1 month, then monthly for 3 months. The Nurse Management Team will be observing nursing staff performing perineal care/indwelling catheter care for correct technique, hand washing, and infection control, daily, Monday – Friday for 4 weeks, then weekly for 1 month, then monthly for 3 months. The Nurse Management Team will be observing licensed staff during wound care for correct technique, hand washing, and infection control, daily, Monday - Friday for 4 weeks, then weekly for 1 month, then monthly for 3 months. Any issues identified in the audits will be reviewed monthly in the Performance Improvement Committee meeting. Revisions will be made to the system as indicated. 5. Date of Compliance: 10/01/10.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF BARDSTOWN	120 LIFE CARE WAY BARDSTOWN, KY 40004

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F 441	Continued From page 12 dressing change. The ADON changed gloves many times during the dressing change but did not always sanitize her hands between glove changes. Gauze wrap was left in the original package and soaked with Dakin's solution. The package was then set on the towel and soiled pad. The ADON cleaned the scissors with an alcohol pad and placed the sharp end in a plastic package with gauze dressing inside; the handle of the scissors was allowed to touch the towel and the soiled pad. The ADON then picked up the scissors with her right hand and cut the gauze. The ADON then used the right hand to pack gauze into the resident's Stage 4 decubitus without changing gloves. After packing the wound with gauze, the ADON removed the gloves and re-gloved without sanitizing her hands and then proceeded to finish the dressing change. Interview with LPN #6 revealed the soiled area on the pad appeared to be a large area of diarrhea stool with some solid particles of stool. Interview with ADON on 08/26/10 at 9:55am revealed she was unaware she had not washed her hands between all the glove changes. She did not realize she had touched her forearm to the soiled pad or contaminated her scissors. She does not normally do wound care but since Resident #15 had a Stage 4 decubitus and had diarrhea she thought she should change the dressing to avoid contamination.	F 441		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		

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NAME OF PROVIDER OR SUPPLIER: LIFE CARE CENTER OF BARDSTOWN

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F 465	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined the facility failed to maintain clean ceiling air vents in the main kitchen and dish washing area, as all vents had dust and a black substance on them. In addition, the facility failed to provide maintenance services necessary to maintain an orderly and comfortable interior on the resident living units as there were holes in walls, handrail brackets broken, Formica missing on sinks, and open boxes of razors stored on a wire shelf in the open. The findings include: Observations of the air vents in the kitchen on 08/26/10 at 8:30am revealed dust and a black substance on six (6) ceiling vents in the main kitchen and three (3) ceiling vents in the dish washing area. There was also, dust and a black substance on the large red air intake vent over the tray line area. Interview on 08/26/10 at 8:57am with the dietary manager revealed the vents are scheduled to be cleaned on a daily bases. Taking a damp cloth the dietary manager wiped the black substance area on the vents and the black area wiped off on the cloth. He acknowledged the red intake air vent over the tray line area had dust. Review of the kitchen cleaning schedule revealed from 08/19/10 to 08/26/10 the evening dish person had not cleaned the vents, the morning dish person documented initials for 08/20, 08/23 and 08/24/10. There were no initials for 08/25	F 465	**Tag # F 465** 1. No residents were affected by this practice. 2. All residents have the potential to be affected by this practice. 100% audit of all resident's rooms was conducted by 9/24/10 by the Executive Director and Maintenance Department to ensure no other bathroom flooring was separating from the edge of the wall, paint was not chipped off, paneling was not missing, no wood was splintered or exposed, no plaster was missing exposing drywall, plastic door flashing was not peeling and exposing rough loose edges, seals around toilets was not yellow, brown, or cracked, slats were not missing form blinds, and drywall mud was not left uneven or unpainted. All repairs will be completed by 9/30/10. The air vents in the kitchen were cleaned immediately by the Dietary staff when identified by the surveyor on 8/26/10. Vents are checked and cleaned daily by Dietary staff. All shower rooms were cleaned of items identified during the survey at the time of notification by the surveyor.	

