

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

PRINTED: 09/14/2010
FORM APPROVED
OMB NO. 0938-0391

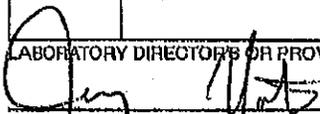
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010
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NAME OF PROVIDER OR SUPPLIER FLORENCE PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042
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F 000	INITIAL COMMENTS	F 000		
F 226 SS=D	<p>A Standard Recertification Survey, and an Abbreviated Survey Investigating ARO# KY00014755 and ARO# KY00015003 were initiated on 08/30/10 and concluded on 09/01/10. Deficiencies were cited with the highest Scope and Severity of an "E". ARO# KY00014755 and ARO# KY15003 were unsubstantiated. A Life Safety Code Survey was conducted on 09/01/10 with the highest Scope and Severity of an "F".</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure criminal background checks were obtained timely for two (2) of seven (7) employees, whose files were reviewed.</p> <p>The findings include:</p> <p>Review of CNA #14's employee file revealed a hire date of 05/14/10 and the date on the criminal record check was noted to be 08/30/10, forty-seven (47) days after the date of hire.</p> <p>Review of Employee # 2's file revealed a hire date of 05/31/10. The date on the criminal record check was noted to be 07/16/10, forty-six (46) days after the hire date.</p>	F 226	<p>This plan of correction shall operate as Florence Park Care Center's written credible allegation of compliance. This plan of correction is not meant to establish any standard of care, contact, obligation, or position and Florence Park Care Center reserves the rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.</p> <p>F226 483.13 Develop/Implement Abuse/Neglect, Etc. Policies</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <ol style="list-style-type: none"> 1. Administrator in-serviced the Human Resource Director on 9/15/10 in regard to the regulations pertaining to Criminal Background checks and timeliness of the process. 2. Administrator will perform Bi-weekly QA's for 3 months to ensure compliance for all new hires. 	9/18/10

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BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 9-17-10
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	Continued From page 1	F 226		
F 281 88=D	<p>Interview with the Human Resource Director, Employee #11, revealed the facility sometimes obtained the criminal record checks immediately and sometimes they did not. She further indicated the background checks were requested on the date of hire. Continued interview revealed the fee for the background check was taken automatically from a checking account which was set up specifically for this purpose. However, sometimes the account balance may be too low, therefore the request for the background checks would not be processed because the fees were not paid with the original request.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure Physician's orders were followed for four (4) of twenty-eight (28) sampled residents (Residents #7, #25, #26, and #27). Resident #7 related to the use of foam boots and elbow protectors and Residents #25, #26, and #27 related to medication administration.</p> <p>The findings include:</p> <p>1. Record review revealed Resident #25 was admitted to the facility on 05/13/09 with diagnoses which included Hypothyroidism, insulin Dependent Diabetes Mellitus, Anemia, Depression, Hypertension, Coronary Artery Disease, and Mitral, Tricuspid, and Aortic Valve</p>	F 281	<p>F281- The facility will ensure that the services provided or arranged by the facility will meet professional standards of quality.</p> <p>1. The DON and Unit Manager immediately educated LPN nurse #6 related to the facility policy for medication administration; medications ordered by the physician were to be given at the time ordered or within sixty (60) minutes before or after the designated time. The physician was notified 8/31/2010 at 145pm related to Resident # 25 9am and 10am medications being given at 1205pm with no new orders received. Resident #25 and resident's family informed of medications being given at 1205pm and MD was aware with no new orders. Resident #25 displayed no negative affects from 9am and 10 am medications being administered at 1205pm. DON interview on 08/31/2010 with LPN # 6 determined no other residents were affected. The facility conducted a house wide audit conducted by DON/Unit Managers at 2pm medication pass on 8/31/2010 to ensure all medications were delivered to the residents at the appropriate time. DON/Unit Managers reviewed each medication pass</p>	9/18/10

