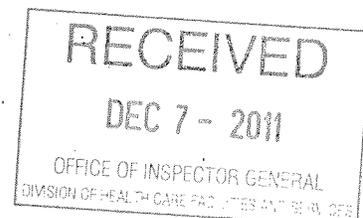




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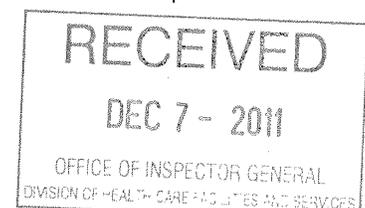
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/03/2011
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
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F 221	Continued From page 1 restraint. If not, then the staff person who assisted the resident with the meal should take it off. CNA #3 stated it should be removed so the resident can get closer to the table.  Review of the medical record for Resident #8 revealed the facility admitted the resident on 12/08/08 with diagnoses including, Alzheimer's, Anxiety, Depression, and Delusional Disorder. Review of the Comprehensive Care Plan revealed the facility assessed the resident as requiring the use of a restraint related to decreased safety awareness, a history of falls and decreased cognition. The care plan directed staff to remove the device during supervised activities. Review of the Certified Nursing Assistant (CNA) daily care guide revealed interventions included a restraint device (Lap Buddy) while in the wheelchair and to remove the device during meals and during care.  Observation of Resident #8, on 11/01/11 at 12:50 PM, revealed the resident was sitting up in a wheelchair in the dining room with staff attempting to assist the resident with lunch. The restraint device (Lap Buddy) remained in place during the entire meal service.  Observation of Resident #8, on 11/01/11 at 2:30 PM, revealed the resident was in the activities room listening to live music. The restraint device (Lap Buddy) remained in place.  Observations of Resident #8, on 11/02/11 at 8:45 AM, revealed the resident was up in a wheelchair in the dining room. At 9:10 AM, Licensed Practical Nurse (LPN) #2 assisted the resident with breakfast. The restraint device (Lap Buddy)	F 221	F 221 1. Resident #8 restraint (lap buddy) has been removed during all meals, activities and care. 2. A 100% audit of residents with a restraint was completed on 11/4/11 by the Director of Nursing to ensure all restraints were removed during meals, activities and care and no other residents were affected. 3. All associates will be re-educated by the Director of Nursing/Assistant Director of Nursing on the Restraint Policy with regard to releasing of a restraint device (i.e. Lap buddy) by December 8, 2011. 4. The Director of Nursing/Assistant Director of Nursing/ Unit Manager/ Charge Nurse/ Nursing Assistant/ Department Manager on Dining Room Duty/Activity personnel will observe residents during meals, activities and care to ensure restraint devices are removed. A random audit consisting of two residents	



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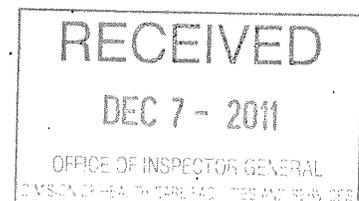
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F 221	<p>Continued From page 2 remained in place.</p> <p>Continued interview with CNA #3, on 11/02/11, revealed she had worked at the facility for eight (8) years, and was assigned to provide care for Resident #8 today. She stated Resident #8 used a restraint device (lap buddy) and it should be removed at all meals, every two (2) hours while the resident was up, and removed when the resident laid down. CNA #8 acknowledged the restraint device had not been removed from Resident #8 during observation of two (2) meal services.</p> <p>Interview with LPN #2, on 11/03/11 at 9:50 AM, revealed the restraint device should be removed every two (2) hours for Resident #8, but she was unsure if it should be removed for meals. When LPN #2 was asked about supervised activities, she stated supervised activities would include music, bingo and group activities. After reviewing the CNA Dally Care Guide and the Comprehensive Care Plan, LPN #2 stated the restraint device should be removed for Resident #8 during meals and supervised activities.</p> <p>Interview with CNA #4, on 11/03/11 at 11:00 AM, revealed she had worked at the facility for ten (10) years. CNA #4 stated she was providing care for Resident #8 on this date. She stated the restraint device should have been removed when the resident attended supervised activities, when the resident received care and during meal times. She stated the reason to remove the restraint device was to allow the resident to get relief from the restraint. CNA #4 stated they were inserviced on restraints about six (6) months ago.</p>	F 221	<p>with a restraint will be completed by the Director of Nursing/Assistant Director of Nursing/Unit Manager daily times two weeks, weekly times four weeks, monthly times 2 months and then quarterly times 2 quarters to ensure a restraint device has been removed at appropriate times. The results of the audits will be reviewed in the monthly Performance Improvement Committee Meeting. Revisions will be made to the systems as indicated.</p>	<p>Completion date: 12/09/11</p>



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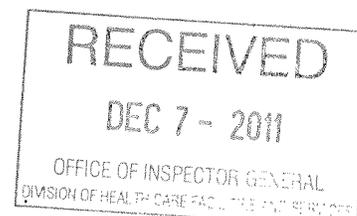
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F 221	Continued From page 3 Review of the CNA training and inservice binder revealed the last inservice documented for restraint use was 10/13/10.	F 221		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to revise the care plan for two (2) of seventeen (17) sampled residents. Resident #8 had a Care Plan for wandering with an intervention for a wandergaurd that had been discontinued on 03/11/10. Resident #11 had a Care Plan for risk for falls,	F 280	F 280 1. Resident #8 care plan was revised by the MDS Coordinator to indicate the discontinuation of the Wanderguards on 11/04/11. Resident #11 care plan was revised by the MDS Coordinator and all non-applicable interventions (proper fitting non-skid soled shoes for ambulating) were resolved on 11/04/11. 2. A 100% audit of all resident care plans will be completed by the Director of Nursing/Assistant Director of Nursing/MDS Coordinator/Assistant MDS Coordinator for accuracy in reflection of current resident status. Any revision necessary will be made during this review process. All reviews will be completed by 12/06/11.	



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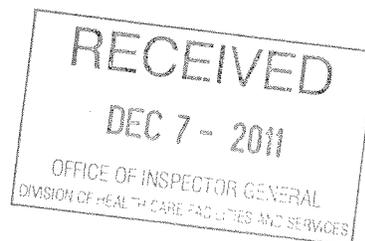
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F 280	Continued From page 4 that included interventions for ambulation, although the resident had a recent left above the knee amputation that resulted in the resident having a double amputation, and was now non ambulatory.  The findings include:  Review of the facility's policy Care Planning Guideline, undated, revealed the care plan documentation should be specific, clear, precise, and all inclusive...to support that skilled care is reasonable and necessary.  1. Review of the medical record for Resident #8 revealed the facility admitted the resident on 12/08/08 with diagnoses including, Alzheimer's, Anxiety, Depression, and Delusional Disorder. The Minimum Data Set (MDS) Annual Assessment revealed the facility was unable to complete the Brief Interview for Mental Status (BIMS). The facility assessed the resident as having short and long term memory problems. The facility assessed the residents mobility as non ambulatory, transfers with extensive assistance of two persons. The facility assessed the resident as having no behaviors. Review of the Quarterly Assessment dated 08/19/11, revealed the facility assessed the resident as having behaviors including rejection of care and wandering.  Review of the Comprehensive Care Plan revealed the facility developed a care plan for "Wanders". The first approach indicated the staff were to "place monitoring device on the resident that sounds alarms when the resident leaves the building".	F 280	3. The Director of Nursing/Assistant Director of Nursing will re-educate the Charge Nurses, Activity Director, Social Service Director, MDS Coordinator, Assistant MDS Coordinator, Dietary Manager and the Therapy Department Manager by December 8, 2011 on initiation and revision of care plans.  4. All physician orders will be reviewed by the Director of Nursing/ Assistant Director of Nursing/ Unit Manager/MDS Coordinator/Assistant MDS Coordinator daily Monday through Friday in the Clinical Meeting with care plan revisions done as applicable. A random audit of ten orders and care plans will be completed by the Director of Nursing/Assistant Director of Nursing/Unit Manager weekly times four weeks, monthly times 2 months and then quarterly times 2 quarters to ensure care plan revision have	



