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

PRINTED: 04/05/2012
FORM APPROVED
OMB NO. 0938-0391

| TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

| IAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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<br><br>An annual recertification survey was conducted on 03/20/12 through 03/22/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum Federal requirements for recertification with the highest S/S of an "F." | F 000 | "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Countryside Care & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." | |
| F 281<br>SS=E | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined the facility failed to ensure services provided by the facility met professional standards of quality related to the administration of oxygen and nebulizer treatments for one resident (#7), as well as the administration of nebulizer treatments for two residents (#9 and #10), in the selected sample of 13 residents.<br><br>Findings include:<br><br>An interview with the Director of Nursing (DON), on 03/22/12 at 5:10 PM, revealed the staff were expected to follow the physician's orders when administering medication. They followed the nursing standards and the staff know to go by what the physician ordered. It was taught in school and it was the facility's expectation. The facility followed the established guidelines of the Kentucky Board of Nursing (KBN) as the basis for their standard of practice in the facility. | F 281 | F281<br>1. The physician for resident #7 was notified of oxygen concentrator setting found at 4 liters by Director of Nursing on 3/22/12. The physician increased oxygen concentrator setting to 4 liters by a nasal canula on 3/22/12. The nebulizer was rinsed and dried on 3/22/12 and resident #7 was assessed by the licensed nurse with no adverse reaction noted. Resident #10 was discharged home on 3/24/12. Resident # 9 was assessed and lungs were auscultated and found to be clear by the licensed nurse with no adverse reactions on 4/6/12.<br><br>2. The nebulizer equipment being used by current residents with an order for a nebulizer treatment was washed and dried on 3/22/12 by the Charge Nurse. Current residents receiving nebulizer treatments have been assessed related to | |

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

D Sharon Cagle — Administrator — 4/12/12

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ır safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing 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 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

NAME OF PROVIDER OR SUPPLIER
COUNTRYSIDE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
47 MARGO AVENUE
BARDWELL, KY 42023