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F 281	<p>Continued From page 2 Disease.</p> <p>Review of the Physician's orders revealed orders for the following medications: Amlodarone 100 milligram (mg) by mouth daily at 9:00 AM, Senokot tablet by mouth two times per day (b.i.d.) at 9:00 AM and 9:00 PM, Colace 100 mg by mouth b.i.d. at 9:00 AM and 9:00 PM, MiraLax Powder 17 grams by mouth daily at 9:00 AM, Lasix 80 mg by mouth daily at 10:00 AM, Bayer Aspirin 81 by mouth daily at 10:00 AM, Coreg 12.5 mg by mouth b.i.d. at 9:00 AM and 9:00 PM, Prednisone 10 mg daily after breakfast at 9:00 AM, Mobic 15 mg by mouth daily at 10:00 AM, Ferrous Sulfate 325 mg by mouth b.i.d. at 10:00 AM, Multivitamin 1 tablet by mouth at 10:00 AM, Calcium 500 mg plus vitamin D by mouth daily at 9:00 AM, Klor-con 20 milliequivalent by mouth daily at 9:00 AM, and BeneProtein 1 scoop three times per day between meals at 10:00 AM.</p> <p>Observation of the noon medication pass on 08/31/10 at 11:59 AM revealed Licensed Practical Nurse #6 administered all of the above medication to Resident #25 at 12:05 PM. Interview with LPN #6 at 12:15 PM revealed she was running a little behind because she normally worked a different unit. She further stated she was aware the facility's policy which stated medications were to be administered at the time ordered, or within sixty (60) minutes before or after the scheduled time.</p> <p>Review of the facility's policy revealed medications were to be given at the time ordered, or within sixty (60) minutes before or after the designated time. Interview with the Director of Nursing (DON) on 08/31/10 at 2:00 PM revealed the medications should have been administered</p>	F 281	<p>time to ensure medications could be passed in the appropriate time frame. Unit Managers will monitor this through QA and staff accordingly. Nursing staff was in serviced on 9/17/2010 regarding facility policy and medication administration. A QA will be conducted to monitor Medication pass by the DON or designee, on one (1) resident a week for three (3) months then quarterly to ensure compliance. The DON and Administrator will discuss the results of the QA at least monthly and re-evaluate effectiveness when/if indicated. The Administrator will ensure compliance.</p> <p>2. Nursing immediately applied elbow protector to left elbow protector and foam posy boots for Resident # 7. Resident #7 did not show any negative affects from elbow protector or foam posy boots not being in place. Nursing staff (RN, LPN, CNA) were in serviced on 9/17/2010 related to monitoring and ensuring all interventions are in place per physician orders. The facility conducted a house wide audit on 9/3/10 to ensure all devices were in place as per physician orders. A QA will be conducted by the DON or designee, on five (5) residents a week for three (3) months to ensure compliance. DON and administrator will discuss the results of the QA at least monthly and re-evaluate effectiveness when/if indicated. The Administrator will ensure compliance.</p>	

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F 281	<p>Continued From page 3</p> <p>at the ordered time and that they would inform the Physician of the incorrect administration time.</p> <p>2. Observation on 08/30/10 at 1:00 PM revealed Resident #7 sitting in the day room in a geri-chair with foam boots on bilateral feet and his/her feet were elevated. Continued observation on 08/30/10 at 2:50 PM, and 3:30 PM revealed the resident was in the bed, and was positioned on his/her left side. Observation revealed the foam boots were in the geri-chair at the resident's bedside. Further observation on 08/31/10 at 2:00 PM, revealed the foam boots were in the resident's bed side chair and the elbow protectors were not observed on the resident or in the resident's room.</p> <p>Review of the Physician's orders printed 08/30/10, revealed the following orders, "Resident to utilize elbow protectors to promote skin integrity may be removed for skin care. Check placement every shift am shift pm shift 7p-7a first date: 04/09/2010" and "Resident to utilize bilateral FOAM POSEY BOOTS TO PROMOTE SKIN INTEGRITY AT ALL TIMES am shift pm shift 7p-7a. Check placement every shift", this order was dated 10/11/09.</p> <p>Interview with State Registered Nurse Aide (SRNA) #12 on 09/1/10 at 9:55 AM, revealed she had taken care of the resident on 08/31/10, she stated the resident's boots and elbow protectors were to be on at all times. She further stated she thought his/her boots were on but she was not sure and she didn't remember if the elbow protectors were on.</p> <p>Interview with SRNA #13 on 09/01/10 at 10:30 AM, revealed she assisted with the resident's care but was not sure about when the foam boots</p>	F 281	<p>3. Kentucky Medication Aide (KMA) # 14 was in serviced on facility medication administration policy for Resident #26 and Resident #27. Neither Resident #26 nor Resident #27 displayed any negative affects from medication being administered at 430pm. DON interview on 08/31/2010 with KMA #14 determined no other residents were affected. The facility conducted a house wide audit was on 8/31/10 to ensure physician orders were transcribed correctly to the medication administration record in the computer. Unit Managers and/or supervisors will check orders daily to ensure accuracy. Nursing staff (RN, LPN) and Kentucky Medication Aides were in serviced on 9/17/10 regarding facility policy and medication administration. A QA will be conducted to monitor medication pass by the DON or designee, on one (1) resident a week for three (3) months then quarterly to ensure compliance. The DON and Administrator will discuss the results of the QA at least monthly and re-evaluate effectiveness when/if indicated. The Administrator will ensure compliance.</p>	