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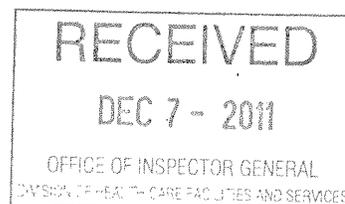
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F 280	Continued From page 5  Review of the Elopement/Wandering Review for Resident #8 revealed the facility discontinued the "wanderguard" on 03/11/10.  Observation, on 11/01/11 at 1:50 PM, of Resident #8 revealed the resident was sitting up in a wheelchair, self propelling up and down the hallways. The resident had a lap buddy in place and sensor pad in place. There was no wanderguard in place on the resident or the wheelchair.  Observation, on 11/02/11 at 9:50 AM, of Resident #8 revealed, the resident was up in the wheelchair self propelling in the hallways. The resident had a lap buddy and sensor pad in place. There was no wanderguard in place.  Interview with LPN #2, on 11/03/11 at 9:25 AM, revealed based on the care plan Resident #8 had a wanderguard. LPN #2 stated that was not true, the resident did not have a wanderguard, and he/she was not an elopement risk. LPN #2 stated she didn't have much to do with Care Plans only when she or the other nurses receive a new order, they will make up an acute care plan. This was usually when a resident was started on an antibiotic. When the staff receive a new order there was a yellow copy that went to the morning meeting, then to the other related departments.  Interview with the Assistant Director of Nursing (ADON), on 11/03/11 at 9:50 AM, revealed she was the MDS coordinator from February 2010 until about a month ago. The ADON stated the MDS staff received copies of all new orders and update the care plans. She stated she was the	F 280	been made. The results of the audits will be reviewed in the monthly Performance Improvement Committee Meeting. Revisions will be made to the systems as indicated.	Completion date: 12/09/11	



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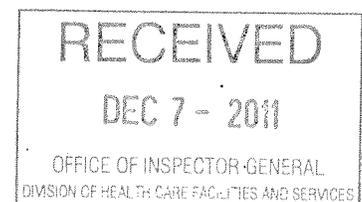
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F 280	<p>Continued From page 6</p> <p>person who completed the elopement summary for Resident #8 on 03/11/10 and discontinued the wanderguard on the assessment and it should have been taken off the care plan. She stated they do care plan meetings every three (3) months or more often if necessary.</p> <p>2. Review of the medical record of Resident #11 revealed the facility admitted the resident on 12/01/10 with diagnoses including status post right above the knee amputation, Osteoporosis, Atrial Fibrillation, Dementia, and Peripheral Vascular Disease.</p> <p>The facility readmitted Resident #11 on 09/23/11 following a left above the knee amputation.</p> <p>Review of the MDS Admission Assessment for the resident on 12/08/10 revealed the facility assessed the resident as having short and long term memory loss. The resident was unable to complete the BIMS interview. The facility assessed the resident as not ambulatory with extensive assistance of two persons for transfers, dressing, bed mobility, and hygiene. Review of the MDS Quarterly Assessment for Resident #11 completed on 10/14/11 revealed the facility had no changes in the Assessment.</p> <p>Review of the Comprehensive Care Plan for Resident #11 revealed the facility developed a care plan for risk for falls on 12/08/10. Approaches included placing the resident in a fall-prevention program, cue the resident with verbal reminders not to ambulate or transfer without assistance, and ensure that the resident had and wore properly-fitting no-skid soled shoes for ambulation. These approaches remained on</p>	F 280		



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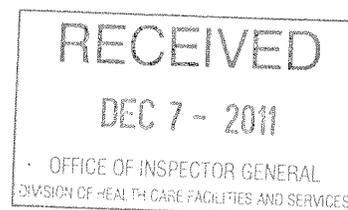
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F 280	Continued From page 7 the care plan following the Quarterly MDS Assessment completed on 10/18/11 and after Resident #11 was readmitted to the facility following a left above the knee amputation.  Observation of Resident #11, on 11/02/11 at 3:20 PM, revealed the resident laying in bed tilted to the right side. Two (2) CNA's were providing incontinent care. Resident #11 was alert, with inconsistent speech. The resident had bilateral above the knee amputations.  Interview with the Minimum Data Set (MDS) Coordinator, on 11/03/11 at 10:50 AM, revealed she had only been her current position for about one (1) month. She stated the system to update care plans was she received copies of all new orders every day and then made the changes to the resident's care plan.  Interview with the MDS Coordinator, on 11/03/11 at 11:55 AM, regarding the care plan for Resident #11 revealed when she completed the residents quarterly assessment she thought she had removed all the non-applicable interventions. She stated the intervention for the resident to wear properly-fitting non skid soled shoes for ambulation was not appropriate for this resident and it just got missed.  Interview with the Assistant Director of Nursing (ADON), on 11/03/11 at 12:00 PM, revealed she was responsible to ensure the accuracy of the MDS's and that the care plan was complete. She stated she did not go through the care plan specifically to ensure all interventions were current.	F 280		
F 282	483.20(k)(3)(II) SERVICES BY QUALIFIED	F 282		



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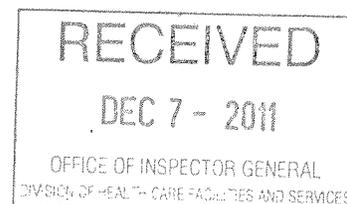
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F 282 SS=D	Continued From page 8 PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to implement Care Plan interventions for one (1) of seventeen (17) sampled residents. The facility failed to ensure Resident #1 had alarms to the wheelchair per care plan intervention related to falls.  The findings include:  Review of the facility's policy Care Planning Guideline, undated, revealed the care plan that you put together must be implemented by appropriate/qualified personnel.  Review of Resident #1's clinical record revealed the facility admitted the Resident on 03/07/11. After being sent to the hospital for increased aggressive behaviors, the facility readmitted the Resident on 10/21/11 with the following diagnoses: Dementia, Depression, and Schizoaffective disorder.  Review of Resident #1's comprehensive plan of care revealed High Risk for Falls with an onset on 03/21/11. The facility determined the following interventions were appropriate for Resident #1: fall mat on the floor during nighttime with half side	F 282	F 282 1. Nurse #4 immediately placed a new alarm to Resident #1 wheelchair upon being notified by surveyor on 11/03/11. 2. A 100% audit of all residents requiring bed and chair alarms was done on 11/04/11 by the Director of Nursing/Assistant Director of Nursing to ensure the alarm was in place and working properly. No other residents were found to be affected by cited deficiency. 3. The Director of Nursing/Assistant Director of Nursing will re-educate all nursing staff and Department Managers by December 8, 2011 on the use of safety alarms and reading and following the Resident Care Guide to ensure the alarms are in place and functioning properly. 4. All residents requiring alarms will be observed during facility rounds done daily by	