| (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 281 | Continued From page 1<br><br>1. A record review revealed the facility admitted Resident #7 on 12/30/11 with a diagnosis to include Chronic Airway Obstruction. A review of the admission Minimum Data Set (MDS), dated 01/09/12, revealed the facility identified the resident as cognitively intact.<br><br>A review of the physician's orders, dated 03/01/12 through 03/31/12, revealed an order for Ipratropium-Albuterol 0.5-2.5 (3) milligrams (mg)/3 milliliters (ml) solution inhalation every four hours everyday - inhalation every four hours as needed (PRN) for shortness of breath.<br><br>An observation on initial tour, on 03/20/12 at 10:50 AM, revealed Resident #7 had a nebulizer machine in the room. The resident wheeled himself/herself over to the nebulizer machine, picked it up, and began a nebulizer treatment independently. The chamber of the machine was partially filled with a clear liquid substance. The resident self-administered the nebulizer treatment for five minutes and turned the machine off. There were no staff members in the room before, during, or after the treatment.<br><br>An interview with Resident #7, on 03/20/12 at 3:30 PM, revealed a nurse added the medication in the nebulizer machine and [he/she] self-administered the treatment, whenever [he/she] needed it.<br><br>A review of the Treatment Administration Record (TAR), dated March 2012, revealed Licensed Practical Nurse (LPN) #1 initialed the record, on 03/20/12, indicating a nebulizer treatment was administered at 10:45 AM. | F 281 | their current respiratory status by the licensed nurse on 4/6/12. Residents' lung status were within their normal limits. Current residents receiving oxygen were reviewed and liter settings were reviewed and verified to be set as ordered on 3/22/12 by licensed nurse.<br><br>3. Reeducation to licensed nurses included resident assessment prior to and after nebulizer treatments, cleaning of nebulizer treatment equipment and verifying oxygen concentrator flow rates as ordered every shift by the Assistant Director of Nursing by 4/11/12.<br><br>4. The licensed nurse will monitor oxygen flow rate on current residents on oxygen weekly x 2 months, then randomly 1 from each hall monthly x 2 months. The Director of Nursing or Assistant Director of Nursing will monitor to verify that lung assessments with nebulizer treatments are completed and that the licensed nurse observes nebulizer treatments through random observations weekly x 2 months; then randomly 1 from each hall monthly x 2 months. The licensed nurse will monitor nebulizer equipment cleaning weekly x 2 months, then randomly 1 from each hall monthly x 2 months. Identified issues will be corrected upon discovery. The Director of Nursing will report for 4 months results to the Performance Improvement Committee which includes the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Manager, MDS Coordinator, | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 281 | Continued From page 2<br><br>An interview with LPN #1, on 03/22/12 at 3:40 PM, revealed she initialed the TAR, on 03/20/12 at 10:45 AM, indicating a nebulizer treatment was administered to Resident #7. She revealed it had been a "busy week," and she had stepped out of the room during the resident's nebulizer treatment. She revealed the "general rule" was to stay with a resident during a nebulizer treatment.<br><br>Further review of the physician's orders, dated 03/01/12 through 03/31/12, revealed an order for oxygen at 3 liters (L) per nasal cannula.<br><br>Observations, on 03/20/12 at 10:50 AM and 3:00 PM, on 03/21/12 at 9:10 AM and 11:20 AM, 12:20 PM, and 2:55 PM, and on 03/22/12 at 11:25 AM and 2:35 PM, revealed oxygen was administered to Resident #7 at 4 liters (L) per nasal cannula.<br><br>An interview with LPN #2, on 03/22/12 at 3:47 PM, revealed the resident's oxygen was supposed to be at 3 L per nasal cannula; however it was observed at 4 L per nasal cannula, on 03/22/12 at 2:37 PM. She revealed she signed the TAR, on 03/22/12, verifying the oxygen was administered at the correct setting. LPN #2 verified she did not ensure the resident's oxygen was at the correct setting prior to signing the TAR.<br><br>An interview with Registered Nurse (RN) #1, on 03/22/12 at 3:10 PM, revealed she signed the TAR, on 03/20/12, verifying the resident's oxygen was at the correct setting; however, she did not check the oxygen setting prior to signing the TAR.<br><br>An interview with the DON, on 03/22/12 at 6:05 | F 281 | House Supervisor, Social Services, Activities, Maintenance, Medical Director and Pharmacy for further recommendations.<br><br>5. Date of Correction | 4-13-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 281 | Continued From page 3<br>PM, revealed she expected the staff to ensure the resident's oxygen was at the correct setting according to the physician's order.<br><br>2. A record review revealed the facility admitted Resident #9 on 03/06/09 with diagnoses to include Alzheimer's Disease, Depressive Disorder, Chronic Ischemic Heart Disease and Senile Dementia. A review of the quarterly MDS, dated 01/21/12, revealed the resident was moderately cognitively impaired in his/her daily decision-making. The resident made poor decisions and required cueing or supervision.<br>A review of the physician's order, dated 03/21/12, revealed an order for Ipratropium-Albuterol 0.5-2.5 (3) mg/3 ml Solution Inhalation four times daily for five days for congestion.<br>An interview with Resident #2 (Resident #9's roommate), on 3/22/12 at 3:45 PM, revealed when the staff administered Resident #9's breathing treatment, the staff never stay in the room. Resident #2 stated they come in and fill up his/her nebulizer and then leave Resident #9 unattended. Resident #2 stated they come in the room and give Resident #9 his/her breathing treatments 3-4 times a day, but never stay with him/her. Resident #2 also stated he/she had not observed the staff listen to Resident #9's lungs after receiving a breathing treatment.<br><br>3. A record review revealed the facility admitted Resident #10 on 02/29/12 with diagnoses to include Chronic Ischemic Heart Disease, Malignant Neoplasm Upper Lobe Bronchus or Lung and Hypertension. A review of the admission MDS, dated 03/07/12, revealed the resident had a Brief Interview of Mental Status (BIMS) score of "13." The resident was assessed | F 281 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

NAME OF PROVIDER OR SUPPLIER
COUNTRYSIDE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
47 MARGO AVENUE
BARDWELL, KY 42023

