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

PRINTED: 05/11/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185287		C 04/27/2012

NAME OF PROVIDER OR SUPPLIER: HARRODSBURG HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 663 LEXINGTON ROAD, HARRODSBURG, KY 40330

(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 000	INITIAL COMMENTS A Recertification Survey and an Abbreviated Survey investigating #KY00018158 was conducted 04/23-27/12. Deficiencies were cited, with the highest scope and severity of a "D". #KY00018158 was substantiated with no related deficiencies cited.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a clean, comfortable, and homelike environment as evidenced by observation of discolored caulking and tile around the commode in a resident room, and an unpleasant odor present in the spa room on the 100 hallway. The findings include: Observation of the bathroom for resident room 400 during initial tour, on the afternoon of 04/23/12, revealed the caulking and tile around the commode was stained with black and brown substances. A second observation of the bathroom for resident room 400, on 04/24/12 at 10:25 AM,	F 252	F252 In room 400 the caulking around the commode has been removed and new caulking applied, and the tile around the commode has been cleaned on 5/15/12. The spa room on the 100 hall was deep cleaned, the floor drain has been cleaned, and tile was replaced on 5/17/12. An audit was conducted on 5/18/12 by the Maintenance Director and the Housekeeping Supervisor of the entire environment to ensure all areas are safe, clean, comfortable and homelike, allowing residents to use his or her personal belongings to the extent possible. Any area found in need of cleaning, repair or deodorizing was corrected during the audit.	6/11/12

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BY

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tonya Haines — TITLE: Executive Director — (X6) DATE: 5/18/12

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 252	Continued From page 1 revealed the caulking and tile around the commode continued to be stained black and brown. A walk-through with the Housekeeping Manager, on 04/25/12 at 9:15 AM, revealed the condition of the caulking and tile around the commode in the bathroom of resident room 400 was unchanged from previous observations. An interview with the Housekeeping Manager at that time, revealed housekeeping staff deep cleaned every resident room, to include bathrooms, at least once a month. In further interview, the Housekeeping Manager agreed that housekeeping staff should be more thorough when cleaning residents' bathrooms. An observation of the spa on the 100 hall, at 3:30 PM on 04/24/12, revealed a foul odor permeating the room. Dirty linen barrels were observed in the right hand corner of the room behind a curtain. It was unclear whether the odor was emanating from the dirty linen barrels or elsewhere in the room. An observation of the spa on the 100 hall, on 04/25/12 at 9:30 AM and 04/26/12 at 1:00 PM, revealed the odor persisted. An interview with the Housekeeping Manager, on 04/26/12 at 1:10 PM, revealed the spa areas were cleaned daily and as needed, and the dirty linen barrels were taken to laundry approximately every two hours by nurse aides.	F 252	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The Housekeeping supervisor will audit the cleanliness of the tile and commode on daily rounds Monday through Friday for four weeks, then weekly for on quarter. The Maintenance Director will audit the condition of the caulking around all toilets weekly for one month, then monthly for three months and then quarterly. The Housekeeping supervisor will monitor the cleanliness and odors in the spa rooms on daily rounds-Monday through Friday to assure the cleanliness, then weekly for one month and then monthly for one quarter. The data will be reviewed and analyzed monthly for three months and then quarterly at the Performance Improvement Committee (PIC) (Members include, but are not limited to, Executive Director, Director of Nursing, Medical Director, Infection Control Nurse, Safety Champion, Unit Managers, Admissions Coordinator, Business Office Manager, Dietician, Activities Director and Social Services) meeting to assure the facility provides a safe, clean and comfortable environment to the residents.	6/11/12
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253		

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F 253	Continued From page 2 The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide maintenance services necessary to maintain an orderly and comfortable interior as evidenced by a leaking bathtub faucet in resident room 203. The findings include: Observation during tour on the afternoon of 04/23/12 revealed the bathtub faucet in resident room 203 was dripping rapidly, almost at a steady stream, with a washbasin placed beneath it which was overflowing. This was observed again on 04/24/12 at 10:00 AM, and again on 04/25/12 at 9:30 AM during walk-through with the Maintenance Director. Interview with the Maintenance Director, on 04/25/12 at 9:30 AM, revealed he had not been made aware of the leak. Further interview revealed he relied on staff to fill out a work order form, located at each nursing station, to keep him informed of maintenance needs. He revealed no maintenance form had been filed for the leaky bathtub faucet in room 203, and no one had informed him of the leak. The Maintenance Director went on to reveal staff was trained on the procedure for filing a work order during orientation and this was reinforced monthly during	F 253	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F253 The bathtub faucet in Room 203 was repaired on 4/25/12. The Maintenance Director completed audits of all other bathtubs and faucets in the facility. There were not other leaky faucets found. The Staff Development Coordinator and the Maintenance Director conducted an in-service on 5/18/12 for all facility staff on when and how to complete a Maintenance work order. The Maintenance Director will bring all work orders to the morning stand up (Monday through Friday) to review and report when issues are completed. The Executive Director will audit the work orders on a weekly basis for one month, then monthly for one quarter and then quarterly to ensure repairs are being reported and completed timely to	6/11/12