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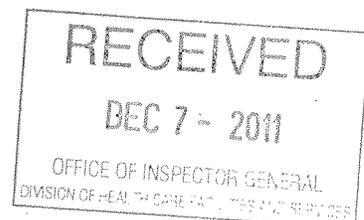
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F 282	<p>Continued From page 9</p> <p>rails in the up position; bed alarm; chair alarm; bed in [the] lowest position; perimeter mattress; toileted every 2 hours and as needed; psychiatric services to evaluate and treat as needed; non skid socks/footwear; re-educate wife on not providing care; and a wedge cushion to the wheelchair. Review of the CNA Daily Care Guide, dated 11/02/11, revealed a chair alarm was to be in place.</p> <p>Observations of Resident #1, on 11/01/11 at 2:45 PM, 3:15 PM and 4:30 PM, revealed the Resident was sitting in the wheelchair without a chair alarm in place.</p> <p>Observation of Resident #1, on 11/02/11 at 8:15 AM, revealed two (2) Certified Nursing Assistants (CNA) assisting the resident with dressing and transfer to the wheelchair. The CNA's did not place an alarm on the wheelchair and left the resident alone in the room. The Director of Nursing, observing the transfer at the time, did not inquire about or replace the alarm.</p> <p>Continued observation of Resident #1, on 11/02/11 at 9:15 AM, 10:00 AM, and 10:40 AM, revealed the Resident was sitting up in the wheelchair without the chair alarm in place.</p> <p>Observation of Resident #1, on 11/03/11 at 9:00 AM, revealed the resident was sitting up in the wheelchair, in the resident's room, without the chair alarm in place.</p> <p>Review of the physician orders, dated 10/25/11, revealed the Resident was to have a bed and chair alarm in place and staff were to check for proper functioning every shift.</p>	F 282	<p>Nursing Assistants/Charge Nurses/Unit Manager/Assistant Director of Nursing/Director of Nursing/Department Managers for placement and proper functioning. A random audit of 10 residents with an alarm will be completed by the Director of Nursing/Assistant Director of Nursing/Unit Manger/Charge Nurse/Department Manager daily times two weeks, weekly times four weeks, monthly times 2 months and then quarterly times 2 quarters to ensure placement and proper working order of the alarm. The results of the audits will be reviewed in the monthly Performance Improvement Committee Meeting. Revisions will be made to the systems as indicated.</p> <p style="text-align: right;">Completion date: 12/09/11</p>



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F 282	<p>Continued From page 10</p> <p>Review of the Treatment Administration Record (TAR), dated 11/2011, revealed the bed and chair alarm functioning check had been signed off by the nurse for 11/01/11 and 11/02/11 indicating the alarm was in place and functioning as it should. However, interview with Licensed Practical Nurse (LPN) #4, on 11/03/11 at 11:02 AM, revealed she was not sure if Resident #1 had a physician order for a chair alarm and did not know if the resident had been care planned for a chair alarm. When asked if she had signed the TAR verifying the alarm was in place, she confirmed it was her signature and stated she signed it out of habit. The LPN revealed the resident could potentially fall without anyone knowing if the alarm was not in place.</p> <p>Interview with CNA #5, on 11/03/11 at 10:55 AM, revealed she did not check the Care Guide provided by the facility to determine if Resident #1 was to have an alarm in place. When asked if the resident was to have a chair alarm, the CNA revealed she thought it was in place.</p> <p>Concurrent observation of CNA #5, on 11/05/11 at 10:55 AM, revealed the CNA was unable to find a chair alarm for the Resident #1 in the resident's room. The CNA notified the nurse, who also searched, and was also unable to locate a chair alarm for the resident.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 11/03/11 at 11:02 AM, revealed she was not sure if Resident #1 was ordered to have a chair alarm. The LPN further revealed she did not know if the resident had been care planned for a</p>	F 282		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/03/2011
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F 282	<p>Continued From page 11</p> <p>chair alarm. When asked if she had signed the TAR verifying the alarm was in place, she confirmed it was her signature and stated she signed it out of habit. The LPN revealed the resident could potentially fall without anyone knowing if the alarm was not in place.</p> <p>Observation, on 11/03/11 at 11:07 AM, revealed LPN #4 placed a chair alarm to Resident #1's wheelchair.</p> <p>Interview with the Director of Nursing (DON), on 11/03/11 at 11:45 AM, revealed the facility ensured the care plans were being followed as it pertains to alarms by placing it on the TAR and the Care Guide. The DON revealed rounds were completed 2 to 3 times a week to ensure the alarms are in place, however, she did not notice Resident #1 did not have an alarm in place for three (3) consecutive days. The DON revealed the current system for monitoring the care plan was not perfect.</p>	F 282		
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,</p>	F 323	<p>F 323</p> <p>1. Nurse #4 immediately placed a new alarm to Resident #1 wheelchair upon being notified by surveyor on 11/03/11.</p> <p>The Charge Nurse spoke with the physician for Resident #12 on November 17, 2011 regarding his wandering and history of aggressive behaviors. New orders were obtained.</p>	

