

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

PRINTED: 04/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/13/2015
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NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102
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(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
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{F 000} INITIAL COMMENTS

An offsite revisit was conducted and based on the acceptable Plan of Correction (POC) the facility was deemed to be in compliance as alleged on 03/16/15.

{F 000}

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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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Acceptable

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F 000

INITIAL COMMENTS

A Recertification Survey was initiated on 03/03/15 and concluded on 03/06/15 with deficient practice cited at the highest scope and severity of an "E."

F 322
SS=D

483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS

Based on the comprehensive assessment of a resident, the facility must ensure that --

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and

(2) 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.

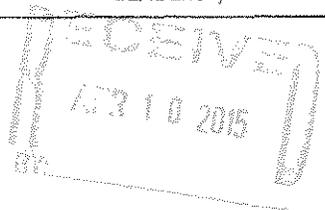
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to administer enteral tube medications according to their policy for one (1) unsampled resident (Resident A).

F 000

F 322

No residents were found to have adverse reactions or outcomes associated with the deficient practice. A house wide education was completed with all nursing staff concerning Kingsbrook Lifecare Center's (KBLC) policy on "Enteral Tube Medication Administration" and safe/proper enteral tube medication administration. This education was completed on 3-6-15 by the Quality Assurance Department nurses (Curtis Metzler, RN, BSN, Robin Davis, LPN, and Scott Mulhearn, LPN). The facility implemented a random audit process, on 3-12-15, to monitor enteral tube medication administrations. Resident Care Managers and Nursing supervisor's (Susan Kempf, RN, Sharon Queen, LPN, Pam Willis, RN, Violet Stewart, RN, Sherry Blackburn, LPN, Rita Hankins, LPN, and Pam Pennington, LPN) will audit enteral tube medication passes each shift every week to monitor for safe/proper medication administration. All audits will be monitored through the monthly QAPI meeting for a period of one year or longer if needed, to ensure compliance. The QAPI meeting is made up of: Lisa Queen (Administrator), Phillip Fioret (Medical Director), Arlene Massie (Director of Nursing), Pam Bryan (Assistant Director of Nursing), Curtis Metzler (Quality Assurance/ Infection Control), Dave Thomas (Finance Director), Teria Maynard (MDS

3-16-15



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Lisa Queen</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4/10/15</i>
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F 322	<p>Continued From page 1</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Enteral Tube Medications Administration", undated, revealed the purpose of the policy was to assure the safe and effective administration of enteral formulas and medications via enteral tubes. Continued review revealed steps in the procedure included the following: each medication was to be administered separately; a warm water flush of at least five (5) milliliters (ml) was to be instilled between each medication; and the cup from which the medication was administered was to be rinsed with water to ensure the entire dose was administered. (An enteral tube is inserted into the stomach, through the abdomen, for the administration of nutritional formulas and medications, for individuals unable to swallow safely.)</p> <p>Clinical record review revealed Resident A was admitted by the facility on 09/24/12 with diagnoses which included Infantile Cerebral Palsy, Convulsions, Chronic Obstructive Airway Disease, Dysphagia, and Status-Post Gastrostomy Tube Insertion.</p> <p>Observation of the medication pass, on 03/03/15 at 4:30 PM, revealed Licensed Practical Nurse (LPN) #2 administered three (3) liquid medications as follows: Colace 100 milligrams (mg), a stool softener given for prevention of constipation; Oxycodone 5 mg, a narcotic given for pain control; and Valproic Acid 125 mg, given for seizure control. Continued observation revealed LPN #2 administered the medications in direct succession without flushing with water between each medication. In addition, LPN #2 did not rinse the cup containing the medications to</p>	F 322	<p>Coordinator), Glenna Greenslade (Social Services), Nathan Holbrook (Maintenance Manager), Charles Erwin (Environmental Services/Risk Management), Arinn McKnight (Admissions/Activities), Erin Littleton (Dietician), Gail Cunningham (Kitchen), Annie Bishop (Therapy Manager), Robin Davis (Quality) Brittany Moore (Treatment Nurse), Jennifer McFarlin (Human Resources), Susan Kempf (RCM), Sharon Queen (RCM), Violet Stewart (RCM), Pam Willis (RCM), Katie Davis (Finance Coordinator), Vicki Baily (Medical Records), and Kathy Schaffer (Pharmacist).</p>		

