

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED G 01/27/2012
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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504
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F 253	<p>Continued From page 1</p> <p>An environmental tour conducted, on 1/26/12 at 10:12 AM, with the Housekeeping Supervisor revealed A black mold like substance observed on the grout in the resident shower room on the west wing. In addition the grout was observed with gaps and tiles were loose.</p> <p>An interview conducted with the Housekeeping Supervisor revealed the Supervisor had attempted to clean the grout but was not able to remove all the the stains. Further interview revealed the Supervisor was not aware of any plans to replace/repair the grout or tile.</p> <p>Observations conducted during an environmental tour on, 01/26/12 at 10:46 AM revealed broken tile in the west wing tub bath and a loose base board near the east wing nurses station.</p> <p>An interview conducted with the Maintenance Director, on 01/26/12 at 10:46 AM, revealed it was facility practice for items in need of repair to be logged in the maintenance log at the nurses' stations and maintenance staff reviewed the logs daily and would sign the log when the repair was completed. Continues interview conducted with the Maintenance Director revealed the Maintenance Director made rounds daily to review maintenance logs and identify items in need of repair. According to the Maintenance Director, he was not aware of the loose/broken tiles, the leaking grout, or the loose baseboard.</p> <p>A review of the east and west wing maintenance logs revealed no evidence the above items in need of repair had been identified.</p>	F 253	<p>Criteria 3: The housekeeping and maintenance staff have received inservice education by the Administrator and/or Housekeeping Supervisor on routine inspection of the resident rooms and care areas to determine that issues are identified and addressed in a timely manner, as provided on 2/15/12, 2/16/12, 2/17/12, 2/18/12, 2/19/12, 2/20/12, 2/21/12, 2/22/12, and 2/23/12. All facility staff has received inservice education as directed by the Administrator on 2/15/12, 2/16/12, 2/17/12, 2/18/12, 2/19/12, 2/20/12, 2/21/12, 2/22/12, 2/23/12, 2/24/12, 2/25/12, 2/26/12, and 2/27/12 to log all maintenance concerns in the maintenance logs located at each nursing station.</p> <p>Criteria 4: The CQI indicator for the monitoring of housekeeping and maintenance issues will be utilized monthly X 2 months then quarterly as per the CQI calendar under the supervision of the Housekeeping and Maintenance supervisors.</p> <p>Criteria 5:</p>	2/29/12
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281	<p>F 281 Services Provided Meet Professional Standards The services provided or arranged by the facility must meet professional standards of quality.</p>	

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F 281	<p>Continued From page 2</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 provide services to meet professional standards of quality for one (1) of twenty-four (24) sampled residents. Resident #6 had a Physician's order to encourage two-hundred and forty (240) cubic centimeters (cc) of pudding thick liquids four (4) times a day with medication pass. However, facility staff failed to encourage or have pudding thick liquids available for Resident #6 during medication pass on 01/26/12.</p> <p>The findings include:</p> <p>Interview with the Administrator on, 01/26/12 at 3:00 PM, revealed the facility did not have a policy related to following Physician's orders.</p> <p>A review of the medical record revealed the facility admitted Resident #6 on 05/12/11 with diagnoses of Dysphagia, Progressive Neurological illness, Senile Dementia, and Depression. A review of the Physician's orders dated January 2012, revealed a Physician's order to encourage two-hundred and forty (240) cc's of pudding thick liquids four (4) times a day with medication pass.</p> <p>A review of the Medication Administration Record (MAR) for 01/12 for Resident #6 revealed Registered Nurse (RN) #4 had initialed the liquids</p>	F 281	<p>Criteria 1: Resident # 6 receives thickened liquids with medications as per MD orders.</p> <p>Criteria 2: An audit of residents with orders for thickened liquids with medications was completed by the Quality Assurance Nurse on 1/30/12 to determine that these are provided as ordered.</p> <p>Criteria 3: -Medication administration staff have received inservice education by the DON/ADON on 1/30/12 on the need to provide all medications and med pass liquids, including thickened liquids, in accordance with MD orders as per the regulations. -Nursing staff have received inservice education by the DON/ADON on 2/1/12, on the need to administer care in accordance with MD orders.</p> <p>Criteria 4: -The CQI indicator for the monitoring of administration of medications and thickened liquids with med pass in accordance with MD orders will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON/ADON. -The CQI indicator for the monitoring of nursing care in accordance with MD orders will be utilized monthly X 2 months and then quarterly as per the established CQI calendar, under the supervision of the DON/ADON.</p>	