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F 253	Continued From page 3 stand-up meetings. An interview with Licensed Practical Nurse (LPN) #3, on 04/25/12 at 2:56 PM, confirmed work order sheets were available at all nursing stations, and employees were trained on hire regarding the use of work orders for any maintenance concerns. LPN #3 revealed this information was also covered during inservices. An interview with Registered Nurse (RN) #5, on 04/25/12 at 3:00 PM, revealed if there was an immediate maintenance concern, she would call maintenance. For something not immediate, she revealed she would complete a work order form. An interview with Certified Medication Aide (CMA) #1, on 04/25/12 at 3:16 PM, revealed if facility equipment was not working properly, but was not causing a danger, she would complete a work order form for maintenance.	F 253	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* assure maintenance services are provided to maintain a sanitary, orderly and comfortable interior. The data will be reviewed and analyzed monthly for three months and then quarterly at the Performance Improvement Committee Meeting to assure maintenance services provides maintain a sanitary, orderly and comfortable environment.	6/11/12
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	F 280		

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F 280	Continued From page 4 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 interview, clinical record review, and review of the facility's Comprehensive Plan of Care policy, it was determined the facility failed to ensure the Comprehensive Plans of Care were revised for three (3) of twenty-two (22) sampled residents (Resident #5, #8, and #13). Resident #5 had a Physician's order, written 03/29/12, to discontinue the resident's pull tab alarm to the wheelchair and bed; however, the facility failed to update the resident's Comprehensive Care Plan to discontinue the intervention for an alarm on the wheelchair and bed. Resident #8 was transferred with a mechanical lift; however, the facility failed to revise the Comprehensive Care Plan to discontinue the intervention to transfer via assist of two staff using a gait belt. Resident #13 did not have a communication board; however, the facility failed to revise the Comprehensive Care Plan by removing this intervention. The findings include:	F 280	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 280 The care plan for Resident # 5 was revised on 5/1/12 to discontinue the bed and wheel chair tab alarm. The care plan for Resident # 8 was revised on 5/1/12 to discontinue the two person assist with gait belt for transfers. The care plan was revised to reflect the intervention of a mechanical lift for transfers. The care plan for Resident # 13 was revised on 5/1/12 to discontinue the use of a communication board. The MDS Coordinator, Case Manager, DNS and Unit Managers conducted an audit on all in-house care plans to assure they accurately reflect the resident's current status and interventions needed. Any revisions necessary were made at the time of the audit.	6/11/12

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F 280	Continued From page 5 Review of the facility's policy titled, "Comprehensive Plan of Care", dated 05/28/08, revealed under "Rationale" the care plan is re-evaluated and modified as necessary to reflect changes in care, service and treatment. In addition, the policy "Procedure" section included under "Communication/Implementation" to update the care plan during the course of care delivery to reflect modified interventions. 1. Review of Resident #5's medical record revealed the facility admitted the resident on 12/17/08, with diagnoses which included Alzheimer's Disease, Osteoarthritis, and Osteoporosis. Review of the annual Minimum Data Set (MDS) Assessment, dated 09/26/11, revealed the resident was severely cognitively impaired. Review of the Care Area Assessment (CAA) Summary, dated 09/27/11, revealed Resident #5 was assessed as being at risk for falls. Further review of the medical record revealed a Physician's order, dated 03/29/12, to discontinue the pull tab alarm for the resident. Continued review of the medical record revealed the resident was care planned for fall prevention, with interventions which included a pull tab alarm to be on Resident #5 when in his/her wheelchair and bed. Observation of Resident #5, on 04/27/12 at 2:45 PM, with Licensed Practical Nurse (LPN) #3 revealed no alarm in place. Interview with Licensed LPN #3, on 04/27/12 at 2:45 PM, revealed the resident did not have alarms in place. LPN #3 stated there was an	F 280	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The Staff Development Coordinator conducted an in-service with all licensed staff to complete care plan updates/revisions as indicated on 5/18/12. The MDS Coordinator and Case Manager will ensure all care plans reflect the resident's current interventions during the quarterly care plan meeting by reviewing and comparing care plan updates/revisions with the comprehensive care plan to ensure all the interventions are current. The ED or DNS will attend Care Plan meetings on a weekly basis for one month, and then monthly for one quarter to audit and to assure the Interdisciplinary Team (Members include, but are not limited to, MDS Coordinator, Dietician, Activities, Nursing, Social Services) is reviewing and revising the care plan according to the need of the Resident.	6/11/12