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F 322	Continued From page 2 ensure the entire dose was administered. Interview with LPN #2, on 03/05/15 at 4:00 PM, revealed she was aware of the facility's policy for enteral tube medication, including the requirement to flush with water between each medication and to add water to the cup as necessary to ensure all of the medication was administered. Continued interview revealed LPN #2 could not say why she did administer the medications correctly. Interview with the Pharmacist, on 03/05/15 at 12:45 PM, revealed the administering nurse should follow the written policy by administering each medication separately, flushing with water between medications, and rinsing the cup as directed by the policy. Interview with the Director of Nursing (DON), on 03/05/15 at 3:35 PM, revealed it was her expectation for all nurses in the facility to administer enteral medications according to the facility's policy. The DON stated she recognized the need for education regarding enteral tube care and proper medication administration.	F 322			
F 411 SS=E	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if	F 411	Dental services were scheduled for Residents #6, #7, #11, #18, and #19 (per resident choice) on 3-6-15, immediately upon notification of deficient practice. A facility wide audit was completed on 3-13-15 to ensure every resident had received proper dental services, was scheduled for dental services, assisted in seeing the dentist of his/her choice, or declined dental services. On 3-13-15, a form was included in KBLC admission paperwork to determine resident dental preference. This form will be completed on all new	3-16-15	

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F 411	<p>Continued From page 3</p> <p>necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure each resident received routine dental services, for five (5) of twenty-four (24) sampled residents (Residents #6, #7, #11, #18 and #19). Review of resident medical records revealed no documented evidence residents received dental services in the past year.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON), on 03/05/15 at 3:18 PM, revealed no policy related to dental care existed; however, she stated it was her expectation for every resident to receive routine dental care.</p> <p>1. Clinical record review revealed the facility admitted Resident #6 on 11/01/12 with diagnoses which included Generalized Muscle Weakness, Depression, Osteoarthritis and Alzheimer's Disease.</p> <p>Review of a Physician's order dated 07/01/2013 revealed Resident #6 was to see a dentist as needed. Continued record review revealed no documented evidence Resident #6 was seen by a Dentist or received dental care within the past year.</p>	F 411	<p>admissions to ensure every resident has his/her dental care needs met. Dr. Deanna Tatterson DMD will make monthly rounds at the facility and as needed for emergencies. Progress notes of each visit will be written in the residents' charts and exam sheets will be scanned into the residents' medical record for storage. RCM Violet Stewart will create a resident list before each visit to ensure every resident is seen on a yearly basis and as needed, unless dental services are refused. At this time, all residents who have requested to see a personal dentist will be assisted with appointments, transportation, and any other needs. Each Resident Care Manager (Susan Kempf, RN, Sharon Queen, LPN, Violet Stewart, RN, Pam Willis, RN) will track the dental preferences and visits of each resident on her floor. Each RCM will complete a monthly audit to ensure that each resident has received proper dental care according to his/her preference and that this care is documented. All audit results will be monitored through monthly QAPI meetings for a period of one year or longer if necessary. The QAPI meeting is made up of: Lisa Queen (Administrator), Phillip Fioret (Medical Director), Arlene Massie (Director of Nursing), Pam Bryan (Assistant Director of Nursing), Curtis Metzler (Quality Assurance/ Infection Control), Dave Thomas (Finance Director), Teria Maynard (MDS Coordinator), Glenna Greenslade (Social Services), Nathan Holbrook (Maintenance Manager), Charles Erwin (Environmental Services/Risk Management), Arinn McKnight (Admissions/Activities), Erin Littleton (Dietician), Gail Cunningham (Kitchen),</p>