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F 465	Continued From page 14 and 8/26/10: Observation in 08/24/10 at 8:05am revealed the West wing back hallway bathing room had razors, shampoo, skin cleansers, and moisture barrier cream stored in an open area of the shower room on a white wire shelf. Observation on 08/24/10 at 8:20am and on 08/24/10 at 2:05pm revealed the East wing front hallway bathing room had razors, shampoo, and opened skin cleansers in an open area of shower room on a white wire shelf. Observation on 08/24/10 at 10:50am revealed the bathroom between rooms 338 and 340, had flooring up against the wall that was separating from the edge of the wall. Room 340 had paint chipped completely off in straight horizontal strips all the way across the lower half of the door between the bedroom and bathroom. Observation on 08/24/10 at 11:10am revealed the door going into the bathroom from room 302 had approximately a two inch piece of paneling missing from the middle portion of the door, exposing splintered wood next to the door handle. Observation on 08/24/10 at 11:20am revealed rooms 306 and 301 had indented horizontal scrapes into the lower half of the walls next to the bathrooms, exposing drywall. Observation on 08/24/10 at 2:10pm revealed room 224 had plastic door flashing located on the lower portion of the door that was peeling off and curling up on the corner exposing a rough loose plastic edge.	F 465	3. The Executive Director in-serviced the Dietary Manager on 8/30/10 on the importance of following and completing the kitchen cleaning schedule and complementing documentation after the cleaning is complete. The Dietary Manager in-serviced all of the dietary staff on 9/1/10 and re-in-serviced by 9/24/10 regarding the kitchen cleaning schedule and completing the documentation after the cleaning is complete. A maintenance log is available for all maintenance requests for the Maintenance Department. The management team will make daily facility rounds using facility rounds tools. Findings will be discussed in the morning stand-up meetings, Monday through Friday. Maintenance Department will report to the Executive Director when maintenance issues are completed. All nursing staff will be in-serviced by 9/24/10 by the Nurse Management team (Director of Nursing, Assistant Director of Nursing, MDS Coordinator, and/or Staff Development Coordinator) regarding proper storing/securing items to protect the health and safety of all residents. 4. Management team will conduct facility rounds Monday – Friday.	

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F 465	Continued From page 15 Observation on 08/25/10 at 9:34am revealed the bathroom between rooms 240 and 238 had cracked caulking, discolored yellow and brown around the bottom seal of the toilet, and the toilet was cracked in one solid piece across the back of the toilet base that connects to the floor. Observation on 08/25/20 at 3:40pm revealed several missing slats from resident's blind in room 235. Observation on 08/25/10 at 3:50pm revealed in the main dining room a wall that was patched with drywall mud leaving the surface uneven and not painted over half of the wall. Interview with maintenance on 08/25/10 at 3:50pm revealed that he had started to repair the wall seven (7) days prior but had not gotten back to finish the job.	F 465	These facility rounds forms will be maintained by the Executive Director. Maintenance will audit five resident rooms weekly x 4 weeks, monthly x4 months, and randomly. Executive Director will review room audits after completion by Maintenance Department. Dietary Manager will audit cleaning schedules daily, Monday – Friday, for compliance by ensuring items on cleaning schedule are cleaned and documentation is complete. Executive Director will audit the Dietary Managers audits for compliance weekly for 4 weeks, then monthly for 3 months, then randomly.	
F 498 SS=E	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the nurse aides were able to demonstrate competency in skills and technique necessary to care for four (4) out of the twenty-three (23) residents sampled.	F 498	The Nurse Management team will perform shower room audits daily, Monday – Friday for 1 month, then weekly for 1 month, then monthly for 3 months. Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated. 5. Date of Compliance 10/01/10.	