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F 280	Continued From page 6 order to discontinue the alarms on 03/29/12 and the alarms should have been discontinued on that date. Interview with State Registered Nursing Assistant (SRNA) #3, on 04/27/12 at 4:00 PM, revealed the resident had not had alarms for the past three (3) or four (4) weeks. Interview with the Director of Nursing (DON), on 04/27/12 at 3:30 PM, revealed the process was staff was supposed to complete a care plan update form when the Physician's order was written to discontinue the alarms on 03/29/12. She stated when the care plan meeting was held the Comprehensive Care Plan was to be revised to discontinue the alarm. Upon review of Resident #5's medical record, the DON stated there was no care plan update form, however should have been. 2. Review of Resident #8's medical record revealed the facility admitted the resident on 09/08/11, with diagnoses which included Parkinson's Disease, Rheumatoid Arthritis, and history of Cerebrovascular Accident (CVA) with right-sided weakness. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 04/17/12, revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of thirteen (13) which indicated the resident was cognitively intact. Review of the Physician's Orders revealed an order dated 02/29/12, for the resident to be transferred with a mechanical lift. Review of the Comprehensive Care Plan dated 03/08/12 revealed an intervention for the resident to be	F 280	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The MDS Coordinator and ED or DNS will report any findings/patterns for three months and then quarterly. The data will be reviewed and analyzed monthly for three months and then quarterly at the Performance Improvement Committee Meeting to assure the care plans are being updated and interventions are currently reflective of the residents needs.	6/11/12

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F 280	Continued From page 7 transferred with the assistance of two (2) staff and a gait belt. Review of the Care Area Assessment (CAA) Summary, dated 04/23/12, revealed the facility assessed Resident #8 to have decreased mobility. Observation, on 04/24/12 at 3:10 PM and 4:00 PM, revealed Resident #8 to be sitting up in his/her wheelchair. Continued observation, on 04/25/12 at 1:15 PM, revealed the resident sitting up in the wheelchair. The Occupational Therapist was observed to be working with Resident #8 at that time. Interview, on 04/25/12 at 1:22 PM, with the Occupational Therapist (OT) revealed Resident #8 was transferred with a mechanical lift. Interview, on 04/25/12 at 1:25 PM, with SRNA #10 revealed the resident was transferred with a mechanical lift. Interview, on 04/25/12 at 1:29 PM, with SRNA #11 revealed Resident #8 was transferred with a mechanical lift. Interview, on 04/27/12 at 2:29 PM, with the Unit Manager revealed Resident #8 was transferred with a mechanical lift. She stated she did not know why the Comprehensive Care Plan had not been revised to discontinue the intervention to transfer via assist of two staff using a gait belt. Interview, on 04/27/12 at 4:37 PM, with the MDS Coordinator revealed Resident #8's Comprehensive Care Plan should have been revised to remove the intervention for the resident to be transferred with the assist of two (2) staff and a gait belt.	F 280		

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F 280	Continued From page 8 3. Review of Resident #13's medical record revealed the facility admitted the resident on 05/31/10, with diagnoses which included history of Cerebrovascular Accident (CVA) with Aphasia (condition characterized by either partial or total loss of the ability to communicate verbally or using written words). Review of the Care Area Assessment (CAA) Summary, dated 12/19/11, revealed the facility assessed Resident #13 to have an inability to make his/her needs known. Review of the Comprehensive Care Plan, dated 02/17/12, revealed on the "I cannot provide my own daily needs" problem there was an intervention that stated "I have a communication board-encourage me to use it as I will allow". Review of the Quarterly Minimum Data Set (MDS) Assessment , dated 04/11/12, revealed the facility assessed Resident #13 to be moderately independent with daily decision making. Further review of the MDS revealed the resident's long and short term memory were intact. Observation, on 04/23/12 at 6:43 PM, 04/24/12 at 10:00 AM and 1:30 PM and 04/25/12 at 1:10 PM, revealed no evidence of Resident #13 having a communication board. Interview, on 04/25/12 at 1:45 PM, with SRNA #10 revealed she did not recall the resident ever having a communication board. Interview, on 04/25/12 at 4:10 PM, with the Speech-Language Pathologist (SLP) revealed Resident #13 had a communication board before in the past, however it was no longer in use related to the resident's inability to "grasp" what it was to be used for.	F 280		

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F 280	Continued From page 9	F 280		
	Interview, on 04/27/12 at 4:50 PM, with the Unit Manager revealed Resident #13 had never had a communication board. She stated Resident #13 had communication cards at one time in the past, however never used them. The Unit Manager stated the Comprehensive Care Plan should have been revised to discontinue the intervention for a communication board. Interview, on 04/27/12 at 4:37 PM, with the MDS Coordinator revealed Resident #13's Comprehensive Care Plan should have been revised to remove the intervention for the communication board. She stated this intervention should have been removed "a long time ago". Interview, on 04/27/12 at 5:47 PM, with the Director of Nursing revealed she had been in her position for two (2) years and had never seen Resident #13 use a communication board. She stated her expectations were that Comprehensive Care Plans would be updated and correct with the appropriate interventions.			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. 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 meet professional standards of quality according to acceptable	F 281		