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F 411	<p>Continued From page 4</p> <p>2. Medical record review revealed Resident #7 was admitted by the facility on 05/10/11 with diagnoses which included Depressive Disorder and Vitamin D Deficiency. Further review revealed no documented evidence routine dental services were offered to or received by Resident #7 in the past year.</p> <p>3. Review of the medical record revealed the facility admitted Resident #11 on 11/13/13 with diagnoses which included End Stage Renal Disease, Diabetes Type II, and Depression. Continued review revealed no documented evidence Resident #11 was seen by the Dentist within the last year.</p> <p>4. Medical record review revealed Resident #18 was admitted by the facility on on 09/25/12, with diagnoses which included Alzheimer's Dementia, Vitamin B Deficiencies, Anxiety, Depression, and Diabetes Type II. Continued review revealed no documented evidence the resident was seen by the Dentist within the past year.</p> <p>5. Clinical record review revealed the facility admitted Resident #19 on 12/20/12 with diagnoses which included Dementia, Depression, Generalized Muscle Weakness, Spinal Stenosis and Anxiety.</p> <p>Review of a Physician's order dated 07/29/2013 revealed Resident #19 was to see a dentist as needed. Continued record review revealed no documented evidence Resident #19 had gone out of the facility to see a Dentist; nor was the resident seen by the Dentist that visited the facility on a scheduled basis.</p> <p>Continued interview with the DON, on 03/05/15 at</p>	F 411	<p>Annie Bishop (Therapy Manager), Robin Davis (Quality) Brittany Moore (Treatment Nurse), Jennifer McFarlin (Human Resources), Susan Kempf (RCM), Sharon Queen (RCM), Violet Stewart (RCM), Pam Willis (RCM), Katie Davis (Finance Coordinator), Vicki Baily (Medical Records), and Kathy Schaffer (Pharmacist).</p>		

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F 411	Continued From page 5 3:18 PM, revealed the Dentist visited the facility monthly. She stated the facility, i.e. the Administrator and the DON, was ultimately responsible for ensuring each resident received routine dental services. Further interview revealed she was unable to find any documented evidence Residents #6, #7, #11, #18, and #19 had been seen by the dentist.	F 411			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431	All opened and unlabeled medications were immediately discarded upon discovery on 3-3-15. No residents were determined to have adverse effects from the deficient practice. A facility wide audit was completed on 3-3-15 to ensure no additional medications were stored improperly. A nursing education was completed on 3-3-15 concerning proper medication storage in accordance with the KBLC policy entitled "Medication Storage in the Facility: Storage of Medications," by the Quality Assurance Department staff (Curtis Metzler, RN, BSN, Robin Davis, LPN, Scott Mulhearn, LPN, and Angie Cisco, LPN). Weekly audits were implemented on 3-13-15 on each unit to ensure compliance with proper medication storage guidelines. Each RCM (Susan Kempf, RN, Sharon Queen, LPN, Violet Stewart, RN, Pam Willis, RN) will audit her unit and report the findings in the monthly QAPI meetings for a period of one year or longer if needed, to ensure compliance. The QAPI meeting is made up of: Lisa Queen (Administrator), Phillip Fioret (Medical Director), Arlene Massie (Director of Nursing), Pam Bryan (Assistant Director of Nursing), Curtis Metzler (Quality Assurance/ Infection Control), Dave Thomas (Finance Director), Teria Maynard (MDS)	3-16-15	

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F 431	<p>Continued From page 6</p> <p>abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to properly store drugs and biologicals in the facility medication room refrigerator.</p> <p>The findings include:</p> <p>Review of the facility's policy, titled "Medication Storage in the Facility: Storage of Medications", undated, revealed medications and biologicals were to be stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Continued review revealed outdated medications were to be immediately removed and disposed of. Further review revealed medication storage conditions were to be monitored monthly and corrective actions taken if problems were identified.</p> <p>Observation of the medication room refrigerator on the Garden View unit, on 03/03/15 at 4:30 PM, revealed a multi-dose vial of Novolog R (insulin) had been opened, but was not labeled with the date, time or initials of the individual who opened the vial. In addition, a multi-dose vial of Lantus Insulin was opened, but unlabelled.</p>	F 431	<p>Coordinator), Glenna Greenslade (Social Services), Nathan Holbrook (Maintenance Manager), Charles Erwin (Environmental Services/Risk Management), Arinn McKnight (Admissions/Activities), Erin Littleton (Dietician), Gail Cunningham (Kitchen), Annie Bishop (Therapy Manager), Robin Davis (Quality) Brittany Moore (Treatment Nurse), Jennifer McParlin (Human Resources), Susan Kempf (RCM), Sharon Queen (RCM), Violet Stewart (RCM), Pam Willis (RCM), Katie Davis (Finance Coordinator), Vicki Baily (Medical Records), and Kathy Schaffer (Pharmacist).</p>		