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F 498	Continued From page 16 The findings include: A review of the Daily Catheter Care Policy and Procedure included in the Key Procedural Points that the bag must be held lower than the bladder at all times to prevent urine in the tubing and drainage bag from flowing back into the urinary bladder and make sure the catheter tubing and drainage bag are kept off the floor. Observation of Nurse Aide #4, on 08/25/10 at 3:20pm, as the Nurse Aid provided indwelling catheter care to Resident #14, revealed the Nurse Aide wiped the peri area from back to front and left the indwelling catheter bag hanging on the floor and the empty privacy bag on the floor. Interview with Nurse Aide #4, on 08/25/10 at 4:00pm, revealed no one had ever told the Nurse Aide the privacy bag could not touch the floor. Observation of Nurse Aide #10, on 08/26/10 at 11:25am, who provided indwelling catheter care to Resident #7, revealed the Nurse Aide used the same area of the wash cloth multiple times, the catheter bag was brought above the resident's bladder, and the urine in tubing was observed going back into the resident. The tubing was observed not securely anchored when the Nurse Aide cleaned the catheter tubing. Interview with Nurse Aide #10, on 08/26/10 at 11:25am, revealed the Assistant Director of Nursing (ADON) did not observe catheter care on a regular basis, and only observed catheter care if the Nurse Aide needed assistance with a resident's ADL's. Observation of Nurse Aide #11, on 08/26/10 at	F 498	**Tag # F498** 1. No residents were affected by this practice. Residents #7, 14, 19, and 20 indwelling catheter tubing, drainage bags and privacy bags were replaced with new ones. 2. All residents requiring indwelling catheters have the potential to be affected by this practice. 3. The Executive Director initially in-serviced all staff on 8/27/10 regarding the infection control practice keeping indwelling catheter tubing, drainage bags, and privacy bags up off the floor. The Regional Director of Clinical Services conducted an in-service and competency with the Nurse Management Team (Director of Nursing, Assistant Director of Nursing, MDS Coordinator, and/or Staff Development Coordinator) on 9/21/10 (train the trainer) regarding infection control, hand washing, wound care, peri-care, indwelling catheter care, and tubing, drainage bags, and privacy bags not touching the floor.	

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F 498	Continued From page 17 10:40am, providing indwelling catheter care to Resident #19, revealed the Nurse Aide placed the indwelling catheter bag on the floor and reused the same washcloth multiple times in same area. The resident's peri area was bright red and shiny. Interview with Nurse Aide #11, on 08/26/10 at 10:45am, revealed she was taught to fold the corners over multiple times, but could not identify which areas of the wash cloth were clean and dirty after folding the wash cloth multiple times. Also, she revealed she did not know how often Resident #19 was supposed to receive peri care. Record Review of Resident #19's plan of care revealed nursing staff were instructed to perform catheter care every shift and as needed per the facility policy. Observation on 08/26/10 at 10:20am during catheter care of Resident #20 revealed Nurse Aide #9 touched the garbage can in the resident's room then provided catheter care to the resident without changing gloves or washing their hands. In addition, the Nurse Aide did not anchor the catheter tubing or pull back the skin during catheter care. Record Review of Resident #20's plan of care revealed nursing staff were instructed to perform catheter care every shift and as needed per the facility policy. Interview with Registered Nurse #1 revealed she did not observe catheter care performed by CNA's or check their work proficiency.	F 498	An in-service will be completed by 9/24/10 by the Nurse Management Team for nursing staff regarding infection control, hand washing, correct placement of indwelling catheter tubing during care to prevent back flow of urine, peri-care, indwelling catheter care, and tubing, drainage bag, and privacy bags not touching the floor. The Nurse Management Team will complete Competencies by 9/24/10 for all C.N.A.'s/Restorative aides for hand washing, peri-care (male and female), indwelling catheter care (male and female), infection control, and to ensure correct placement of indwelling catheter tubing during care to prevent back flow of urine, and not allowing catheter tubing, drainage bags, and privacy bags to touch the floor. Nurse Management Team will complete competencies by 9/24/10 for all licensed staff for hand washing, aseptic wound care dressing changes, proper handling of soiled linen to avoid contamination, peri-care (male and female), indwelling catheter care (male and female), infection control, and not	

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allowing catheter tubing, drainage bags, and privacy bags not touching the floor.