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F 281	<p>Continued From page 4</p> <p>were to be on or off. On 09/01/10 at 10:46 AM, SRNA #13 stated, "I looked that up and the resident was to have the boots on at all times". She continued, "I don't remember if (he/she) had them on in the bed".</p> <p>Interview with Licensed Practical Nurse (LPN) #5, Unit Manager, on 09/01/10 at 10:10 AM, revealed she had written a clarification order that morning that the foam boots were to be on as tolerated. She was not aware of the elbow protectors order. She stated she would have to check on the order. LPN #5 checked the Physician's orders and stated he/she was to have elbow protectors at all times. She proceed to check the resident for the elbow protectors and the resident had an elbow protector on the right elbow and none on the left elbow.</p> <p>3. Review of the clinical record revealed Resident # 26 was admitted to the facility on 07/20/09, with diagnoses which included Dementia, Depression and Behavioral Disturbances.</p> <p>Observation of the 4:00 PM medication pass revealed Resident #26 received Haldol 1 milligram (mg). Reconciliation of the medications revealed the signed Physician's order in the resident's medical record stated Haldol 1 mg by mouth b.i.d. (twice a day) 09:00 AM and 9:00 PM, the order start date was 04/20/10.</p> <p>4. Review of Resident #27 clinical record revealed the resident was admitted to the facility on 12/29/08, with diagnoses which included Dementia, Psychosis and anxiety.</p> <p>Observation of the 4:00 PM medication pass</p>	F 281			

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F 281	Continued From page 5 revealed Resident #27 received Risperdal 0.5 mg and Zyprexa 5 mg. Reconciliation of the medication revealed the signed Physician's order in the resident's medical record stated Zyprexa 5 mg b.i.d. 6:00 AM and 6:00 PM, the order start date was 08/05/09. Risperdal 0.5 mg was to be given twice a day at 9:00 AM and 9:00 PM, the order start date was 08/14/10. Interview with the SRNA, Kentucky Medication Aide (KMA) #14 on 08/30/10 at 4:30 PM revealed she looked at the Medication Administration Record for each resident on the computer and administered the resident's medications according to the times listed in the computer. Interview with the Director of Nursing (DON) on 08/31/10 at 3:00 PM revealed the facility's Nurses put the Physician's orders in the computer and made changes as needed to existing orders. She further stated the medications for Residents #26 and #27 were given at the wrong time according to the signed Physician's orders.	F 281		
F 282 SS=D	483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to follow the Comprehensive Plan of Care for one (1) of twenty four (24) sampled residents (Resident #7). Review of Resident #7's care plan	F 282		

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F 282	<p>Continued From page 6</p> <p>revealed the resident was to have bilateral foam boots on at all times and bilateral elbow protectors at all times. However, observation revealed the resident did not have these on at all times.</p> <p>The findings include:</p> <p>Observation on 08/30/10 at 1:00 PM revealed Resident #7 was sitting in the day room in a geri-chair with foam boots on bilateral feet and his/her feet were elevated. Continued observation on 08/30/10 at 2:50 PM, and 3:30 PM, revealed the resident was in the bed, and was positioned on his/her left side. The foam boots were in the geri-chair at the resident's bedside. Further observation on 08/31/10 at 2:00 PM, revealed the foam boots were in the resident's bed side chair and the elbow protectors were not observed to be on the resident or in the resident's room.</p> <p>Review of the Care Plan, revealed the resident was to have foam boots to bilateral heels, treatment as ordered and elbow protectors while up or in bed.</p> <p>Interview with State Registered Nurse Aide (SRNA) #12 on 09/1/10 at 9:55 AM, revealed she had taken care of the resident on 08/31/10. Further interview revealed the resident's boots and elbow protectors were to be on at all times. She stated she thought his/her boots were on, but she was not sure and didn't remember if the elbow protectors were on.</p> <p>Interview with SRNA #13 on 09/01/10 at 10:30 AM, revealed she assisted with the resident's care, but she was not sure about when the foam boots were to be on or off. On 09/01/10 at 10:45</p>	F 282	<p>F282 The facility will ensure that the services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Nursing immediately applied elbow protectors and foam posy boots for Resident #7. Resident #7 did not display any negative affects from the devices not being in place. The facility conducted a house wide audit by DON/Unit Mangers on 9/3/10 to ensure all devices were in place as per physician orders and the comprehensive plan of care. All nursing staff (RN, LPN, CNA) were in serviced by the DON/Unit Managers on 9/17/2010 related to monitoring and ensuring all interventions are in place per physician orders and according to Comprehensive Plan of Care. A QA will be conducted by DON or designee on five (5) residents a week for three (3) months to ensure compliance. DON and Administrator will discuss the results of the QA at least monthly and re-evaluate effectiveness when/if indicated. The Administrator will ensure compliance.</p>	9/18/10