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F 431	<p>Continued From page 7</p> <p>Interview with LPN #3 and LPN #4, on 03/03/15 at 4:35 PM, revealed they did not know what to do with the opened, unlabelled multi-dose insulin medication vials. They stated they would contact their nursing supervisor for further instructions.</p> <p>Interview with LPN #5, on 03/03/15 at 4:45 PM, revealed she was a Nursing Supervisor and the Infection Control Coordinator. She stated all insulin vials should be labeled immediately upon opening with the date and time the vial was opened, and the initials of the facility personnel who opened the vial. Continued interview revealed insulin vials should be discarded after being open for 28 days, and the discard date could not be determined if the vial was not labelled correctly upon opening.</p> <p>Interview with the Pharmacist, on 03/05/15 at 12:45 PM, revealed insulin vials were to be labelled immediately upon opening with the date and time, and the initials of the nurse who opened the vial. Continued interview revealed twenty-eight (28) days was the maximum time the insulin could be open without being used. After that time, the vial must be discarded. Further interview revealed proper labelling upon opening indicated the accurate use-by date.</p> <p>Interview with the Director of Nursing (DON), on 03/05/15 at 3:40 PM, revealed it was her expectation for all facility nursing staff to immediately label newly-opened medication vials with the date, time, and initials of the nursing staff. Continued interview revealed the DON recognized a need for training relating to the facility's policy regarding proper medication storage. She further stated she would need to provide follow-up on the monthly monitoring of</p>	F 431		

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F 431	Continued From page 8 the facility's medication and biologicals storage practices.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	Residents #3 and #14 were determined to have no adverse effects as a result of deficient practice. A facility wide nursing education was completed on 3-5-15 concerning infection control and the prevention of the development/transmission of disease and infection including proper handwashing and head-to-toe assessment. This education was completed by the Quality Assurance Department Staff (Curtis Metzler, RN, BSN, Robin Davis, LPN, Scott Mulhearn, LPN, Angie Cisco, LPN). A facility wide random audit was implemented on 3-10-15 to ensure compliance with infection control and the prevention of the development/transmission of disease and infection, including handwashing and head-to-toe assessments. Audits will be completed each shift every week by the Quality Assurance Department staff (Curtis Metzler RN, BSN, Robin Davis, LPN, Scott Mulhearn, LPN, and Angie Cisco, LPN). All Audits will be monitored through monthly QAPI meetings for a period of one year or longer if needed, to ensure compliance. The QAPI meeting is made up of: Lisa Queen (Administrator), Phillip Fioret (Medical Director), Arlene Massie (Director of Nursing), Pam Bryan (Assistant Director of Nursing), Curtis Metzler (Quality Assurance/ Infection Control), Dave Thomas (Finance Director), Teria Maynard (MDS Coordinator), Glenna Greenslade (Social Services), Nathan Holbrook (Maintenance Manager), Charles Erwin (Environmental Services/Risk Management),	3-16-15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2015	
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102		
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F 441	<p>Continued From page 9 infection.</p> <p>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 ensure licensed nursing personnel washed their hands and changed gloves as required to help prevent the spread and transmission of disease for two (2) of twenty-four (24) sampled residents (Residents #3 and #14).</p> <p>The findings include:</p> <p>Review of the "Nursing Policy and Procedure for Handwashing", revised February 2003, revealed the purpose of handwashing was to remove contaminants acquired by recent contact with infected residents or environmental sources. Continued review revealed personnel who had contact with a resident's excretions, secretions, or blood, either directly or through contaminated articles, could acquire contaminants. Further review revealed to reduce the risk of spreading infection from one resident to another, staff should wash their hands and change gloves when moving from a "dirty" area to a "clean" area.</p> <p>1. Medical record review revealed Resident #3 was admitted by the facility on 07/19/11 with diagnoses which included Senile Dementia, Congestive Heart Failure, and Coronary Artery Disease.</p>	F 441	<p>Arinn McKnight (Admissions/Activities), Erin Littleton (Dietician), Gail Cunningham (Kitchen), Annie Bishop (Therapy Manager), Robin Davis (Quality) Brittany Moore (Treatment Nurse), Jennifer McFarlin (Human Resources), Susan Kempf (RCM), Sharon Queen (RCM), Violet Stewart (RCM), Pam Willis (RCM), Katie Davis (Finance Coordinator), Vicki Baily (Medical Records), and Kathy Schaffer (Pharmacist).</p>	