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F 281	<p>Continued From page 3</p> <p>to have been offered to Resident #6 during the 10:00 AM medication pass on 01/26/12.</p> <p>An interview conducted with RN #4, on 01/26/12 at 10:55 AM, revealed she had documented the Physician's order for two-hundred and forty (240) cc's of fluid as being encouraged for Resident #6 with the 10:00 AM medication pass on 01/26/12. Continued interview with RN #4 revealed she had failed to offer Resident #6 pudding thick liquids as ordered by the physician. Further interview and observations of the medication cart and medication room confirmed there were no pudding thick liquids available on the unit to be administered to Resident #6.</p> <p>Interview with the Director of Nursing (DON), on 01/26/12 at 2:30 PM, revealed she ensured Physician's orders were carried out by reviewing documentation periodically throughout the month. Further interview with the DON revealed RN #4 should have administered the pudding thick liquids as ordered by the Physician.</p>	F 281	Criteria 5:	2/29/12
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure services were provided in accordance with the resident's written</p>	F 282	<p>F282 Services by Qualified Persons/Per Care Plan The services provided or arranged by the facility shall be provided by qualified staff in accordance with each resident's plan of care.</p> <p>Criteria 1: Resident # 22 is provided the assist of 2 staff with lift use as per the care plan.</p>	

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F 282	<p>Continued From page 4</p> <p>Comprehensive Plan of Care for one (1) of twenty-four (24) sampled residents, (Resident #22). It was identified facility staff failed to follow the Plan of Care related to the transfer interventions for Resident #22. Following the transfer, the resident later complained of pain and was sent out for evaluation.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Policy and Procedure Mechanical Lifts", revised date 05/06/11, revealed residents requiring more assistance with transfers than two people can safely provide by themselves will be transferred by means of a mechanical lift. Under Procedure section number ten (10): Using the control, lift resident off bed/chair with one State Registered Nurse Aide (SRNA) at the control and the other SRNA behind the resident.</p> <p>Medical record review revealed Resident #22 was admitted by the facility on 12/14/11, with diagnoses which included Closed Fracture Intertrochanteric Section Femur (left hip fracture) and Osteoarthritis. Review of the Admission Minimum Data Set (MDS) Assessment, dated 12/21/11, revealed Resident #22 was assessed as needing total dependence of staff for transfers between surfaces, including to or from the bed or wheelchair, with at least two staff persons for physical assist with the transfer. Further review of the MDS revealed the resident's Brief Interview for Mental Status (BIMS) assessment score was nine (9), which indicated the resident's cognitive status was moderately impaired.</p> <p>Review of the Comprehensive Plan of Care for</p>	F 282	<p>Criteria 2: Residents who require the use of a lift are provided the assist of 2 staff as per the care plan, as determined by care observations performed on 2/28/12 and 2/29/12 by the Unit Coordinators.</p> <p>Criteria 3: -L.P.N.'s, R.N.'s, C.M.T.'s, and C.N.A.'s have received inservice education from the DON/ADON on provision of all care in accordance with the care plan, including compliance with the assist of 2 staff with lift use as per the care plan, and the need to report non-compliance to the Unit Managers/DON/ADON, as provided on 2/1/12.</p> <p>Criteria 4: The CQI indicator for the monitoring of implementation of care plan interventions, including the provision of 2 staff assist with lift use, will be utilized monthly X 2 months, then quarterly as per the established CQI calendar, under the supervision of the DON. This is accomplished with each indicator by observing care provided to 5 selected residents as compared to the care plan interventions, and documentation of the findings on the CQI indicator tool, with review of the findings in the monthly CQI meetings.</p> <p>Criteria 5:</p>	2/29/12