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F 281	Continued From page 10 standards of clinical practice for three (3) of twenty-two (22) sampled residents (Residents #5, #8, and #9). Resident #9 had a Physician's order for Pataday eye drops dated 04/13/11 however, the facility failed to ensure the medication was re-filled. Resident #5 had a tab alarms discontinued on 03/29/12 however, the facility failed to discontinue the intervention from the April 2012 Treatment Administration Record (TAR) and facility staff failed to identify the alarms were not in place and continued initialing on the TAR the alarms were in place. Resident #8 had a Physician's order for a left arm bolster however, observation revealed the facility failed to ensure the resident had a left arm bolster in place. The findings include: Review of the facility's policy, "Medication Ordering and Receiving", dated 10/31/09, revealed the facility maintains accurate records of medication order and receipt that accounts for all medications. Continued review of the policy revealed under the "Procedure" step 2 to order refills by writing the medication name, prescription number, or bar coded peel-off label on the reorder sheet and faxing or communicating to the pharmacy. Reorder medication in advance (three to four days) of need to assure an adequate supply is on hand as established by the pharmacy process. Review of the facility's policy: "Medication	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F281 The Pataday eye drops for Resident #9 were reordered from pharmacy on 4/27/12. Resident #9's family and MD were notified and a medication variance report was completed. An order was received to administer the Pataday eye drops when it was received. The resident has no adverse reaction. The pull tab alarm to bed and wheelchair was discontinued from the TAR for Resident # 5 on 4/27/12. The Left arm bolster was placed on Resident # 8's wheelchair on 4/25/12. On 5/9/12 the medication in the medication carts and the MARs (Medication Administration Record) were audited by the Licensed Nurses and the Unit Managers to ensure the medications in the cart matched the MAR. There were no other issues noted.	6/11/12

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	185287		C 04/27/2012

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STREET ADDRESS, CITY, STATE, ZIP CODE: 863 LEXINGTON ROAD, HARRODSBURG, KY 40330

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F 281	Continued From page 11 Administration", dated 08/31/11, revealed nursing staff uses the medication cart to distribute physician ordered medications to patients. Review of the section "Procedure" revealed #17, staff are to document administration of the medication after administration on the Medication Administration Record (MAR) and #29, staff are to inventory for low stock medications. 1. Review of Resident #9's medical record revealed the facility admitted the resident on 09/28/07 with diagnoses which included Macular Degeneration, Cataracts, Diabetes II, and Alzheimer's Disease. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 02/06/12, revealed the resident was severely cognitively impaired. Review of the Physician's Orders for April 2012 revealed a start order date of 04/13/11 for the drug Pataday eye drops. The order stated to administer one (1) drop to each eye daily. Review of the eMedTV document "Pataday Uses", provided by the facility on 04/27/12, revealed the drug Pataday was a prescription eyedrop used for treating eye allergy symptoms. It was approved for treating eye itching related to allergies and belonged to a group of medications known as antihistamines. Further review of the Physician's Orders revealed in addition, Resident #9 had an order for Artificial Tears 1-2 drops in each eye twice a day for dry eyes. Observation, on 04/27/12 at 9:30 AM, of the medication cart with Licensed Practical Nurse (LPN) #3/Unit Manager, revealed no evidence that Pataday eye drops were available for administration to the resident.	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The TARs (Treatment Administration Records) were audited by the DNS and Unit Managers to assure orders on the TAR for monitoring are accurate. The discontinued orders for the TAR will be audited to ensure they are no longer on the TAR. Any revisions necessary were made at the time of the audit. The physician's orders for positioning devices were audited to the care plan, CNA Assignment sheet and resident on 5/17. Any revisions necessary were made at the time of the audit. The Pharmacy on 5/17/2012 completed an audit of the Medication Carts to the MAR to assure the medications on hand matched the order on the MAR. The Staff Development Coordinator conducted an in-service with the Licensed staff on ordering medications,	6/11/12