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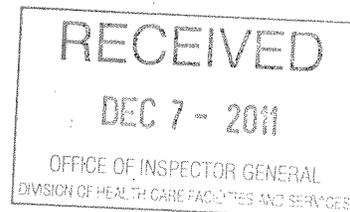
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F 323	<p>Continued From page 12 and review of the facility's policy titled Falls Management, it was determined the facility failed to ensure alarms were in place and adequate supervision was provided for two (2) of the seventeen (17) sampled residents (#1 and #12). Resident #1 did not have a chair alarm in place for three (3) consecutive days as care planned related to a history of falls. In addition, Resident #12 did not have adequate supervision to prevent wandering into other resident rooms when the Resident had a history of wandering.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Falls Management, not dated, revealed each resident will be assessed throughout the course of treatment for different parameters such as: cognition, safety awareness, fall history, mobility, sensory status, medications, or predisposing health conditions that may contribute to fall risk. An interdisciplinary plan of care will be developed, implemented, reviewed and updated as necessary to reflect each resident's current safety needs and fall reduction interventions.</p> <p>Review of Resident #1's clinical record revealed the facility admitted the Resident on 03/07/11. After being sent to the hospital for increased aggressive behaviors, the facility readmitted the Resident on 10/21/11 with the following diagnoses: Dementia, Depression, and Schizoaffective disorder. The facility assessed the resident as a high falls risk, with nine (9) falls documented since 05/17/11. The facility assessed the Resident on the Minimum Data Set (MDS), on 09/15/11, as having severely impaired vision, a cognitive deficit, requiring a 2 person</p>	F 323	<p>2. A 100% audit of all residents requiring bed and chair alarms was done on 11/04/11 by the Director of Nursing/Assistant Director of Nursing to ensure the alarm was in place and working properly. No other residents were found to be affected by cited deficiency. A 100% audit of all residents who have been identified as having wandering behaviors were observed by the Director of Nursing/Assistant Director of Nursing on 11/04/11 for wandering, staff observation and timeliness and ease with redirection. No other residents were affected. All "stop sign barriers" were re-positioned on 11/4/11 by the Maintenance Director to be visible at sitting level to deter wandering residents from entering resident rooms.</p> <p>3. All licensed nurses will be re-educated by the Director of Nursing/Assistant Director of Nursing by December 8, 2011, on verifying the alarms in place and functioning prior</p>	
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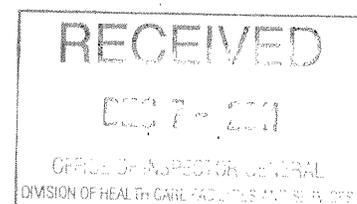
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F 323	<p>Continued From page 13</p> <p>assist with transfers, bed mobility, and ambulation, only able to stabilize balance with human assistance during transition and walking, requiring the use of a wheelchair for mobility, and frequently incontinent of bladder.</p> <p>Review of Resident #1's comprehensive plan of care revealed High Risk for Falls with an onset on 03/21/11. The facility implemented the following interventions: bed alarm; chair alarm; non skid socks/footwear; and a wedge cushion to the wheelchair.</p> <p>Observations of Resident #1, on 11/01/11 at 2:45 PM and 3:15 PM, revealed the resident was sitting in the lounge, listening to music, with no alarm in place to the wheelchair. At 4:30 PM, the Resident was sitting up in the wheelchair, in the resident's room, with no chair alarm in place.</p> <p>Observation of Resident #1, on 11/02/11 at 8:15 AM, revealed two (2) Certified Nursing Assistants (CNA) assisted the resident with dressing and transfer to the wheelchair. The CNA's did not attach a wheelchair alarm and left the resident alone in the room. The Director of Nursing was in the room at the time observing the transfer and did not intervene related to the chair alarm.</p> <p>Continued observation of Resident #1, on 11/02/11 at 9:15 AM, 10:00 AM, and 10:40 AM, revealed the resident was sitting up in the wheelchair without the chair alarm in place.</p> <p>Observation of Resident #1, on 11/03/11 at 9:00 AM, revealed the resident was sitting up in the wheelchair, in the resident's room, without the chair alarm in place.</p>	F 323	<p>to signing the TAR. The Director of Nursing/Assistant Director of Nursing will re-educate all nursing staff and Department Managers by December 8, 2011 on the use of safety alarms and reading and following the Resident Care Guide to ensure the alarms are in place and functioning properly. All associates will be re-educated by the Director of Nursing/Assistant Director of Nursing on Caring for a Wandering Resident - specifically observation, redirection, notification (physician, Director of Nursing, Assistant Director of Nursing), documentation, "stop sign barrier" placement and placing a resident on every fifteen minute observation as needed. All education will be completed by December 8, 2011. The Director of Nursing will attend the next scheduled Resident Council Meeting on December 7, 2011 to discuss</p>	
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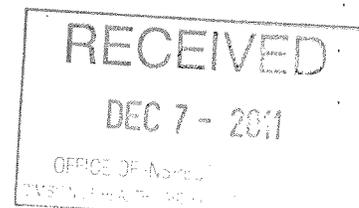
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F 323	Continued From page 14  Review of the physician orders, dated 10/25/11, revealed the resident was to have a bed and chair alarm in place and staff were to check for proper functioning every shift.  Review of the Treatment Administration Record (TAR), dated 11/2011, revealed the nurse had signed the TAR on 11/01/11 and 11/02/11 indicating the bed and chair alarm were in place and functioning  Review of the CNA Daily Care Guide, dated 11/02/11, revealed a chair alarm was to be in place.  Interview with CNA #5, on 11/03/11 at 10:55 AM, revealed she thought the alarm was in place even though she did not attach it or check the Care Guide provided by the facility to determine if the resident was to have an alarm in place.  Concurrent observation of CNA #5, on 11/05/11 at 10:55, revealed the CNA was unable to find a chair alarm for the Resident in the Resident's room. The CNA notified the nurse, who also searched, and was also unable to locate a chair alarm for the Resident.  Interview with CNA #6, on 11/03/11 at 11:00 AM, revealed she had assisted the Resident up to the wheelchair that morning. The CNA revealed she was aware the Resident was to have a chair alarm but did not check to assure it was in place. The CNA revealed without the chair alarm the resident could fall out of the char trying to get up. The CNA further revealed she did not recall having training on falls prevention as it pertains to	F 323	with the Residents what to do if a wandering resident enters your room. 4. All residents requiring alarms will be observed during facility rounds done daily by Nursing Assistants/Charge Nurses/Unit Manager/Assistant Director of Nursing/Director of Nursing/Department Managers for placement and proper functioning. A random a audit of 10 residents with an alarm will be completed by the Director of Nursing/Assistant Director of Nursing/Unit Manger/Charge Nurse/Department Manager daily times two weeks, weekly times four weeks, monthly times 2 months and then quarterly times 2 quarters to ensure placement and proper working order of the alarm. The results of the audits will be reviewed in the monthly Performance Improvement Committee Meeting. Revisions will be made to the systems as indicated.	

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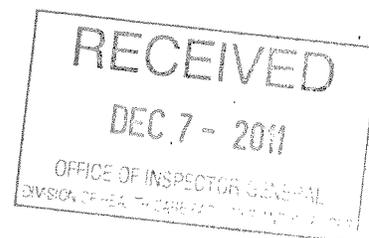
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F 323	Continued From page 15 alarms.  Interview with Licensed Practical Nurse (LPN) #4, on 11/03/11 at 11:02 AM, revealed she was not sure if the resident was ordered to have a chair alarm. When asked if she had signed the TAR verifying the alarm was in place, she confirmed it was her signature and stated she signed it out of habit. She further revealed she did not have training on falls prevention as it pertains to alarms. The LPN revealed the Resident could potentially fall without anyone knowing if the alarm was not in place.  Observation, on 11/03/11 at 11:07 AM, revealed LPN #4 placed a chair alarm to Resident #1's wheelchair.  Interview with the Director of Nursing (DON), on 11/03/11 at 11:45 AM, revealed the interdisciplinary team discussed falls in the morning meetings to determine appropriate interventions for each resident. The DON stated each fall was followed by the team for a four (4) week time period. The DON revealed alarms are placed on the Care Guide to ensure the CNA's were aware of what was to be put into place. The DON revealed she monitored for alarms by doing a visual check while going up and down the halls but did not notice Resident #1 did not have one in place for three (3) consecutive days. The DON revealed the current system of using the Care Guide for communication was flawed. She further revealed she does monitor the TAR, but looks for holes where they had not been signed. The DON revealed she did not have a reason to think a nurse would sign the TAR and not ensure the Alarm was in place. She further revealed the	F 323	All rooms with "stop sign barriers" will be observed during facility rounds daily by the Charge Nurses/Nursing Assistants/Department Managers for proper placement. A random audit of four rooms with "stop sign barriers" will be completed by the Director of Nursing/Assistant Director of Nursing/Unit Manager/Department Manager to ensure proper placement daily times two weeks, weekly times four weeks, monthly times two months, quarterly times two quarters. The results of the audits will be reviewed in the monthly Performance Improvement Committee Meeting. Revisions will be made to the systems as indicated. The Charge nurses will document on the 24-Hour Report and notify the Director of Nursing/Assistant Director of Nursing of any wandering behaviors that required 15-	