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F 282	<p>Continued From page 5</p> <p>Resident #22, dated 12/21/11 revealed a plan for Activities of Daily Living (ADL's) with an intervention for transfers using a mechanical lift with assistance of two staff. The Daily Care Plan Record for aides, dated 12/11 called for the resident to be transferred using a mechanical lift with assist of two staff.</p> <p>Review of the Nurse's Notes revealed, on 01/14/12 at 2:50 AM, the resident complained of left hip and leg pain and complained of his/her right hand hurting worse. The resident was given an as needed medication for pain, Hydrocodone (Lortab) 7.5-32.6 milligrams, and sent to the Emergency Room for evaluation. The resident's Power of Attorney was called and a message was left.</p> <p>Interview, on 01/27/12 at 11:45 AM, with the resident's POA revealed the resident told her/him that after being transferred to the bed, when using the mechanical lift, he complained of pain and was sent to the hospital for an x-ray.</p> <p>Interview, on 01/27/12 at 5:35 PM, with SRNA #4 revealed, the care plan for Resident #22 called for a mechanical lift for transfers with two staff performing the transfer. The SRNA revealed she did not follow the plan of care and transferred the resident to his/her bed using the mechanical lift by herself. There was help available but she did not call for assistance. Further interview revealed the SRNA felt the transfer was done safely and the resident did not complain of pain right after he was lowered to the bed.</p> <p>Interview, on 01/17/12 at 1:15 PM, with the Director of Nursing (DON) revealed Resident #22</p>	F 282		

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F 282	Continued From page 6 complained of his left hip hurting after the transfer and was sent out for an x-ray. The SRNA did not follow their policy or the care plan when performing the transfer. When using the mechanical lift two people were supposed to be in the room. One was supposed to operate the lift and the other maneuver the resident. The resident was care planned for a two person transfer using the mechanical lift.	F 282		
F 371 SS=F	<p>483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, policy review and cleaning schedule review it was determined the facility failed to store, distribute and serve food under sanitary conditions. Observations revealed pans stored wet and dirty, plates and trays stored wet, in addition, improper hand sanitation was observed when kitchen staff failed to sanitize hands between tasks.</p> <p>The findings include: Review of the facility's policy titled "Pots and Pans", not dated, revealed the process for</p>	F 371	<p>F 371 Food Procure, Store/Prepare/Serve - Sanitary The facility must store, prepare, distribute, and serve food under sanitary conditions.</p> <p>Criteria 1: -The pans, plates, and trays have been washed and air dried as per dietary sanitation standards of practice. -Dietary staff perform hand sanitation and glove use in accordance with dietary infection control standards of practice.</p> <p>Criteria 2: -Pans, plates, and trays are washed and air dried as per dietary sanitation standards of practice. -Dietary staff perform hand sanitation and glove use in accordance with dietary infection control standards of practice.</p>	