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F 282	Continued From page 7 AM, SRNA #13 stated she looked at the care plan, and the resident was to have the boots on at all times. She continued she didn't remember if the resident had them on in the bed.	F 282		
F 322 SS=D	Interview with Licensed Practical Nurse (LPN) #5, Unit Manager, on 09/01/10 at 10:10 AM, revealed she was not aware of the elbow protectors order and stated she would have to check on that. She checked the Physician's orders and care plan and stated the resident was to have elbow protectors at all times. She proceed to check the resident for the elbow protectors. The resident had an elbow protector on the right elbow and none on the left elbow. 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure one (1) of twenty-eight (28) sampled residents (Resident #19) received appropriate treatment of a tube feeding. The finding include: Record review revealed Resident #19's tube	F 322	F322 The facility will ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and the restore, if possible, normal eating skills. Resident #19 tube feeding was replaced on 9/1/2010 at 9am with new bottle and tubing, as per physician orders, both the bottle and tubing were dated. Resident #19 displayed no negative affects from tube feeding dated 8/29/10. Nursing staff (RN, LPN) were in serviced per DON and Unit Managers on 9/1/2010 and 9/17/2010 related to facility policy and proper tube feed hang time. The facility conducted a house audit on 9/3/2010 to ensure all feeding bottles and tubing were signed and dated and within acceptable time compliance (less than 48 hours). A QA will be conducted by DON or designee on five (5) residents a week for three (3) months. DON and Administrator will discuss the results of the QA at least monthly and re-evaluate effectiveness when/if indicated. The Administrator will ensure compliance.	9/18/10

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F 322	<p>Continued From page 8</p> <p>feeding order was for 2 Cal Hn at 35 cubic centimeters (cc) per hour. Initial observation on 08/31/10 at 5:50 PM revealed the tube feeding of 2 Cal Hn infusing at 35 ccs, per hour per pump. The tube feeding label indicated it had been hung at 5:00 PM on 08/29/10. The pump tubing was also labeled 08/29/10 at 5:00 PM.</p> <p>Interview, on 09/01/10 at 11:10 AM, with Licensed Practical Nurse (LPN) #1, who usually provided care for the resident on Tuesday, revealed she knew Resident #19 was on 2 Cal Hn which was a high calorie tube feeding. She thought 2 Cal Hn could hang for thirty-six (36) hours following initial spike. Further interview revealed LPN #1 was unsure of the date the bottle of tube feeding was hung.</p> <p>Interview with LPN #4 on 09/01/10 at 11:50 AM revealed when a new bottle of tube feeding was hung, the bottle and tubing should be dated and timed, per facility policy.</p> <p>Interview with the Director of Nursing (DON) on 09/01/10 at 12:20 PM, revealed she was aware 2 Cal Hn tube feeding could hang for forty-eight (48) hours before being changed. She further stated when the tube feeding was changed, the tubing also needed to be changed, dated and timed. Observations of the tube feeding from 08/31/10 to 09/01/10 revealed the bottle of 2 Cal Hn at 35 ccs per hour, dated 08/29/10 at 5:00 PM, was still hanging on 09/01/10 at 7:00 AM, a total of sixty-two (62) hours.</p> <p>Review of the manufacturer's label instructions revealed the product should not hang longer than forty-eight (48) hours to prevent excessive microbial growth.</p>	F 322		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6976 BURLINGTON PIKE FLORENCE, KY 41042	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 88=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure the residents' environment remained as free from accidental hazards as possible and each resident received adequate assistive devices to prevent accidents. The facility identified six (6) unsampled residents as requiring the use of smoke aprons while smoking for resident safety. Observations revealed these aprons were worn, frayed, ragged and contained numerous holes.</p> <p>The findings include:</p> <p>Observation throughout the day on 08/30/10 and 08/31/10 revealed several residents in the hallway and in the smoke room wearing tan colored aprons. Observations revealed these aprons were ragged, frayed and contained multiple holes. Interview with Licensed Practical Nurse #1 on 08/31/10 at 3:00 PM revealed these aprons were smoke aprons to protect the residents and their clothing from burns, while smoking.</p> <p>Interview with the Central Supply Manager on 08/31/10 at 2:15 PM, revealed the facility had</p>	F 323	<p>F323 The facility will 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>Smoking aprons for all residents who were utilizing these devices were immediately replaced with new fire retardant aprons; older smoking aprons were discarded to ensure none would be in use within the facility. Each residents smoking assessment was reviewed on 9/2/2010 by DON and Social Services to ensure appropriateness. A QA will be conducted by Social Services or designee to monitor five (5) smoking residents a week for three (3) months, then quarterly with each smoking resident's MDS schedule. DON and Administrator will discuss the results of the QA at least monthly and re-evaluate effectiveness when/if indicated. The Administrator will ensure compliance.</p>	9/18/10