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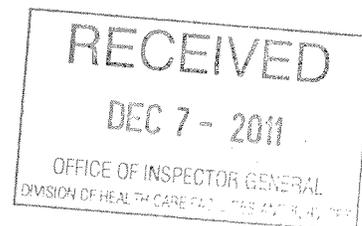
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F 323	<p>Continued From page 16</p> <p>facility had not provided training to the facility staff on falls prevention as it pertains to the application of alarms.</p> <p>2. Review of the medical record of Resident #12, revealed the facility admitted the resident on 01/25/10 with diagnoses of Dementia, Anxiety, Behaviors, and Physical Abuse. On 01/27/11 Resident #12 was care planed for combative behaviors and staff identified that Resident #12 was difficult to re-direct. An interdisciplinary plan of care problem identified on 09/23/11 revealed Resident #12 rolled himself/herself sitting in a wheelchair into unauthorized areas, resident rooms, and staff offices. Behaviors were identified which described Resident #12 as aggressive at times.</p> <p>Observations, on 11/03/11 at 8:30 AM, revealed Resident #12 was sitting by the nurses station on the 300 hallway. Resident #12 would sit quietly for several minutes and then propel the wheelchair to another area in the hallway.</p> <p>Interview with Resident #5, on 11/3/11 at 8:10 AM, revealed Resident #12 had come into his/her bedroom during the night and was sitting next to the Resident #5's bed. Resident #5 stated this behavior made him/her uncomfortable and he/she asked Resident #12 to leave the room. Resident #12 did leave the room as requested. Resident #5 also reported this to the nurse on duty; however, did not remember the nurses name.</p> <p>Interview, on 11/3/11 at 9:15 AM, with the Director of Social Services revealed she was aware of Resident #12's wandering. In addition she stated,</p>	F 323	<p>minute observation and/or resulted in aggressive behavior by the resident. The Director of Nursing/Assistant Director of Nursing/Unit Manager will review those residents charts daily Monday through Friday for documentation, notification of physician, following and/or changes to the care plan interventions. A random audit of two residents who have been identified as having wandering behaviors will be observed by the Director of Nursing/Assistant Director of Nursing/Unit Manager/Department Manager for wandering, staff observation and timeliness and ease with redirection daily times two weeks, weekly times four weeks, monthly times 2 months and then quarterly times 2 quarters. The results of the audits will be reviewed in the monthly Performance Improvement Committee Meeting. Revisions will be made to the systems as indicated.</p>
			<p>(X4) COMPLETION DATE</p> <p>Completion date: 12/09/11</p>



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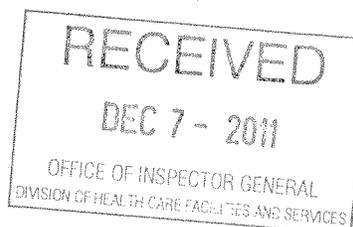
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F 323	<p>Continued From page 17</p> <p>staff are to re-direct Resident #12. She was unaware Resident #12 was entering other resident's rooms.</p> <p>Interview with Nurse #7, on 11/02/11 at 10:30 AM, revealed Resident #12 was re-directed from another residents room around 9:00 AM the morning of the second (2nd) She further stated Resident #12 wandered and entered other resident rooms.</p> <p>Interview with Nurse #4, on 11/03/11 at 10:49 AM, revealed Resident #12 wandered into other residents' rooms. She further stated the "STOP" barriers do not keep Resident #12 from entering a resident's room, because he/she bends over in the wheelchair and passes under the barrier. Nurse #4 also stated residents that attempt to elope or that have aggressive behaviors are put on fifteen (15) minute watch's.</p> <p>Observation of the "STOP" barrier, on 11/03/11 at 11:00 AM, revealed the barrier was above the waistline of a 5'7" person.</p> <p>Interview with the DON, on 11/03/11 at 11:05 AM, revealed she felt the "STOP" barriers would prevent a resident from wandering into another resident's room. She further added Resident #12 often came to her office and if Resident #12 became restless during the night, staff would get the resident up and place the resident in a wheelchair. The DON had not received any reports of Resident #12 entering residents' rooms at 1:00 AM in the morning.</p> <p>Interview, on 11/03/11 at 11:40 AM, with the ADON confirmed Resident #12 had aggressive</p>	F 323			



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F 323	Continued From page 18 behaviors at times and at times it was difficult to re-direct Resident #12. The ADON also, confirmed Resident #12 had the potential to be aggressive towards another resident.	F 323		
F 371 SS=F	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  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy's titled Using the Cleaning Schedule and Cleaning Procedures and Cleaning and Caring for Equipment, it was determined the facility failed to ensure sanitary conditions the meat slicer and mixer which were soiled, covered and ready for use.  The findings include:  Review of the facility's policy titled Using the Cleaning Schedule and Cleaning Procedures, not dated, revealed responsibilities of each associate are to ensure that an item or area has been cleaned appropriately before initialling that the task has been completed. Each associate is trained how to clean and sanitize all equipment and areas of the department. Be sure that each	F 371	F 371 1. The Dietary Manager sanitized the mixer and meat slicer immediately upon notification by the surveyor on 11/01/11. 2. The Dietary Manager visually inspected all appliances in the kitchen on 11/01/11 and no other appliances were found to be effected. 3. All dietary associates were re-educated by the Dietary Manager and the Registered Dietician on November 22, 2011 regarding sanitation procedures for all kitchen equipment. 4. The Dietary Manager will review and sign the Daily Cleaning Schedule Log for completion daily Monday through Friday. A random audit by visual inspection of four kitchen appliances will be completed by the Dietary Manager/Registered	



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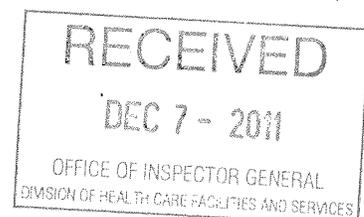
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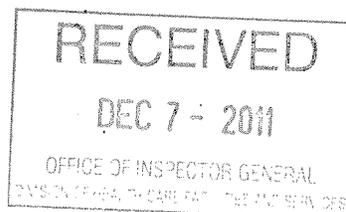
F 371	<p>Continued From page 19 item is as clean as it should be.</p> <p>Review of the facility's policy titled Cleaning and Caring for equipment, not dated, revealed kitchen staff are to clean equipment and utensils thoroughly after each use. Protect equipment by covering it when not in use or while in storage to protect it from splashing, dust, and other means of contamination.</p> <p>Observation during the initial kitchen tour, on 11/01/11 at 9:15 AM, revealed a large mixer sitting on the counter covered with plastic. A yellow, creamy textured substance was found on the back of the mixer and on the splash guard of the mixer. A meat slicer was noted on the preparation counter covered with plastic. A cream colored substance was splattered behind the blade and on the blade lever.</p> <p>Interview with the Dietary Manager, on 11/03/11 at 8:40 AM, revealed the meat slicer and the mixer should be cleaned after each use and covered by the person assigned on the cleaning schedule. The Dietary Manager further revealed monitoring was completed by doing sanitary audits weekly at random times.</p> <p>Review of the sanitary audit revealed cleaning and storage of the mixer and slicer are included on the audit. Review of the cleaning schedule for the slicer and the mixer revealed both were signed off as clean by the evening staff on 10/31/11, and by the morning staff on 11/01/11.</p> <p>Continued interview with the Dietary Manager, on 11/03/11, revealed the audit was not completed for the week. The Dietary Manager further</p>	F 371	<p>Dietician/Executive Director to ensure proper sanitation weekly times four weeks then monthly for three months then randomly. The results of the audits will be reviewed in the monthly Performance Improvement Committee Meeting. Revisions will be made to the systems as indicated.</p>	<p>Completion date: 12/09/11</p>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/03/2011
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
F 371	Continued From page 20 revealed the the Dietary assistant that cleaned the meat slicer was not trained how to properly clean the slicer. The Dietary Manager stated the system for monitoring the cleanliness of the mixer and meat slicer had been working, but feels the staff are slacking off on proper cleaning procedures. The Dietary Manager indicated there was a potential for infection and food bourne illness and stated ultimate responsibility for the sanitary conditlons of the kitchen area.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431	F 431 1. The Charge Nurse/Director of Nursing corrected all three medication carts immediately upon notification by the surveyor on 11/02/11. 2. A 100% audit of all medication carts was completed on 11/3 and 11/4/11 by the Director of Nursing and all medications were found to be stored properly. 3. All Licensed nurses will be re-educated by December 8, 2011 by the Director of Nursing/Assistant Director of Nursing on Drug Storage Policy.	