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F 371	<p>Continued From page 7</p> <p>cleaning and sanitizing pots and pans included scrubbing all surfaces, scraping excess residue from ware and letting items air dry.</p> <p>Review of the facility's "Dietary Department Weekly Cleaning Schedule", revised January 2009, revealed ovens were cleaned once weekly.</p> <p>Observation, on 01/24/12 at 9:30 AM, revealed one (1) hotel pan stored wet and three (3) hotel pans stored with a brown substance and particles inside them.</p> <p>Observation, on 01/26/12 at 12:30 PM, revealed a wet tray was sent down resident tray line.</p> <p>Observation, on 01/25/12 at 12:40 PM, revealed three (3) trays stored with a white sticky substance on them and wet and one (1) tray stored wet.</p> <p>Interview with Cook #2, on 01/26/12 at 12:40 PM, revealed the items should not be stored wet or with the white sticky substance on them secondary to bacteria growth.</p> <p>Interview with the Dietary Manager, on 01/24/12 at 9:40 AM, revealed the pans should not be stored in this manner secondary to bacterial growth occurring on these types of surfaces.</p> <p>Observation, on 01/25/12 at 11:40 AM, revealed Cook #1 opened the oven door to obtain a piece of fried chicken, however, did not change her gloves or wash her hands prior to returning to resident tray line.</p> <p>Observation, on 01/26/12 at 11:45 AM, revealed</p>	F 371	<p>Criteria 3: -Inservice education has been provided by the Dietary Manager for the dietary staff on 2/15/12, 2/16/12, 2/17/12, 2/18/12, 2/19/12, 2/20/12, 2/21/12, 2/22/12, and 2/23/12 on compliance with all dietary sanitation requirements, including the correct cleansing and air drying of pans, plates and trays, and hand sanitation and glove use in accordance with dietary infection control standards of practice.</p> <p>Criteria 4: The CQI indicator for The monitoring of the proper storage, preparation, distribution and service of food/ dietary sanitation and hand hygiene will be utilized monthly as per the established CQI calendar under the supervision of the Dietary Manager.</p> <p>Criteria 5:</p>	2/29/12

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F 371	<p>Continued From page 8</p> <p>Cook #1 opened the oven door to obtain a piece of fried chicken and failed to wash her hands prior to returning to resident tray line.</p> <p>Interview with Cook #1, on 01/26/12 at 11:16 AM, revealed she should have washed her hands and changed her gloves before returning to tray line after opening the oven.</p> <p>Interview, on 01/27/12 at 5:45 PM, with the Dietary Manager revealed the Cook should have washed her hands and changed her gloves after switching tasks and opening the oven door before returning to resident tray line.</p>	F 371		
F 517 SS=E	<p>483.75(m)(1) WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS</p> <p>The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations of fire pull stations, interviews with facility staff, and a review of the facility Evacuation and Safety Floor Plan it was determined the facility failed to have a Evacuation and Safety Floor Plan which was accurate and accurately indicated the location of facility fire alarm stations.</p> <p>The findings include: A review of the the facility Evacuation and Safety Floor Plan (undated) indicated fire pull stations were located in the facility dining room and in the</p>	F 517	<p>F 517 Written Plans to Meet Emergencies/Disasters The facility must have detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather and missing residents.</p> <p>Criteria 1: The facility floor plan was revised by the Administrator to accurately display the location of fire alarm pull devices.</p> <p>Criteria 2: The facility floor plan was revised by the Administrator to accurately display the location of fire alarm pull devices.</p> <p>Criteria 3: -Facility staff, including laundry staff, have received inservice education on facility emergency fire procedures and the location of the fire alarm pull devices as provided by the</p>	