4. The Nurse Management team (Director of Nursing, Assistant Director of Nursing, MDS Coordinator, and/or Staff Development Coordinator) will be conducting facility rounds to ensure residents requiring indwelling catheters do not have catheter tubing, drainage bags, or privacy bags touching the floor, and to ensure correct placement of indwelling catheter tubing during care to prevent back flow. These rounds will be conducted daily, Monday – Friday for 4 weeks, then weekly for 1 month, then monthly for 3 months.

   The Nurse Management team will be observing nursing staff performing perineal care/indwelling catheter care for correct technique and placement of indwelling catheter tubing during care, hand washing, and infection control, daily, Monday – Friday for 4 weeks, then weekly for 1 month, then monthly for 3 months.

   The Nurse Management Team will be observing licensed staff during wound care for correct technique, hand washing, and infection control, daily, Monday – Friday for 4 weeks, then weekly for 1 month, then monthly for 3 months.

   Any issues identified in the audits will be reviewed monthly in the Performance Improvement committee meeting. Revisions will be made to the system as indicated.

5. Date of Compliance 10/01/10.

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	185149	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/26/2010

NAME OF PROVIDER OR SUPPLIER: LIFE CARE CENTER OF BARDSTOWN

STREET ADDRESS, CITY, STATE, ZIP CODE: 120 LIFE CARE WAY, BARDSTOWN, KY 40004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 08/26/10. The facility was found not to meet the minimal requirements with 42 Code of the Federal regulations, Part 483.70. The highest scope and severity deficiency identified was an "E".	K 000		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview conducted during the tour of the building on 08/26/10, it was determined the facility failed to ensure a complete sprinkler system according to NFPA standards. The findings include: Observation on 08/26/10 at 11:45am with the Administrator and Maintenance Director, revealed the canopies with combustible construction, located over the smoking area and patio did not have sprinkler protection.	K 056	**Tag # K056** 1. No residents were found to be affected by this practice. 2. All residents had the potential to be affected. 3. Canopies over the smoking area and patio will have sprinkler protection installed by 9/30/10 by approved vendor according to industry specifications. 4. Maintenance Supervisor will ensure new sprinklers are included in required maintenance schedules including quarterly inspection by approved contracted service representatives. Any issues identified in the audits will be reviewed monthly in the Performance Improvement Committee meeting. Revisions will be made to the policy as indicated. 5. Date of Compliance 10/01/10.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jackie Carter — TITLE: Executive Director — (X6) DATE: 9/23/10

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

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SEP 23 2010
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 09/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185149	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/26/2010

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LIFE CARE CENTER OF BARDSTOWN	120 LIFE CARE WAY BARDSTOWN, KY 40004

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K 056	Continued From page 1 Interview with the Administrator on 08/26/10 at 2:30pm, revealed they were unaware of the canopies needing protection. Reference NFPA 13/1999 (Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056	**Tag # K073** 1. No residents were found to be affected by this practice. 2. All residents had the potential to be affected. 3. Letters to Responsible Parties was mailed on 9/21/10 indicating that all items needed to be removed from resident doors prior to 9/30/10. Maintenance Department will remove any remaining items on 9/30/10. New residents will be informed during admission process. 4. Maintenance Supervisor and Executive Director will observe resident doors during daily rounds, Monday – Friday, to ensure no item has been attached to the door without flame retardant treatment. Any issues identified during rounds will be reviewed monthly in the Performance Improvement Committee meeting. Revisions will be made to the policy as indicated. 5. Date of Compliance 10/01/10.	
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The findings include: Observation on 08/26/10 at 11:30am, revealed hanging decorations attached to six (6) resident room doors numbered 201, 221, 223 226, 305 and 310. Interview with the Administrator and Maintenance Director on 08/26/10 at 11:30am, revealed they were unaware of the requirement that these decorations had to be treated for flame retardant. NFPA Standard NFPA 101.2000 Edition 19.7.5.4	K 073		

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K 073	Continued From page 2 Combustable decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073		

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