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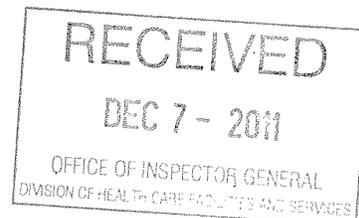
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F 431	<p>Continued From page 21</p> <p>Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy Medication Storage and Security in the Facility, it was determined the facility failed to properly store medications. Observation revealed oral medications were not separated from medications intended for external use for three (3) of four (4) medication carts on the East and West Wings.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding storage of medications Medication Storage and Security in the Facility, (revised 06/06), revealed medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations of those of the supplier.... 4). Orally administered medications are kept separate from externally used medications (e.g., suppositories, liquids, lotions, and tablets.....6). Eye medications are kept separate from ear medications.</p> <p>Interview with the Medication Nurse, LPN #3, on 11/02/11 at 2:35 PM, revealed the Exelon Patches were usually kept with the oral medications, and stated the rest of the</p>	F 431	<p>4. The Director of Nursing/Assistant Director of Nursing/Unit Manager will observe all medication carts daily Monday through Friday during facility rounds for proper medication storage. A random audit of two carts will be completed by the Director of Nursing/Assistant Director of Nursing/Unit Manager to ensure proper medication storage weekly times four weeks, monthly times 2 months and then quarterly times 2 quarters. The results of the audits will be reviewed in the monthly Performance Improvement Committee Meeting. Revisions will be made to the systems as indicated.</p>	<p>Completion date: 12/09/11</p>
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F 431	<p>Continued From page 22</p> <p>medications should be kept together in another drawer.</p> <p>Interview with Medication Nurse LPN #1, on 11/02/11 at 2:55 PM, revealed the patches, eye drops, inhalers, and ear drops should be stored separately. The LPN stated the Unit Manager was responsible for checking all the medication carts; in addition, the Pharmacy Consultant, who visits monthly for drug reviews, is responsible for checking the medication carts during their visit to the facility.</p> <p>Interview with the Director of Nursing, on 11/2/11 at 2:45 PM, revealed all patches, suppositories, eye, and ear medications should be stored away from the oral medications.</p> <p>Interview with the Administrator, on 11/03/11 at 10:30 AM, revealed that oral and external medications should be separated.</p> <p>An inspection of the West Wing Medication Cart #2, on 11/02/11 at 2:30 PM, revealed two (2) vials of Flonase Nasal spray, six (6) Dulcolax suppositories, and one (1) Exelon patch were stored with the oral medications.</p> <p>Further inspection of the East Wing Medication Cart #1, on 11/02/11 at 2:50 PM, revealed one (1) box of four (4) Estradiol Patches, sixteen (16) Exelon Patches, and an empty body of Transderm Scopolamine Patches stored with the oral medications. Review of East Wing Medication Cart #2 revealed one (1) Lidoderm Patch, one (1) bottle Calcitine Salmon nasal spray, two (2) bottles of Ear Drops, and two (2) boxes of Exelon Patches stored with the oral</p>	F 431	

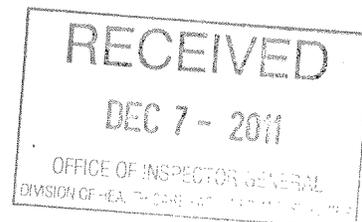
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F 431	Continued From page 23 medications.	F 431	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (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	F 441	F 441 1. A new ice scoop and container was provided at the beverage station immediately upon notification from the surveyor on 11/03/11. 2. A 100% audit of all ice scoops was done by the Director of Nursing/Assistant Director of Nursing on 11/04/11 and all scoops were stored properly. 3. All associates will be re-educated by the Director of Nursing/Assistant Director of Nursing on the Infection Control policy related to proper storage of the ice scoop by December 8, 2011.

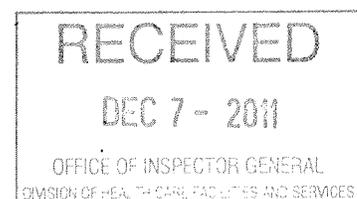
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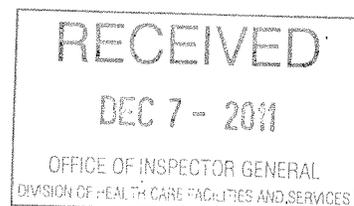
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F 441	<p>Continued From page 24</p> <p>from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing 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 review of the facility's policy titled Ice Chest and Ice Machines, it was determined the facility failed to follow their policy related to the storage of the ice scoop during two (2) of three (3) meal observations and an activity.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Ice Chests and Ice Machines, dated 05/21/04, revealed ice scoops used should be smooth and impervious and should be kept on an uncovered stainless steel, impervious plastic, or fiberglass tray on top of the chest or in a mounted holder when not in use.</p> <p>Observation, on 11/02/11 at 10:15 AM, of an activity in the dining room revealed a clear plastic ice container, with the ice scoop stored in the ice, sitting on the beverage counter. Staff were</p>	F 441	<p>4. The Dietary Manager/Meal Manager/Activity personnel will observe the beverage station during meals and activities for proper storage of the ice scoop daily. A random audit of one ice scoop will be completed by the Dietary Manager/Meal Manager to ensure proper storage daily times two weeks, weekly times four weeks, monthly times 2 months and then quarterly times 2 quarters. The results of the audits will be reviewed in the monthly Performance Improvement Committee Meeting. Revisions will be made to systems as indicated.</p>	<p>Completion date: 12/09/11</p>



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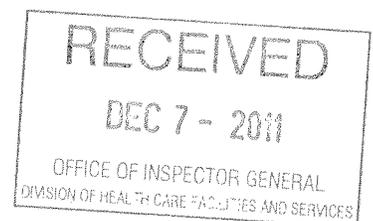
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F 441	<p>Continued From page 25</p> <p>observed periodically reaching into the container to retrieve the ice scoop to prepare beverages for the residents in attendance, then returning the scoop back into the ice container.</p> <p>Observation of the meal service, on 11/02/11 at 11:10 AM, revealed two (2) Certified Nursing Assistants (CNA) storing the ice scoop in the ice on the beverage counter in the dining room after preparing beverages for both the first and second seating.</p> <p>Observation of the meal service, on 11/03/11 at 8:30 AM, revealed the ice scoop being stored in the ice in the dining room.</p> <p>Interview with CNA #1, on 11/03/11 at 8:30 AM, revealed the dietary department usually sets out the ice container with the scoop stored inside the ice. The CNA revealed a potential for infection by using the scoop then storing it back in the container.</p> <p>Interview with CNA #8, on 11/03/11 at 8:35 AM, revealed the Dietary Department set up the ice container on both 11/02/11 and 11/03/11. The CNA revealed a potential for cross-contamination and infection by storing the ice scoop in the ice. The CNA further revealed she had not been trained on proper storage of the ice scoop or facility policy.</p> <p>Interview with the Dietary Aide, on 11/03/11 at 8:36 AM, revealed he set up the ice container for the morning meal service. He stated the ice scoop was usually kept in a separate bucket, but he had never been told he could not just place it in the ice container. The Dietary Aide revealed</p>	F 441			



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F 441	<p>Continued From page 26</p> <p>storing the ice scoop in the container could potentially cause infection problems.</p> <p>Interview with the Dietary Manager, on 11/03/11 at 8:40 AM, revealed the Kitchen sets up the beverage counter with the ice container. The Dietary Manager revealed the ice scoop should be stored in a pitcher covered with plastic wrap. The Dietary Manager stated the staff had been trained, but the facility had not had an in-service on the storage of the ice scoop. The Dietary Manager revealed improper storage of the ice scoop could potentially cause problems with infection control.</p> <p>Interview with the Director of Nursing (DON), on 11/03/11 at 11:45 AM, revealed she was not aware CNA's were storing the ice scoop in the ice container in the dining room. The DON revealed she thought all the staff was aware of the proper storage of the ice scoop. She further revealed she had not noticed the scoop being stored in the ice during meal observations, but had only been monitoring the storage of the scoop on the nursing units.</p>	F 441			