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F 441	<p>Continued From page 10</p> <p>Observation of a skin assessment for Resident #3, performed by Licensed Practical Nurse (LPN) #6, on 03/04/15 at 10:00 AM, revealed after touching the resident's perineal area and rectal area, she failed to remove her gloves or wash her hands prior to repositioning the resident and adjusting the resident's clothes and linens.</p> <p>2. Medical record review revealed Resident #14 was admitted by the facility on 02/17/15 with diagnoses which included Chronic Ischemic Heart Disease, Atrial Fibrillation (irregular heartbeat), and Status Post Aortic Valve Replacement.</p> <p>Observation of LPN #6, on 03/05/15 at 2:15 PM, revealed she performed a skin assessment for Resident #14. LPN #6 examined and touched the resident's perineal area with her gloved hands. Continued observation revealed LPN #6 proceeded to reposition Resident #14, touching the resident's arms and back, without washing her hands or changing her gloves.</p> <p>Interview with LPN #6, on 03/05/15 at 3:00 PM, revealed she was knowledgeable regarding the facility's infection control policy on proper handwashing and gloving techniques to prevent cross-contamination when moving from a "dirty" area to a "clean" area. She stated she did not know why she did not perform the proper hand washing and gloving technique, which was her usual practice, during the skin assessments for Residents #3 and #14. She further stated she was nervous because she knew she was being watched.</p> <p>Interview with the Director of Nursing (DON), on 03/05/15 at 3:35 PM, revealed it was her expectation for all facility staff to follow the</p>	F 441			

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F 441	Continued From page 11 facility's policy related to handwashing and gloving techniques, in order to prevent cross-contamination. She stated handwashing and a change of gloves should be completed when moving from a "dirty" area of the body to a "clean" area. Continued interview revealed the DON recognized staff needed re-education related to the importance of infection control measures, including proper handwashing and gloving.	F 441			

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NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102
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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: Construction Date 05/18/02 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: Two (2) Story, Type II (222) Protected SMOKE COMPARTMENTS: Six (6) smoke compartments. COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM originally installed in April 2002 and upgraded in July 2011 FULLY SPRINKLED, SUPERVISED (Wet SYSTEM) original in April 2002 EMERGENCY POWER: Type II Diesel Generator. Original in April 2002 A Life Safety Code Survey was conducted on 03/04/15. The facility was found not to be in substantial compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred and forty-seven (147) beds and the census was one hundred and forty (140) the day of the survey. Deficiencies were cited with the highest Scope and Severity of an "F".	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Lisa Queen Administrator</i>	TITLE	(X6) DATE 4/10/15
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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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K 000	Continued From page 1 The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire).	K 000		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the automatic sprinkler system had an internal pipe inspection performed, according to National Fire Protection Association (NFPA). The deficiency had the potential to affect six (6) of six (6) smoke compartments, one hundred and forty-three (143) residents, staff and visitors. The findings include: Review of the automatic sprinkler inspection records on 03/04/15 at 4:14 PM, with the Maintenance Director, revealed the facility had failed to have an internal pipe inspection performed within the last five (5) years. Interview, with the Maintenance Director at the time of the review, revealed the facility did not have documented proof an internal pipe inspection had been performed within the last five (5) years. The findings were acknowledged by the Administrator during the exit conference.	K 062	No residents were found to be affected by deficient practice at this time. Upon discovery of need for internal pipe inspection Heritage Fire Protection was scheduled to complete the inspection. The internal pipe inspection was completed and documented on 3-17-15. The maintenance department has started a log of all life safety/environmental inspections, due dates, and documentation. This log will be tracked by Nathan Holbrook (Maintenance Manager) and will be audited monthly to ensure no inspections are missed, and the internal pipe inspection will be completed every five years, according to National Fire Protection Association (NFPA) regulations. Results will be monitored through monthly QAPI meetings. The QAPI meeting is made up of: Lisa Queen (Administrator), Phillip Fioret (Medical Director), Arlene Massie (Director of Nursing), Pam Bryan (Assistant Director of Nursing), Curtis Metzler (Quality Assurance/Infection Control), Dave Thomas (Finance Director), Teria Maynard (MDS Coordinator), Glenna Greenslade (Social Services), Nathan Holbrook (Maintenance Manager), Charles Erwin (Environmental Services/Risk Management), Arinn McKnight (Admissions/Activities), Erin Littleton	3-18-15