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F 281	Continued From page 12 Interview, on 04/27/12 at 10:00 AM, with a Pharmacy Tech from the facility's contracted pharmacy revealed Pataday eye drops were an antihistamine and Artificial Tears eye drops were used to moisten the eye. Further interview with the Pharmacy Tech revealed the last time the Pataday eye drops were refilled by the pharmacy was on 11/23/11. There were fifty (50) drops in the bottle which, based on the order, would be a twenty-five (25) day supply according to the Pharmacy Tech. The Pharmacy Tech stated it would have been the facility's nurses' responsibility to fax in or phone in a request to refill the Pataday eye drop medication. Interview, on 04/27/12 at 10:20 AM, with LPN #3 revealed she administered Resident #9's morning medications on 04/17/12 through 04/20/12 and thought she remembered giving the resident two (2) different eye drop medications. She stated she thought the Artificial Tears and the Pataday Eye Drops were the same medication. The LPN further stated she could not recall if she had contacted the pharmacy and clarified if Pataday and Artificial Tears were the same medication. Interview, on 04/27/12 at 10:35 AM, with LPN # 5 revealed she had given the Artificial Tears and the Pataday eye drops to Resident #9 on 04/27/12. She stated she had initialed the April 2012 MAR for 04/27/12. When informed only the Artificial Tear eye drop medication was available in the medication cart, she stated she had thought they were the same medication. Further interview revealed she should have clarified the order. Interview, on 04/27/12 at 12:30 PM, with the	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* medication administration and accurate documentation on the MAR and TAR with emphasis on meeting professional standards for accurate documentation. On 5/18/12 the Staff Development Coordinator conducted an in-service with the CNA's regarding the implementation/following the CNA assignment sheets and reporting any issues with adaptive equipment to the charge nurse. The Medication Carts and MARs will be audited by the Unit Managers monthly for one quarter and the Pharmacy will audit the Medication Cart and MARs quarterly to assure the medications and MAR are accurate. The Staff Development Coordinator will conduct one random medication pass observation weekly for one month and then quarterly to assure the licensed staff are meeting professional standard for accurate documentation.	6/11/12

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F 281	Continued From page 13 Pharmacy Director at the facility's contract pharmacy revealed according to records, the most recent dispensing dates of the Pataday medication were 11/23/11 and 04/27/12. Interview with Resident #9's Physician, on 04/27/12 at 3:25 PM, revealed the Pataday medication prescribed was for allergies. He stated his expectation was that the eye drop medication would be administered by the facility as per his order. Interview, on 04/27/12 at 4:30 PM, with the Director of Nursing (DON) revealed the facility's medication restocking process was if the medication supply was low, the nurse would pull the sticker and re-order the medication. She stated that based on the supply records it appeared the nurses failed to follow the Physician's order (for administering the eye drop medication). In addition, she stated the nurses administering the medication should have ensured they had the medication available as ordered. The DON indicated nurses should have called the pharmacy if the medication was not available for administration. According to the DON, the nurses failed to follow the process for re-supplying the eye drop medication. 2. Review of the facility's policy related to "Physician Orders" revealed under Procedure, staff was to record an order on the physician order sheet/telephone order sheet if it was a verbal order, and was to place the order on the Medication Administration Record (MAR) or Treatment Administration Record (TAR). Review of Resident #5's medical record revealed	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The Unit Managers will audit the TARs for accuracy to assure the licensed staff are meeting professional standard for accurate documentation. The Unit Mangers will audit the CNA assignment sheets to the Residents to assure the CNA's are following the care plan weekly for one month and then monthly for one quarter. The audits will be reviewed and analyzed monthly for three months and then quarterly at the Performance Improvement Committee Meeting to assure the nursing staff are meeting professional standard for accurate documentation.	6/11/12

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F 281	Continued From page 14 the facility admitted the resident on 12/17/08, with diagnoses which included Alzheimer's Disease, Chronic Ischemic Heart Disease, Osteoarthritis, and Osteoporosis. Further review of the medical record revealed a Physician's telephone order, dated 03/29/12, to discontinue the pull tab alarm to Resident #5's chair and bed. Review of the TAR for April 2012 revealed an order for a pull tab alarm (order dated 05/26/11) on resident while up in the wheel chair and while in bed. Further review of the TAR revealed staff had initialed each shift (7:00 AM - 7:00 PM and 7:00 PM - 7:00 AM) from April 1st thru April 26th (7:00 AM - 7:00 PM shift) that the alarm was in place. Observation, on 04/27/12 at 2:45 PM, of Resident #5 with Licensed Practical Nurse (LPN) #3 revealed no pull tab alarm was observed on Resident #5. Interview, on 04/27/12 at 2:45 PM, with LPN #3/Unit Manager, revealed the resident did not have an alarm in place. She stated there was an order to discontinue the alarm on 03/29/12. LPN #3/Unit Manager stated when the order was written the alarm should have been discontinued on that date as ordered. Interview, on 04/27/12 at 2:55 PM, with Registered Nurse #4, who verified the alarm was not in place, revealed she had been initialing the TAR and should not have done so without checking to ensure the alarm was in place. Further interview, on 04/27/12 at 3:00 PM, with LPN#3/Unit Manager, revealed the facility's	F 281		