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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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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  BUILDING: 01  PLAN APPROVAL: 1978  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One (1) story, Type V (000)  SMOKE COMPARTMENTS: Eight (8) smoke compartments.  FIRE ALARM: Complete fire alarm system with heat and smoke detectors.  SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.  GENERATOR: Type II generator. Fuel source is propane gas.  A standard Life Safety Code survey was conducted on 11/01/11. Life Care Center of Bardstown was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one-hundred (100) beds and the census was eighty-four (84) on the day of the survey.  The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000	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 to service as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*[Signature]*

TITLE

*[Signature]*

(X8) DATE

12/7/11

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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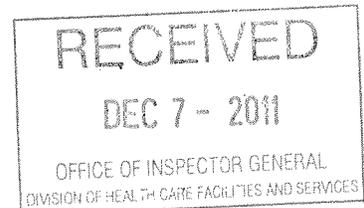
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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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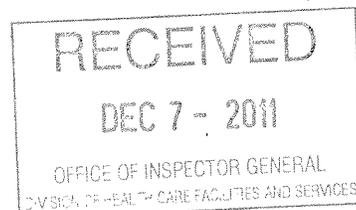
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K 000	Continued From page 1	K 000		
K 029 SS=D	<p>Deficiencies were cited with the highest deficiency identified at F level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for one-hundred (100) beds, and the census was eighty-four (84) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 11/01/11 at 9:30 AM, with the Maintenance Director revealed the ceiling in the Central Mechanical Room had been penetrated by cables and data lines. The room was not</p>	K 029	<p>K-029</p> <ol style="list-style-type: none"> <li>The ceiling in the Central Mechanical room penetrated by cables and data lines was sealed with fireproof silicone on 11/1/11.</li> <li>No other areas were identified that needed to be sealed.</li> <li>Maintenance will oversee the installation and repairs in the facility provided by outside contractors. Upon the completion of any service by contractors, Maintenance will ensure that no holes were created within the fire rated construction. Any areas identified will be sealed immediately.</li> <li>Maintenance Supervisor and/or Maintenance Assistant will audit 50% of the ceilings in the facility to ensure the fire rated construction has not been compromised. Each audit will consist of the</li> </ol>	



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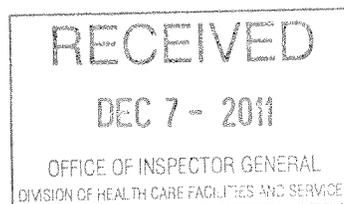
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K 029	Continued From page 2 sealed to resist the passage of smoke.  Interview, on 11/01/11 at 9:30 AM, with the Maintenance Director revealed he was unaware the holes in the ceiling had not been sealed smoke tight.  Reference: NFPA 101 (2000 edition)  19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible	K 029	Maintenance Supervisor or Maintenance Assistant to physically inspect the ceilings to ensure the fire rated construction has not been compromised. Auditing will be completed weekly for two months, semi-monthly for two months and then monthly thereafter. Executive Director will review audit findings from Maintenance Supervisor and/or Maintenance Assistant weekly for two months, semi-monthly for two months and then monthly thereafter. The Performance Improvement Committee will review the monthly findings for trends/needs for continued need of audits.	December 9, 2011	



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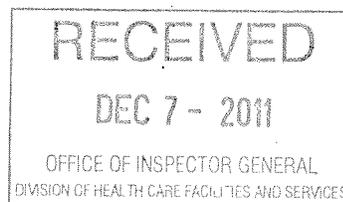
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  11/01/2011
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K 029	Continued From page 3 supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051	K-051  1. The fire alarm pull station located near the exit in kitchen is now accessible as the storage rack was moved from that location.  2. No other fire alarm pull stations were identified to be inaccessible.  3. All staff will be in-serviced by December 8, 2011 by Director of Nursing and/or Assistant Director of Nursing to understand that fire alarm pull stations must be accessible and not be blocked by any equipment or furniture.	



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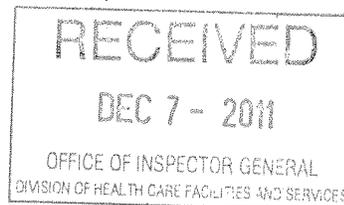
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K 051	Continued From page 4  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure a building fire alarm system's initiating device was maintained as required by NFPA standards. The deficient practice had the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred (100) beds with a census of eighty-four (84) on the day of the survey.  The findings include:  Observation, on 11/01/11 at 10:35 AM, with the Maintenance Director revealed the fire alarm pull station located near the exit from the Kitchen, was obstructed by a storage rack and determined to be inaccessible.  Interview, on 11/01/11 at 10:35 AM, with the Maintenance Director revealed there was a lack of space within the Kitchen and the storage rack should be relocated to gain access to the pull station in the event of an emergency.  Reference: NFPA 72 (1999 Edition).  2-1.3.3 Initiating devices shall be installed in all	K 051	4. Maintenance Supervisor and/or Maintenance Assistant will audit 100% of the fire alarm pull stations in the facility to ensure the accessibility has not been compromised by physically inspecting each fire alarm pull station. Auditing will be completed weekly for two months, semi-monthly for two months and then monthly thereafter. Executive Director will review audit findings from Maintenance Supervisor and/or Maintenance Assistant weekly for two months, semi-monthly for two months and then monthly thereafter. The Performance Improvement Committee will review the monthly findings for trends/needs for continued need of audits.  December 9, 2011	



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K 051	Continued From page 5	K 051		
K 052 SS=F	<p>areas where required by other NFPA codes and standards or the authority having jurisdiction. Each installed initiating device shall be accessible for periodic maintenance and testing.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to test the fire alarm system quarterly per NFPA standards. The deficiency had the potential to affect each of the eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for one-hundred (100) beds with a census of eighty-four (84) on the day of the survey.</p> <p>Findings include:</p>	K 052	<p><b>K-052</b></p> <ol style="list-style-type: none"> <li>No residents were affected by cited deficiency.</li> <li>No residents were affected by cited deficiency.</li> <li>Executive Director identified that prior two quarters of Fire Alarm System Testing was not completed as required including 4<sup>th</sup> quarter 2010 and 1<sup>st</sup> quarter 2011. Upon notification to Fire Alarm Company, miscommunication from company and facility had occurred and Fire Alarm Company did not perform required testing. Fire Alarm Company re-initiated testing on 8/29/11 with no issues identified during testing. Scheduled dates for quarterly</li> </ol>	