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F 323	Continued From page 10 purchased new fire retardant aprons about a year ago. However, the facility was not using them. Further interview revealed the facility did not have the manufacture's information on the aprons they were currently using. Interview with the Director of Nursing (DON) on 08/31/10 at 2:20 PM, revealed the residents did not like the new aprons because they were stiff and did not have pockets and they wanted to wear the old aprons. Review of the information provided by the facility and interview with the DON revealed all residents that smoked were assessed by the facility for safety. Record review revealed the facility had ten (10) residents that were smokers. The facility had determined through their assessment that six (6) residents required the use of a smoking apron for safety while smoking.	F 323			
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure it was free of medication error rates of five percent (5%) or greater. Observation of the 4:00 PM medication passes on 08/30/10, and the morning medication pass, as well as the noon medication pass on 08/31/10, revealed seven (7) medication errors were assessed out of a total of forty-three (43) opportunities, for a medication	F 332	F332 The facility will ensure that it is free of medication error rates of five (5) percent or greater. 1. The DON and Unit Manager immediately educated LPN nurse #6 related to the facility policy for medication administration, medications ordered by the physician were to be given at the time ordered or within sixty (60) minutes before or after the designated time also LPN nurse #6 was educated on the importance of checking vitals as indicated for each medication given and hold for parameters defined by the physician orders. The physician was notified 8/31/10 at 145pm related to resident #25 receiving 9am and 10am medications at 1205pm with no new orders received, resident #25 and resident's family were also notified. Resident #25 displayed no negative affects from the 9am	9/18/10	

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F 332	<p>Continued From page 11 error rate of sixteen percent (16%).</p> <p>The findings include:</p> <p>1. Record review revealed Resident #25's diagnoses included Hypothyroidism, Insulin Dependent Diabetes Mellitus, Anemia, Depression, Hypertension, Coronary Artery Disease, and Mitral, Tricuspid, and Aortic Valve Disease. During the noon medication pass conducted at 11:58 AM, observation revealed Licensed Practical Nurse (LPN) #6 administered fourteen (14) oral medications to Resident #25. Review of the Medication Administration Record (MAR) revealed all of the fourteen (14) medication administered were scheduled to be administered at either 9:00 AM or 10:00 AM. Interview with LPN #6 on 08/31/10 at 12:10 PM, revealed she was administering these medications late because she was running a little behind because she normally worked on a different unit. She further stated she was aware of the facility's policy that medications should be administered either sixty (60) minutes before or after the scheduled time.</p> <p>Observation revealed Amlodarone 100 milligrams (antiarrhythmic) and Coreg 12.5 milligrams (hypertension) were administered at 12:05 PM. Review of the Physician's order revealed these medications were scheduled to be administered at 9:00 AM and to hold if the heart rate was less than fifty (50). Further observation revealed Licensed Practical Nurse (LPN) #6 did not take the resident's pulse or a blood pressure prior to administering the medications. Review of the MAR revealed the resident's pulse was taken at 9:00 AM and was 68 beats per minute, and the blood pressure was taken at 10:00 AM and was</p>	F 332	<p>and 10am medications being given at 1205pm. DON interview on 08/31/2010 with LPN #6 determined no other residents were affected. Facility wide audit was conducted by DON and Unit Managers at 2pm medication pass on 8/31/2010 to ensure all medications were delivered to the residents at the appropriate time. DON and Unit Managers reviewed each medication pass time to ensure medications could be passed in the appropriate time frame. Unit Managers will monitor this through QA and staff accordingly. Nursing staff was in serviced on 9/17/10 regarding facility policy and medication administration. A QA will be conducted to monitor Medication pass by the DON or designee, on one (1) resident a week for three (3) months, then quarterly to ensure compliance. The DON and Administrator will discuss the results of the QA at least monthly and re-evaluate effectiveness when/if indicated. The Administrator will ensure compliance.</p> <p>2 Kentucky Medication Aide #14 was in serviced on facility medication administration policy for Resident #26 and Resident #27. Neither Resident #26 nor Resident #27 displayed any negative affects from medication being administered during the 4pm medication pass. DON interview on 08/31/2010 with KMA # 14 determined no other residents were affected. A facility wide audit was conducted by DON/Unit Managers on 8/31/2010 on physician orders to ensure all physician orders were transcribed correctly to the medication administration record in the computer. Unit Managers and/or supervisor with check orders daily to ensure accuracy. All nursing staff and Kentucky Medication Aides were in serviced on 9/17/10 regarding facility policy and medication administration. A</p>	