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F 517	<p>Continued From page 9 facility laundry area.</p> <p>Observations conducted, on 01/25/12 at 14:30 PM, revealed no evidence of fire pull stations in the facility dining room or in the laundry room. Additional observations revealed a walled area attached to the dining room not indicated on the floor plan did have a fire pull station and a locked maintenance area attached to the laundry room had a fire pull station.</p> <p>An interview conducted with the Maintenance Director, on 1/25/12 at 2:45 PM, revealed the facility floor plan had been updated and the Maintenance Director was not aware the floor plan did not accurately reflect the location of the fire pull stations or include the additional walled areas in the the dining room or the laundry.</p>	F 517	<p>Administrator and Housekeeping Supervisor on 1/26/11 and 2/15/12, 2/16/12, 2/17/12, 2/18/12, 2/19/12, 2/20/12, 2/21/12, 2/22/12, 2/23/12, 2/24/12, 2/25/12, 2/26/12, and 2/27/12. -The Administrator will be responsible for updating the facility floor plan and inservicing facility staff whenever renovation changes are made which alter the locations of the fire alarm pull devices.</p> <p>Criteria 4: The CQI indicator for the monitoring of facility fire emergency procedures will be utilized monthly as per the established CQI calendar under the supervision of the Administrator.</p> <p>Criteria 5:</p>	2/29/12
F 518 SS=D	<p>483.76(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS</p> <p>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Based on Interview and record review it was determined the facility failed to periodically review fire procedures with existing staff. Three (3) facility staff were not aware of where the facility fire pull stations were in the facility, and one (1) staff was not aware of the facility fire policy for the laundry area.</p>	F 518	<p>F 518 Train All Staff - Emergency Procedures and Drills The facility must train all staff on emergency procedures.</p> <p>Criteria 1: Laundry staff are familiar with the facility emergency fire procedures.</p> <p>Criteria 2: Facility staff are familiar with the facility emergency fire procedures.</p>	

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F 518	<p>Continued From page 10</p> <p>The findings include:</p> <p>A review of the facility's policy titled, Fire and Emergency Procedures (Undated) revealed in the event of a fire staff was required use the overhead page and announce "CODE RED" and the location of the fire. Further review of the policy revealed staff was also required to active the fire alarm.</p> <p>An interview conducted with Laundry Staff #1, on 01/25/12 at 2:30 PM, revealed the Laundry staff was not aware of the location of the closest fire pull station and traveled to the east wing exit door when ask to identify the the nearest fire pull station. In addition the staff stated she would call 911 to notify of the fire.</p> <p>An interview conducted with the Activities Director and a State Registered Nurse Aide (SRNA) #10, on 01/25/12 at 3:05 PM, revealed the staff was not aware of the location of fire pulls stating there was one outside the dining room. However the staff had to walk to the east wing exit door to locate a fire pull. A fire pull was located inside a walled off area attached to the dining room and neither staff was aware of the location.</p> <p>An interview Conducted with the Maintenance Director, on 01/26/12 at 10:45 AM, revealed the Maintenance Director had not conducted a fire drill in the laundry because the laundry staff worked for a contract agency and was supervised by the Housekeeping Supervisor.</p> <p>An interview conducted with the Housekeeping Supervisor, on 01/26/12 at 10:20 AM, revealed laundry employees were given an employee</p>	F 518	<p>Criteria 3: Facility staff, including laundry staff, have received inservice education on facility emergency fire procedures and the location of the fire alarm pull devices as provided by the Administrator and Housekeeping Supervisor on 1/26/11 and 2/15/12, 2/16/12, 2/17/12, 2/18/12, 2/19/12, 2/20/12, 2/21/12, 2/22/12, 2/23/12, 2/24/12, 2/25/12, 2/26/12, and 2/27/12.</p> <p>Criteria 4: The CQI indicator for the monitoring of facility fire emergency procedures will be utilized monthly as per the established CQI calendar under the supervision of the Administrator.</p> <p>Criteria 5:</p>	2/29/12