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F 281	Continued From page 15 process was when the Physician's order to discontinue the alarm was received, nurses should have noted it on the March TAR. In addition, nurses were supposed to reconcile the April TAR to the April orders to ensure they were correct. She stated nurses should not have initiated the alarm was in place unless they checked to see if one was in place. According to LPN #3/Unit Manager it appeared the nurses had not checked to see the alarm was in place because it had been discontinued. Interview, on 04/27/12 at 4:10 PM, with the Director of Nursing (DON) revealed the expectation would be for the alarm's discontinuation as ordered. She stated the alarm use should not have been on the April TAR, as it had been discontinued on 03/29/12. The DON stated nurses should have clarified why the alarm had remained on the April TAR. Additionally, the DON indicated it was important to clarify orders to ensure they were being followed. The DON stated nurses should not document on the TAR that an alarm was in place without observing there was an alarm on the resident's chair or bed. 3. Review of Resident #8's medical record revealed the resident was admitted by the facility on 09/08/11, with diagnoses which included Parkinson's Disease, Rheumatoid Arthritis, and history of Cerebrovascular Accident (CVA) with right-sided weakness. Review of the Physician's Orders revealed an order dated 03/27/12 for Resident #8 to have a left arm bolster on at all times when in his/her wheelchair. Review of the Comprehensive Care	F 281		

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F 281	Continued From page 16 Plan dated 03/08/12 revealed an update dated 03/27/12, for the resident to have a left arm bolster in place at all times when he/she was up in the wheelchair. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 04/17/12, revealed the facility assessed Resident #8 to require total assistance with all Activities of Daily Living (ADLs) except for eating (which he/she required extensive assistance with). Observation, on 04/24/12 at 3:10 PM and 4:00 PM, revealed Resident #8 was sitting up in his/her wheelchair with no left arm bolster in place. Observation revealed the resident was leaning to the left side of the wheelchair. Continued observation on 04/25/12 at 1:15 PM revealed the resident was sitting up in the wheelchair with no left arm bolster in place and leaning to the left side of the wheelchair. The Occupational Therapist was observed to be working with Resident #8 at that time. Interview, on 04/25/12 at 1:22 PM, with the Occupational Therapist (OT) #1 revealed Resident #8 should have had a left arm bolster on while up in the wheelchair, however she stated she was unable to locate it. The OT #1 stated she would obtain another one and put it in place on Resident #8's wheelchair. Interview, on 04/25/12 at 1:25 PM, with SRNA #10 revealed she didn't think Resident #8 ever had a left arm bolster on his/her wheelchair. Interview, on 04/25/12 at 1:29 PM, with SRNA #11 revealed she was not aware Resident #8 was to have a left arm bolster on his/her wheelchair. Review of the Nurse Aide Care Plan SRNA #11	F 281		

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F 281	Continued From page 17 had in her pocket revealed Resident #8 was to have a left arm bolster in place to his/her wheelchair at all times. Interview, on 04/27/12 at 2:29 PM, with the Unit Manager revealed Resident #8 should have had a left arm bolster in place when up in his/her wheelchair as per the Physician order. Interview, on 04/27/12 at 5:47 PM, with the DON revealed her expectations were that Physician's Orders would be carried out as ordered. She stated Resident #8 should have had a left arm bolster in place at all times when he/she was up in the wheelchair as ordered. The DON stated if the State Registered Nursing Assistants (SRNAs) noticed the left arm bolster wasn't in place they should have notified the nurse or therapist.	F 281		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by:	F 514		

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F 514	Continued From page 18 Based on interview and record review it was determined the facility failed to maintain clinical records on each resident in accordance with acceptable professional standards and practices that were complete and accurately documented for two (2) of twenty-two (22) sampled residents (Residents #5 and #9) and one (1) unsampled resident (Unsampled Resident C). Resident #5 had sensor alarms discontinued 03/29/12; however, facility staff failed to discontinue the intervention on the April 2012 Treatment Administration Record (TAR) and staff continued to initial the alarm was in place from 04/01/12 through 04/26/12. Resident #9 had an order for Pataday Eye Drops which pharmacy records and statements revealed were last dispensed to the facility on 11/23/11 (a bottle of 25 doses); however, facility staff documented inaccurately on the Resident's Medication Administration Records (MAR) for January, February, March, and April (1st through 27th) for 2012, the medication was administered. Unsampled Resident C had a Physician's Orders, dated April 2012, for Folic Acid; however, the order failed to list the medication's strength. The findings include: Review of the facility's policy: "Patient Medical Records", dated 08/31/11, revealed medical records were maintained on each patient in accordance with accepted professional standards and practice, provided a basis for determining and managing the patient's progress including response to treatment, change in condition, and	F 514	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F514 The pull tab alarm to bed and wheelchair was discontinued from the TAR for Resident # 5 on 4/27/12. The Pataday eye drops for Resident #9 were reordered from pharmacy on 4/27/12. Resident #9's family and MD were notified and a medication variance report was completed. An order was received to administer the Pataday eye drops when it was received. The resident has no adverse reaction. On 4/27/12 the Folic Acid order for unsampled Resident C was clarified to reflect the 1 mg order from 7/19/11. The resident was receiving the correct dosage/strength.	6/11/12