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F 332	<p>Continued From page 12</p> <p>recorded as 142/70. Resident #25's pulse and blood pressure were not check prior to administration of the medication on 08/31/10, resulting in the facility being assessed medication errors.</p> <p>Observation revealed Lasix 80 milligrams (diuretic) was administered at 12:05 PM. Review of the Physician's order revealed this medication was scheduled to be administered at 10:00 AM.</p> <p>Observation revealed Prednisone 10 milligrams (corticosteroid) was administered at 12:05 PM. Review of the Physician's order revealed this medication was to be given daily, after breakfast at 9:00 AM. As a result of the observation, the facility was assessed with a total of four (4) medication errors related to Resident #25.</p> <p>Review of the facility's policy revealed medications were to be given at the time ordered, or within sixty (60) minutes before or after the designated time. Interview with the Director of Nursing (DON) on 08/31/10 at 2:00 PM revealed the medications should have been given at the ordered times.</p> <p>2. Record review revealed Resident #26 was admitted to the facility on 07/20/09, with diagnoses which included Dementia, Depression and Behavioral Disturbances.</p> <p>Observation of the 4:00 PM medication pass revealed Resident #26 received Haldol 1 milligram (mg). Reconciliation of the medications revealed the signed Physician's order in the resident's medical record stated Haldol 1 milligram by mouth, twice a day at 9:00 AM and 9:00 PM, the order start date was 04/20/10.</p>	F 332	<p>QA will be conducted to monitor medication pass by the DON or designee, on one (1) resident a week for three (3) months then quarterly to ensure compliance. The DON and Administrator will discuss the results of the QA monthly and re-evaluate effectiveness when/if indicated. The Administrator will ensure compliance.</p>	

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F 332	Continued From page 13 3. Review of the clinical record revealed Resident #27 was admitted to the facility on 12/29/08, with diagnoses which included Dementia, Psychosis and anxiety. Observation of the 4:00 PM medication pass revealed Resident #27 received Risperdal 0.5 mg and Zyprexa 5 mg. Reconciliation of the medication revealed the signed Physician order in the resident's medical record stated Zyprexa 5 mg twice a day at 6:00 AM and 6:00 PM, the order start date was 06/05/09; and, Risperdal 0.5 mg at 9:00 AM and 09:00 PM, the order start date was 06/14/10. Interview with the SRNA, Kentucky Medication Aide (KMA) #14 on 08/30/10 at 4:30 PM revealed she looked at the Medication Record for each resident on the computer and administered residents' medications according to the times listed in the computer. Interview with the Director of Nursing (DON) on 08/31/10 at 3:00 PM revealed the facility Nurses put the Physician orders in the computer and made changes as needed to existing orders. She further stated the medications for Residents #26 and #27 were given at the wrong time according to the signed Physician's orders.	F 332		
F 371 SS-E	483.36(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by five (5) deep half-sized hotel pans were noted to be stored wet, inadequate hot holding temperatures on the resident trayline, inappropriate usage of gloves and handwashing, employee observed to be in kitchen without a hairnet and employee observed to be in kitchen with no beard guard in place. The findings include: 1. Observation on 08/30/10 at 10:48 AM revealed five (5) deep half-sized hotel pans stored wet. Interview with the Dietary Manager on 08/30/10 at 10:50 AM revealed the pans were to be air dried before being stored for use due to the possibility of bacteria growth. 2. Observation on 08/31/10 at 7:50 AM revealed sausage patties being stored on the hot trayline for the breakfast meal at a temperature of 102.8 degrees Fahrenheit. Observation on 08/31/10 at 8:38 AM revealed a sausage patty being plated for a resident and was distributed to that resident. Interview with the resident revealed the sausage patty was a little warm.	F 371	F371 483.35 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. 1. There were no negative outcomes to any residents due to 5 deep half-sized pans being stored wet, inadequate holding temperature, inappropriate glove use, handwashing, and an employee being observed in the kitchen without a beard guard and hairnet. 2. All dietary employees were in-serviced on 9/15/10 with regard to wet pan storage, inadequate holding temperatures, handwashing, glove changes, and hairnet policy. In-service on file. 3. Maintenance Director was in-serviced on hairnet policy on 9/15/10 by the Dietary Director. In-service on file. 4. Additional wall fans were installed on 9/13/10 to aid in drying. 5. Dietary Director or designee will perform a QA weekly for 3 months to ensure that all pans are dried prior to being stored. QA's will be turned in to the Administrator weekly to ensure compliance. 6. All hot holding sausage will be done by using hot beef broth to aid in maintaining proper temperature. Dietary Director will perform a QA weekly for 3 months to ensure that hot holding minimum temps are met. QA will be submitted to the Administrator weekly to ensure compliance.	9/18/10