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K 062	Continued From page 2 Reference: NFPA 25 (1998 Edition) 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.	K 062	(Dietician), Gail Cunningham (Kitchen), Annie Bishop (Therapy Manager), Robin Davis (Quality) Brittany Moore (Treatment Nurse), Jennifer McFarlin (Human Resources), Susan Kempf (RCM), Sharon Queen (RCM), Violet Stewart (RCM), Pam Willis (RCM), Katie Davis (Finance Coordinator), Vicki Baily (Medical Records), and Kathy Schaffer (Pharmacist).	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure emergency generator inspections were properly documented according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, one hundred and forty-three (143) residents, staff and visitors.	K 144	No residents were affected by deficient practice at this time. The facility's inspection logs for the emergency generator entitled "Generator Run Report" were updated on 3-5-15 to include a column for Load Transfer Time. The generator will be inspected weekly and load transfer times documented monthly to ensure load transfer time (time it takes for the emergency generator to transfer the facility from regular power to emergency power) is within 10 seconds, in compliance with regulations. The logs will be monitored by Nathan Holbrook (Maintenance Manager). Results will be reported in monthly QAPI meetings. The QAPI meeting is made up of: Lisa Queen (Administrator), Phillip Fioret (Medical Director), Arlene Massie (Director of Nursing), Pam Bryan (Assistant Director of Nursing), Curtis Metzler (Quality Assurance/Infection Control), Dave Thomas (Finance Director), Teria Maynard (MDS Coordinator), Glenna Greenslade (Social Services), Nathan Holbrook (Maintenance Manager).	3-6-15

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K 144	Continued From page 3 The findings include: Review of the facility's inspection logs for the emergency generator on 03/04/15 at 3:30 PM, with the Maintenance Director, revealed the facility had failed to document the time it took for the emergency generator to transfer the facility from regular power to emergency power. Interview, with the Maintenance Director at the time of review, revealed the facility had an outside contractor educate him on the procedures for inspecting and maintaining the generator. The Maintenance Director stated however, the contractor had not discussed the need to document transfer times of the generator. The findings were acknowledged by the Administrator during the exit conference. Reference: NFPA 99 (1999 edition) 3-5.3.1 Source. The emergency system shall be installed and connected to the alternate source of power specified in 3-4.1.1.2 and 3-4.1.1.3 so that all functions specified herein for the emergency system will be automatically restored to operation within 10 seconds after interruption of the normal source.	K 144	Charles Erwin (Environmental Services/Risk Management), Arinn McKnight (Admissions/Activities), Erin Littleton (Dietician), Gail Cunningham (Kitchen), Annie Bishop (Therapy Manager), Robin Davis (Quality) Brittany Moore (Treatment Nurse), Jennifer McFarlin (Human Resources), Susan Kempf (RCM), Sharon Queen (RCM), Violet Stewart (RCM), Pam Willis (RCM), Katie Davis (Finance Coordinator), Vicki Baily (Medical Records), and Kathy Schaffer (Pharmacist).		