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/27/2012
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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504
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F 518	Continued From page 11 handbook with fire procedures however the Supervisor had not conducted any fire drills with laundry staff and was not aware the laundry staff was unaware of the facility's fire policy or the location of the nearest fire pull station.	F 518		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186444	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/24/2012
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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1974</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) Story, Type V (111) Unprotected</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM originally installed in 1974</p> <p>FULLY SPRINKLED, SUPERVISED (Dry SYSTEM) original in 1974</p> <p>EMERGENCY POWER: Type II Diesel Generator. Original in 1974</p> <p>A life safety code survey was initiated and concluded on 01/24/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for one hundred eighteen (118) beds and the census was one hundred one (101) the day of the survey.</p>	K 000	<p>Plan of Action Cambridge Place Standard Survey 1/24-27/2012</p> <p>Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.</p> <div data-bbox="1021 1160 1348 1357" style="border: 1px solid black; padding: 5px; width: fit-content; margin: 20px auto;"> <p>RECEIVED MAR - 1 2012</p> </div>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X8) DATE 8/1/12
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ny 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 CAMBRIDGE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504
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K 000 K 062 SS=D	<p>Continued From page 1</p> <p>Deficiencies were cited with the highest deficiency identified at "D" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: -----Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained as required. The facility is licensed for one hundred eighteen (118) beds and the census the day of the survey was one hundred one (101).</p> <p>The findings include:</p> <p>Observation during the Life Safety Code survey tour, on 1/24/12 at 12:40 PM with the Maintenance Director, revealed corrosion on three (3) sprinkler heads under the canopy outside the front entrance. Not maintaining sprinkler heads can decrease their ability to react as intended.</p> <p>Interview with the Maintenance Director, on 1/24/12 at 12:40 PM, revealed he was not aware of that requirement.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of</p>	K 000 K 062	<p>K 062 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.</p> <p>Criteria 1: -The three (3) sprinkler heads under the canopy outside the front entrance have been replaced by the facility's designated sprinkler system service company.</p> <p>-The four (4) Regular Response Sprinkler Heads that were mixed with ten (10) Quick Response Sprinkler Heads in the same compartment have been replaced by the facility's designated sprinkler system service company.</p> <p>-The wires hanging over the sprinkler pipes in the attic in the Northwest and Southwest Wings have been secured so that they are not resting on the pipes.</p> <p>Criteria 2: -An audit was performed by the Maintenance Director on 2/23/12 through the entire building to identify that there are no Regular Response Sprinkler Heads in the same compartment with Quick Response Sprinkler Heads and that all sprinkler heads are free of corrosion.</p> <p>-An audit was performed by the Maintenance Director on 2/23/12 over the entire building to identify any wires resting over the pipes in the attic.</p>	

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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504
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K 062	<p>Continued From page 2</p> <p>corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>Observation during Life Safety Code tour, on 1/24/12 at 12:31 PM, with the Maintenance Director revealed four (4) Regular Response Heads mixed in the same compartment with ten (10) Quick Response Heads. Where Quick Response heads are installed, all sprinklers within the compartment shall be of the Quick Response type.</p> <p>Interview with the Maintenance Director, on 1/24/12 at 12:31 PM, revealed he was unaware of this requirement and stated that he thought the sprinkler company would have know about this during quarterly inspections and replaced them as required.</p> <p>Throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied:</p> <p>(1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height</p> <p>The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for</p>	K 062	<p>Criteria 3: -The maintenance staff have received inservice education by the Administrator on 2/15/12 regarding the routine inspection of the sprinkler heads for corrosion and the regulation of requiring Quick Response Heads to be installed in the same compartment as other Quick Response Sprinkler Heads.</p> <p>-The maintenance staff have received inservice education by the Administrator on 2/15/12 regarding the regulation that the sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe.</p> <p>Criteria 4: The CQI indicator for the monitoring of sprinkler system compliance will be utilized monthly as per the established CQI calendar under the supervision of the Administrator.</p> <p>Criteria 5:</p>	2/29/12

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K 062	<p>Continued From page 3</p> <p>determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.</p> <p>Observation, on 1/24/12 at 11:14 AM, with the Maintenance Director revealed wires hanging over sprinkler piping in the attic in the Northwest and Southwest wings. This was confirmed by the Maintenance Director. The deficiency had the potential to affect two (2) of six (6) smoke compartments forty-two (42) residents, staff and visitors.</p> <p>Reference: NFPA 25 (1998 edition)</p> <p>2-2.2* Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, corrosion, and misalignment. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. Exception No. 1:* Pipe and fittings installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Pipe installed in areas that are</p>	K 062		

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K 062	Continued From page 4 Inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062		