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F 514	Continued From page 19 changes in treatment; and were complete and accurately documented. 1. Review of Resident #5's medical record revealed the resident was admitted by the facility, on 12/17/08, with diagnoses which included Alzheimer's Disease, Osteoarthritis, and Osteoporosis. Review of Physician orders for April 2012 revealed the pull tab alarm on resident while up in wheel chair and bed was discontinued 03/29/12. Review of the TAR for April 2012 revealed an intervention for a pull tab alarm (order dated 05/26/11) on resident while up in the wheel chair and while in bed and was to be assessed each shift (7 AM - 7 PM and 7 PM - 7 AM). Further review of the TAR revealed staff was initialing each shift from April 1st through April 26th that the alarm was in place. Interview, on 04/27/12 at 4:05 PM, with Registered Nurse #4, who had verified the alarm was not in place, revealed she had been initialing the TAR without looking (to see if the alarm was in place). Observation, of Resident #5, on 04/27/12 at 2:45 PM, with Licensed Practical Nurse (LPN) #3 revealed no pull tab alarm was observed on Resident #5. Further interview with LPN#3/Unit Manager, on 04/27/12 at 3:00 PM, revealed the facility's process was when the Physician's order on 03/29/12 was received to discontinue the alarm staff should have noted on the March TAR the alarm was discontinued. In addition, they were	F 514	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The TARs (Treatment Administration Records) were audited by the DNS and Unit Managers to assure orders on the TAR for monitoring are accurate. The discontinued orders for the TAR will be audited to ensure they are no longer on the TAR. Any revisions necessary were made at the time of the audit. On 5/9/12 the medication in the medication carts and the MARs (Medication Administration Record) were audited to ensure the medications on hand matched the MAR. There were no other issues noted. The MARs were audited for correct dosage/strength on 5/3/12 by the pharmacy consultant. There were no other issues noted. On 5/18/12 the Staff Development Coordinator conducted an in-service the Licensed staff regarding accurate documentation on the MAR and TAR, Medication Administration and there was	6/11/12

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F 514	Continued From page 20 supposed to reconcile the April TAR to the April orders to make sure they match. The process in place to reconcile the current TAR to the current orders failed to identify the order for the alarm had been discontinued and note this on the April TAR if the alarm was still listed. Staff should not have initialed the alarm was in place unless they saw it. It appeared the nurses had not checked to see the alarm was in place because it had been discontinued. Interview with the Director of Nursing (DON), on 04/27/12 at 3:30 PM, revealed the nurse who took the order should have noted on the TAR when the order was received on 03/29/12 to discontinue the alarm. Review of the March TAR did not show the alarm was discontinued. They failed to document on the TAR the order was discontinued. The facility's process was to compare the prior month's TAR (March) to the newly printed TAR (April), but the March TAR did not show the alarm was discontinued. In addition, the nurse failed to review the April orders to see the alarms were discontinued and take them off the TAR. Interview, on 04/27/12 at 4:10 PM, with the DON revealed the expectation would have been the alarm was discontinued when the order was received and the tab alarm intervention discontinued on the April 2012 TAR. Nurses should not have documented on the TAR without observing if the alarm was in place. 2. Review of the facility's policy: "Medication Administration", dated 10/31/09, revealed staff was to document, on the MAR, administration and/or refusal of the medication after the	F 514	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* an order for dosage/strength documented on the MAR. The Unit Managers will audit the TARs for accuracy weekly for one month and then monthly for one quarter to assure the licensed staff are meeting professional standard for accurate documentation in the medical record. The Medication Carts and MARs will be audited by the Unit Managers monthly for one quarter and the Pharmacy will audit the Medication Cart and MARs quarterly to assure the medications and MAR are accurate. The Staff Development Coordinator will conduct one random medication pass observation weekly for one month and then quarterly to assure the licensed staff are documenting accurately in the medical record.	6/11/12

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NAME OF PROVIDER OR SUPPLIER: HARRODSBURG HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 853 LEXINGTON ROAD, HARRODSBURG, KY 40330