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F 371	<p>Continued From page 15</p> <p>Interview with Cook #6 on 08/31/10 at 7:50 AM revealed she knew the sausage was done and that it would get warmer the longer it sat on the trayline. She further indicated she liked for the temperatures to be greater then one hundred sixty-five (165) degrees Farenheit for food to be stored on the hot trayline.</p> <p>interview with the Dietary Manager on 08/31/10 at 8:52 AM revealed he expected the temperature to be at least one hundred thirty-five degrees on the hot holding trayline and the one hundred two (102) degrees Farenheit of the sausage patties was inappropriate.</p> <p>3. Observation on 08/30/10 at 6:15 PM revealed Cook #4 putting on oven mlts over both of her gloved hands to retrieve food items from the oven, she was then observed to take the gloves off and continue on the trayline without changing gloves or washing her hands.</p> <p>Observation on 08/30/10 at 6:20 PM revealed Cook #4 cracking eggs with gloved hands and then using gloved hands to lift the trash can lid to dispose of egg shells. She was then noted to change gloves and replace new gloves without washing her hands prior to putting on new gloves.</p> <p>Observation on 08/31/10 at 8:06 AM revealed Cook #6 cracking two (2) eggs to fry with gloves on, she was noted to plate the eggs and return to the trayline without changing gloves or washing hands.</p> <p>Observation on 08/31/10 at 8:10 AM revealed Cook #6 cracking two (2) eggs to fry with gloves on, she was noted to plate the eggs and return to the trayline without changing gloves or washing</p>	F 371	<p>7. All eggs will be prepared prior to trayline service and held hot on the steamwell. Therefore, eliminating the potential for cross contamination. QA will be performed weekly for 3 months by the Dietary Director to ensure compliance. QA will be submitted to the Administrator weekly to ensure compliance.</p> <p>8. All dietary employees were in-serviced on Beard Guard and Hairnet Policy. In-service on file.</p>	

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F 371	<p>Continued From page 16 hands.</p> <p>Interview with Cook #6 on 08/31/10 at 8:20 AM revealed she usually changed gloves and washed her hands when trayline was over because she did not have time when she was on the trayline. She stated gloves should probably be changed between tasks involving going from the trayline to the stove top but the staff just did not have the time.</p> <p>Interview with the Dietary Manager on 08/31/10 at 8:23 AM revealed he would expect his staff to change gloves and wash hands after frying eggs before returning to the trayline.</p> <p>4. Observation on 08/30/10 at 10:43 AM revealed the Maintenance Supervisor walking through the kitchen without a hairnet in place.</p> <p>Interview with the Maintenance Supervisor on 08/30/10 at 10:45 AM revealed he did not normally enter the kitchen without a hairnet and he should have put one on before entering the kitchen. He stated that he was looking for a maintenance employee and did not think about putting on a hairnet.</p> <p>Observation on 08/31/10 at 8:15 AM revealed Dietary Aide #7 entering the kitchen with two (2) frozen rounds of meat, which he placed into a hotel pan and transported to the freezer. He was noted to have a beard, with no beard guard in place.</p> <p>Observation on 08/31/10 at 8:47 AM revealed Dietary Aide #7 was putting away new stock. He was noted to enter the refrigerator/freezer with stock. Observation revealed no beard guard in</p>	F 371		

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F 371	Continued From page 17 place. Interview with Dietary Aide #7 revealed he should have had a beard guard on when he was putting the meat in the pan to thaw. He further indicated that he normally had a beard guard on but he did not have one on at this time because he was mainly dealing with stock. Review of the facility's policy titled, "Dietary Department Handwashing and Hairnet Policy", dated 07/30/10 revealed a hairnet must be worn whenever entering the kitchen and when working in the kitchen.	F 371			