| (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 281 | Continued From page 4 | F 281 | | |
| | as cognitively intact.<br>A review of the physician's order, dated 03/01/12 through 03/31/12, revealed an order for Xopenex 1.25 mg/3 ml nebulization solution inhalation every six hours PRN and to be discontinued on 03/13/12. Further review revealed , on 03/13/12, the physician ordered Albuterol Sulfate Inhalation 2.5 mg/3 ml every six hours PRN for Chronic Obstructive Pulmonary Disease (COPD).<br>An interview with Resident #10, on 3/22/12 at 3:15 PM, revealed he/she received his/her breathing treatment every six hours when he/she needed them. Resident #10 stated when they give him/her the breathing treatment, they never stay in the room with him/her. Resident #10 stated they put the medication in the nebulizer and hand it to him/her and leave. The resident stated when they come back, they do not listen to his/her lungs.<br><br>An interview with the Director of Nursing (DON), on 03/22/12 at 6:05 PM, revealed a nebulizer treatment should last approximately fifteen minutes. She revealed the staff should stay in the vicinity of the resident's room while a nebulizer treatment was in progress; however, it was not acceptable to leave the medication in the machine without initiating the treatment. | | | |
| F 328<br>SS=E | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS<br><br>The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care; | F 328 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 328 | Continued From page 5<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of the facility's policy/procedures, it was determined the facility failed to ensure residents received proper administration of oxygen and nebulizer treatments for one resident (#7), as well as the administration of nebulizer treatments for two residents (#9 and #10), in the selected sample of 13 residents.<br><br>Findings include:<br><br>A review of the facility's policy/procedure, "Respiratory Care Services for Hand Held Nebulizer-Aerosolized Medication Administration," revised July 2000, revealed the staff should assemble the equipment and activate gas flow, verifying aerosol generation. The resident should be instructed of the proper method of taking a treatment. The method was slow diaphragmatic breathing with inspiratory hold. The aerosol should be nebulized until all of the medication was gone.<br><br>A review of the facility's policy/procedure, "Respiratory Care Services Policy/Procedure for Oxygen Concentrator Management," revised July 2000, revealed staff should obtain a physician's order to include liter flow and indications. A hazard of oxygen use included Barotrauma due | F 328 | F 328<br>1. The physician for resident #7 was notified of oxygen concentrator setting found at 4 liters by Director of Nursing on 3/22/12. The physician increased oxygen concentrator setting to 4 liters by a nasal canula on 3/22/12. The nebulizer was rinsed and dried on 3/22/12 and resident #7 was assessed by the licensed nurse with no adverse reaction noted. Resident #10 was discharged home on 3/24/12. Resident # 9 was assessed and lungs were auscultated and found to be clear by the licensed nurse with no adverse reactions on 4/6/12.<br><br>2. The nebulizer equipment being used by current residents with an order for a nebulizer treatment was washed and dried on 3/22/12 by the Charge Nurse. Current residents receiving nebulizer treatments have been assessed related to their current respiratory status by the licensed nurse on 4/6/12. Residents' lung status were within their normal limits. Current residents receiving oxygen were reviewed and liter settings were reviewed and verified to be set as ordered on 3/22/12 by licensed nurse. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

NAME OF PROVIDER OR SUPPLIER
COUNTRYSIDE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
47 MARGO AVENUE
BARDWELL, KY 42023