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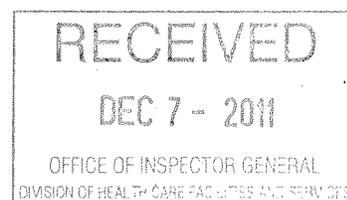
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K 052	Continued From page 6	K 052	inspections for the remainder of 2011 included 11/7/2011 and was completed as scheduled with no concerns identified. 2012 was scheduled by Fire Alarm Company and Executive Director to ensure proper testing. Maintenance Supervisor given list of upcoming dates to ensure testing completed within required time frame.	
	<p>Record review of the Fire Alarm System, on 11/01/11/11 at 1:15 PM, revealed no documentation that the facility's Fire Alarm System had been tested quarterly per NFPA requirements. The records indicated the System was previously tested in September, 2010 during the third quarter of 2010. In addition, two (2) quarterly tests had been completed in May 2011 during the second quarter and in August 2011 during the third quarter.</p> <p>Interview, on 11/01/11 at 2:30 PM, during the exit conference with the Administrator and the Maintenance Director, revealed there was a misunderstanding with the facility and the company contracted to perform the inspections. As a result, two (2) quarterly inspections / testing had not been performed.</p> <p>Reference: NFPA 101 (2000 edition).</p> <p>9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.</p>	4.	Maintenance Supervisor has dates for upcoming 2011 and 2012 fire alarm system testing. Maintenance Supervisor will contact Fire Alarm Company by the next business day if the fire alarm system testing has not been completed as scheduled. Verification that quarterly fire alarm testing was completed will be audited by the Maintenance Supervisor by reviewing and signing completed Fire Alarm Inspection Report and reviewed/signed by the Executive Director on a quarterly basis. The Performance Improvement Committee will review the quarterly findings for trends/needs for continued need of audits.	
K 062 SS=D	<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>	K 062		December 9, 2011



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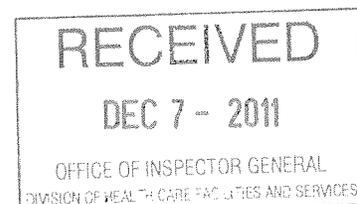
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K 062	Continued From page 7	K 062	K-062	
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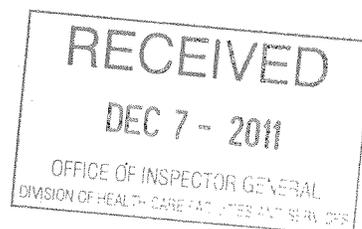
K 130 SS=E	<p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure fire extinguishers had the proper signage according to NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for one-hundred (100) beds, and the census was eighty-four (84) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 11/01/11 at 10:30 AM, with the Maintenance Director revealed the portable "K" type fire extinguisher located next to the exhaust hood in the kitchen, did not have the required signage on display.</p> <p>Interview, on 11/01/11 at 10:30 AM, with the Maintenance Director revealed he was unaware of the requirement that a sign was to be displayed near the "K" type fire extinguisher that stated the fire protection system shall be activated prior to using the fire extinguisher.</p> <p>Reference: NFPA 10 (1998 edition)</p> <p>2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.</p> <p>NFPA 101 MISCELLANEOUS</p> <p>OTHER LSC DEFICIENCY NOT ON 2786</p>	K 130	<ol style="list-style-type: none"> <li>1. Facility posted sign above K type fire extinguisher in the kitchen indicating it is the secondary method for extinguishing fire, after the range hood extinguisher is initialized.</li> <li>2. No other K type fire extinguishers in the facility.</li> <li>3. Maintenance Supervisor was in-serviced by Executive Director on 12/1/11 regarding the K-type fire extinguisher is the secondary means, after the fire protection range hood extinguishing system, for extinguishing a fire on the range/grill and need for appropriate signage. Dietary staff will be in-serviced by December 8, 2011 by Dietary Manager and/or Maintenance Supervisor as to the K type</li> </ol> <p style="text-align: right;">See attached sheet</p>	
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K-062 (continued)

fire extinguisher is the secondary means, after the fire protection range hood extinguishing system, for extinguishing a fire on the range/grill. All staff will be in-serviced by December 8, 2011 by Director of Nursing and/or Assistant Director of Nursing regarding the extinguishing systems in the kitchen including the fire protection range hood extinguishing system and the K type fire extinguisher.

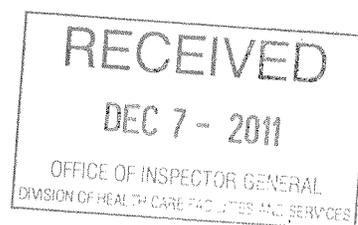
4. Maintenance Supervisor and/or Maintenance Assistant will audit to ensure the sign above the K type fire extinguisher is posted and accessible in the kitchen. Auditing will be completed weekly for two months, semi-monthly for two months and then monthly thereafter. Executive Director will review audit findings from Maintenance Supervisor and/or Maintenance Assistant weekly for two months, semi-monthly for two months and then monthly thereafter. The Performance Improvement Committee will review the monthly findings for trends/needs for continued need of audits.
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K 130	Continued From page 8  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress, per NFPA standards. The deficiency had the potential to affect four (4) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for one-hundred (100) beds and the census was eighty-four (84) on the day of the survey.  The findings include:  Observations, on 11/01/11 between 9:00 AM and 11:30 AM, with the Maintenance Director revealed unapproved locks (slide bolt type) were installed on four (4) doors within the facility.  1. A slide bolt lock on the door to the restroom located in the Central East Corridor. 2. A slide bolt lock on the door to the restroom located in the Central West Corridor. 3. A slide bolt lock on the door to the closet located in Resident Room 225. 4. A slide bolt lock on the door to the restroom / lockers located in the Staff Lounge.  Interviews, on 11/01/11 between 9:00 AM and 11:30 AM, with the Maintenance Director revealed he was aware of the locks installed on the doors; however he was not aware that slide bolt locks were prohibited.	K 130	K-130  1. The slide bolt lock on the closet door in resident room 225 was removed 11/1/11. The slide bolt lock on the Central East Corridor, Central West Corridor and Staff Lounge restroom were removed on 11/9/11.  2. The slide bolt lock on the public restroom by the front lobby was removed on 11/22/11. No other slide bolt locks were identified in the facility upon physical inspection.  3. All staff will be in-serviced by December 8, 2011 by Director of Nursing and/or Assistant Director of Nursing to understand the hazards associated with the use of slide bolt locks and to report to Maintenance and/or Executive Director if any slide bolt locks are identified.  4. Maintenance Supervisor and/or Maintenance Assistant will audit 50 % of facility by physically inspecting closet and bathroom doors to ensure no slide bolt locks are being used for any reason. Auditing will be	



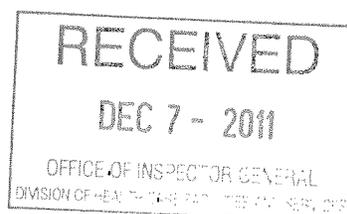


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K 147	Continued From page 10  Interviews during the survey, on 11/01/11 between 9:00 AM and 11:30 AM, with the Maintenance Director revealed he was unaware of a power strip being used to power a microwave oven and a small refrigerator in the Director of Nursing Office, and a power strip being used to power a small refrigerator in Resident Room 340.  Reference: NFPA 99 (1999 edition)  3-3.2.1.2 D  Minimum Number of Receptacles: The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	power strip cords upon physical inspection.  3. All staff will be in-serviced by December 8, 2011 by Director of Nursing and/or Assistant Director of Nursing to understand that appliance such as refrigerators and microwaves cannot be plugged into power strips or extension cords due to the electrical voltage. Any appliance, such as refrigerators and... microwaves, will be inspected and installed by the Maintenance Department to ensure the items are plugged into appropriate electrical outlets and not power strips or extension cords.  4. Maintenance Supervisor and/or Maintenance Assistant will audit 50% of facility by physically inspecting to ensure appliances such as refrigerators and microwaves are not plugged into power strips or extension cords in any location in the facility. Auditing will be completed weekly for two months, semi-monthly for two months and	

See attached sheet



K-147 (continued)

then monthly thereafter. Executive Director will review audit findings from Maintenance Supervisor and/or Maintenance Assistant weekly for two months, semi-monthly for two months and then monthly thereafter. The Performance Improvement Committee will review the monthly findings for trends/needs-for-continued need of audits.

- 5. Completion Date:  
December 9, 2011

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