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K 000	INITIAL COMMENTS	K 000		
K 029 SS=D	<p>A Life Safety Code survey was initiated and concluded on 09/01/2010. The facility was found to not meet the minimal requirements with 42 Code of the Federal regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</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 that hazardous areas maintained a smoke resistant rating and doors were equipped with door closures as required.</p> <p>The findings include:</p> <p>Observation on 09/01/2010 at 10:15 AM, revealed the fifteen (15) panel glass door to the storage room on the A-Wing was not an approved fire rated door with a self-closing device. Further observation revealed two (2) medication carts and</p>	K 029	<p>This plan of correction shall operate as Florence Park Care Center's written credible allegation of compliance. This plan of correction is not meant to establish any standard of care, contact, obligation, or position and Florence Park Care Center reserves the rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.</p> <p>K029 NFPA 101 Life Safety Code Standard</p> <p>Isolated hazardous areas shall be protected in accordance with 9.7.1.2. For new installations in existing health care facilities, where more than two sprinklers are installed in a single area, water flow detection shall be provided to sound the building fire alarm, or to notify by signal, any constantly attended location, such as PBX, security, or emergency room, at which the necessary corrective action shall be taken.</p> <ol style="list-style-type: none"> 1. There were no negative outcomes to any residents due to the A-Wing door not being a fire rated, self-closing door. 2. Maintenance department purchased a fire rated door. Invoice is on file. 	9/18/10

RECEIVED
SEP 24 2010
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X8) DATE 9-17-10
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6875 BURLINGTON PIKE FLORENCE, KY 41042	
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K 029	Continued From page 1 one clean linen cart stored in this room.	K 029	3. In-service was conducted on 9/15/10 by the Administrator with the Maintenance Director with regard to ensuring necessary doors are 1 hour fire rated and doors. In-service documentation on file.	
K 056 SS=F	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 it was determined the facility failed to ensure the building had a complete sprinkler system, according to NFPA standards. The findings include: Observation on 09/01/2010 at 10:30 AM with the Maintenance Director, revealed three (3) canopies with combustible construction, the first canopy was located over the front entrance to the building. The second canopy was located over the smoking area next to the breakroom. And, the third canopy was located over the emergency exit	K 056	K056 NFPA 101 Life Safety Code Standard Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. 1. There were no negative outcomes to any residents due to 3 canopies not being sprinkled. 2. Canopy number three was removed from the building on 9/2/10. 3. Job bid received on 9/17/10 for sprinkling the remaining 2 canopies. Invoice on file. Awaiting contractor services.	9/18/10

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2010
NAME OF PROVIDER OR SUPPLIER FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6976 BURLINGTON PIKE FLORENCE, KY 41042		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 056	Continued From page 2 next to the C-wing dining room. Interview with the Maintenance Director on 09/01/2010 at 10:30 AM, indicated that his understanding was that they had until 2013 to come into compliance with this requirement. 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	K066 NFPA 101 Life Safety Code Standard Smoking regulations shall be adopted and include no less than the following provisions: 1. Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. 2. Smoking by patients classified as not responsible is prohibited, except when under direct supervision. 3. Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. 4. Metal Containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4.	9/18/10	
K 066 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066			

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NAME OF PROVIDER OR SUPPLIER FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6976 BURLINGTON PIKE FLORENCE, KY 41042	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 066	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure noncombustible ashtrays were provided in the smoking areas, according to NFPA standards. The findings include: Observation on 09/01/2010 at 10:45 AM, revealed five (5) plastic ashtrays located in the smoking areas of the facility. Interview with the Maintenance Director on 09/01/2010 at 10:45 AM, indicated that he was unaware that these ashtrays were not acceptable. Reference NFPA 101 (2000 Edition) 19.7.4 Smoking	K 066	1. There were no negative outcomes to any residents due to the use of 5 plastic ashtrays that were located in the smoking areas. 2. All 5 plastic ashtrays were removed and replaced with ashtrays of noncombustible material and safe design on 9/9/10. 3. Maintenance director was in-serviced by the Administrator in regards to providing ashtrays of noncombustible material and safe design in all smoking areas. In-service on file.	
K 073 89=F	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 09/01/2010 at 10:00 AM, revealed hanging decorations attached to fourteen (14)	K 073		

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NAME OF PROVIDER OR SUPPLIER FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6976 BURLINGTON PIKE FLORENCE, KY 41042	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 073	Continued From page 4 residents' room doors numbered 111, 123, 207, 222, 223, 300, 303, 307, 308, 310, 314, 316, 323, and 325. Interview with the Maintenance Director on 09/01/2010 at 10:00 AM, 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 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073	K073 NFPA 101 Life Safety Code Standard No furnishings or decorations of highly flammable character are used. 1. There were no negative outcomes to any residents due to 14 rooms having combustible decorations hanging on the doors. 2. All 14 decorations were removed from the doors on 9/2/10. 3. All appropriate nursing staff was in-serviced on 9/2/10 in regard to combustible decorations on 9/2/10. In-service on file. 4. Maintenance Director was in-serviced on 9/15/10 in regard to combustible decorations hanging from doors.	9/18/10