(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 514	Continued From page 21 administration and/or the attempt to administer the medication. Review of Resident #9's medical record revealed the resident was admitted by the facility on 09/28/07 with diagnoses which included Macular Degeneration, Cataracts, Diabetes II, and Alzheimer's Disease. Review of the Physician's Orders for April 2012 revealed an order for the drug Pataday (an antihistamine), start order date 04/13/11, eye drops 1 drop each eye daily related to dryness. In addition, the resident had an order for Artificial Tears 1-2 drops in each eye twice a day dry eye. Observation of the medication cart with LPN #3/Unit Manager, on 04/27/12 at 9:30 AM, revealed no Pataday eye drops were available for the resident. Review of the 2012 MAR for January, February, March, and April revealed staff had initialed administering the Pataday medication. Interview, on 04/27/12 at 10:35 AM, with LPN #5 revealed she had given the Artificial Tears and the Pataday eye drops to Resident #9 and initialed the April 2012 MAR for 04/27/12. When informed only the Artificial Tear eye drop medication was available in the medication care, she stated she had thought they were the same medication. Further interview revealed she should have clarified the order since it was on two different places on the MAR. Interview with the Pharmacy Tech, on 04/27/12 at 10:00 AM, revealed the last time the Pataday eye	F 514	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The Pharmacy Consultant will audit monthly for one quarter to assure dosage/strength is on the MAR. The Unit Managers will audit the orders weekly for one month and then quarterly to assure the correct dosage is on the MAR. The audits will be reviewed and analyzed monthly for three months and then quarterly at the Performance Improvement Committee Meeting to assure the nursing staff are documenting accurately in the medical record.	6/11/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185287		C 04/27/2012

NAME OF PROVIDER OR SUPPLIER
HARRODSBURG HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
853 LEXINGTON ROAD
HARRODSBURG, KY 40330

(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 514	Continued From page 22 drops were refilled by the pharmacy was on 11/23/11. There were fifty (50) drops in the bottle which, based on the order, would be a twenty-five (25) day supply. . Interview with the DON, on 04/27/12 at 4:30 PM, revealed based on review of the supply records it appeared the nurses did not have the medication available to administer from January through April 27th 2012. If they did not give it, they should not have initialed it on the MAR. Based on the evidence, by initialing the MAR it did not appear the nurses accurately documented this medicine was not administered. They did not ensure the MAR was accurate. 3. Review of the facility's policy, "Physician Orders", revised date 4/28/11, revealed it was the policy of the facility to obtain medication orders that specified name of medication, strength of medication where indicated and dosage. The policy also stated verify dosages and/or orders that appear inappropriate. In addition the policy stated clarify any orders observed to be incomplete. Record review revealed the facility re-admitted Unsampled Resident C on 07/19/11 with diagnoses which included Vitamin and Mineral Deficiency. Record review of Unsampled Resident C's Physician Orders, dated April 2012, revealed an order for Folic Acid, however there was no strength listed. Interview with Licensed Practical Nurse (LPN) #8, on 04/23/12 at 4:35 PM, revealed the April 2012	F 514	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185287		C 04/27/2012

NAME OF PROVIDER OR SUPPLIER: HARRODSBURG HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 863 LEXINGTON ROAD, HARRODSBURG, KY 40330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 514	Continued From page 23 Physician's Orders should have listed a strength for the Folic Acid medication prescribed for Unsampled Resident C. Interview with Unit Manager, on 04/24/12 at 3:00 PM, revealed the original order on 07/19/11 listed the medication strength as one (1) milligram (mg), however when the orders were copied for April 2012 the strength was omitted and the facility had failed to notice the April 2012 order for Unsampled Resident C's Folic Acid was incomplete. Interview with the DON, on 04/27/12 at 10:50 AM, revealed Nursing and Pharmacy conducted monthly reviews of the residents' medication orders, including completeness [name of medication, strength of medication where indicated and dosage]. Interview with the facility Pharmacist, on 04/27/12 at 12:30 PM, revealed orders were reviewed monthly and Unsampled Resident C's April 2012 Physician's Orders should have specified strength and dosage to be considered a complete order for Folic Acid. However, further interview revealed pharmacy failed to identify the facility record as incomplete during chart review.	F 514		

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

PRINTED: 05/11/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185287		04/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRODSBURG HEALTH CARE CENTER	863 LEXINGTON ROAD HARRODSBURG, KY 40330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS CFR : 42CFR483.70(a) Building: 01 Plan Approval: 12/01/76 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One Story, Type V (000) Unprotected SMOKE COMPARTMENTS: Five (5) COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM (original installed) FULLY SPRINKLERED, SUPERVISED (Dry SYSTEM) updated 2006 EMERGENCY POWER: Type II Diesel installed in 2000 A life safety code survey was initiated and concluded on 04/24/12. Harrodsburg Health Care Center was in compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found in compliance with the Requirements for Participation for Medicare and Medicaid and no deficiencies cited. The facility is licensed for one hundred twelve (112) beds and the census was one hundred six (106) on the day of the survey.	K 000	RECEIVED MAY 21 2012 BY:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 5/18/12

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.