| (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 328 | Continued From page 6<br>to prolonged high concentrations of oxygen.<br><br>1. A record review revealed the facility admitted Resident #7 on 12/30/11 with a diagnosis to include Chronic Airway Obstruction. A review of the admission Minimum Data Set (MDS), dated 01/09/12, revealed the facility identified the resident as cognitively intact.<br><br>A review of the physician's orders, dated 03/01/12 through 03/31/12, revealed an order for Ipratropium-Albuterol 0.5-2.5 (3) milligrams (mg)/3 milliliters (ml) solution inhalation every four hours everyday - inhalation every four hours as needed (PRN) for shortness of breath.<br><br>An observation on initial tour, on 03/20/12 at 10:50 AM, revealed Resident #7 had a nebulizer machine in the room. The resident wheeled himself/herself over to the nebulizer machine, picked it up, and began a nebulizer treatment independently. The chamber of the machine was partially filled with a clear liquid substance. The resident self-administered the nebulizer treatment for five minutes and turned the machine off. There were no staff members in the room before, during, or after the treatment.<br><br>An interview with Resident #7, on 03/20/12 at 3:30 PM, revealed he/she had to ask for nebulizer treatments when needed. A nurse added the medication in the nebulizer machine and [he/she] self-administered the treatment.<br><br>A review of the Treatment Administration Record (TAR), dated March 2012, revealed Licensed Practical Nurse (LPN) #1 initialed the record, on 03/20/12, indicating a nebulizer treatment was | F 328 | 3. Reeducation to licensed nurses including resident assessment prior to and after nebulizer treatments, cleaning of nebulizer treatment equipment and verifying oxygen concentrator flow rates as ordered every shift will be provided by the Assistant Director of Nursing by 4/11/12.<br><br>4. The licensed nurse will monitor oxygen flow rate on current residents on oxygen weekly x 2 months, then randomly 1 from each hall monthly x 2 months. The Director of Nursing or Assistant Director of Nursing will monitor to verify that lung assessments with nebulizer treatments are completed and that the licensed nurse observes nebulizer treatments through random observations weekly x 2 months; then randomly 1 from each hall monthly x 2 months. The licensed nurse will monitor nebulizer equipment cleaning weekly x 2 months, then randomly 1 from each hall monthly x 2 months. Identified issues will be corrected upon discovery. The Director of Nursing will report for 4 months results to the Performance Improvement Committee which includes the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Manager, MDS Coordinator, House Supervisor, Social Services, Activities, Maintenance, Medical Director and Pharmacy for further recommendations.<br><br>5. Date of Correction | 4-13-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 328 | Continued From page 7<br>administered at 10:45 AM.<br><br>An interview with LPN #1, on 03/22/12 at 3:40 PM, revealed she initialed the TAR, on 03/20/12 at 10:45 AM, indicating a nebulizer treatment was administered to Resident #7. She revealed it had been a "busy week," and she had stepped out of the room during the resident's nebulizer treatment. She revealed the "general rule" was to stay with a resident during a nebulizer treatment.<br><br>Further review of the physician's orders, dated 03/01/12 through 03/31/12, revealed an order for oxygen at 3 liters (L) per nasal cannula.<br><br>Observations, on 03/20/12 at 10:50 AM and 3:00 PM, on 03/21/12 at 9:10 AM and 11:20 AM, 12:20 PM, and 2:55 PM, and on 03/22/12 at 11:25 AM and 2:35 PM, revealed oxygen was administered to Resident #7 at 4 liters (L) per nasal cannula.<br><br>An interview with LPN #2, on 03/22/12 at 3:47 PM, revealed the resident's oxygen was supposed to be at 3 L per nasal cannula; however it was observed at 4 L per nasal cannula, on 03/22/12 at 2:37 PM. She revealed she signed the TAR, on 03/22/12, verifying the oxygen was administered at the correct setting. LPN #2 verified she did not ensure the resident's oxygen was at the correct setting prior to signing the TAR.<br><br>An interview with Registered Nurse (RN) #1, on 03/22/12 at 3:10 PM, revealed she signed the TAR, on 03/20/12, verifying the resident's oxygen was at the correct setting; however, she did not check the oxygen setting prior to signing the TAR. | F 328 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 328 | Continued From page 8<br>An interview with the DON, on 03/22/12 at 6:05 PM, revealed she expected the staff to ensure the resident's oxygen was at the correct setting according to the physician's order.<br><br>2. A record review revealed the facility admitted Resident #9 on 03/06/09 with diagnoses to include Alzheimer's Disease, Depressive Disorder, Chronic Ischemic Heart Disease and Senile Dementia. A review of the quarterly MDS, dated 01/21/12, revealed the resident was moderately cognitively impaired in his/her daily decision-making. The resident made poor decisions and required cueing or supervision.<br>A review of the physician's order, dated 03/21/12, revealed an order for Ipratropium-Albuterol 0.5-2.5 (3) mg/3 ml Solution Inhalation four times daily for five days for congestion.<br>An interview with Resident #2 (Resident #9's roommate), on 3/22/12 at 3:45 PM, revealed when the staff administered Resident #9's breathing treatment, the staff never stay in the room. Resident #2 stated they come in and fill up his/her nebulizer and then leave Resident #9 unattended. Resident #2 stated they come in the room and give Resident #9 his/her breathing treatments 3-4 times a day, but never stay with him/her. Resident #2 also stated he/she had not observed the staff listen to Resident #9's lungs after receiving a breathing treatment.<br><br>3. A record review revealed the facility admitted Resident #10 on 02/29/12 with diagnoses to include Chronic Ischemic Heart Disease, Malignant Neoplasm Upper Lobe Bronchus or Lung and Hypertension. A review of the admission MDS, dated 03/07/12, revealed the resident had a Brief Interview of Mental Status | F 328 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 328 | Continued From page 9<br>(BIMS) score of "13." The resident was assessed as cognitively intact.<br>A review of the physician's order, dated 03/01/12 through 03/31/12, revealed an order for Xopenex 1.25 mg/3 ml nebulization solution inhalation every six hours PRN and to be discontinued on 03/13/12. Further review revealed , on 03/13/12, the physician ordered Albuterol Sulfate Inhalation 2.5 mg/3 ml every six hours PRN for Chronic Obstructive Pulmonary Disease (COPD).<br>An interview with Resident #10, on 3/22/12 at 3:15 PM, revealed he/she received a breathing treatment every six hours when he/she needed them. Resident #10 stated when they give him/her the breathing treatment, they never stay in the room with him/her. Resident #10 stated they put the medication in the nebulizer and hand it to him/her and leave. The resident stated when they come back, they do not listen to his/her lungs.<br><br>An interview with the Director of Nursing (DON), on 03/22/12 at 6:05 PM, revealed a nebulizer treatment should last approximately fifteen minutes. She revealed the staff should stay in the vicinity of the resident's room while a nebulizer treatment was in progress; however, it was not acceptable to leave the medication in the machine without initiating the treatment. | F 328 | | |
| F 425<br>SS=F | 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general | F 425 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 425 | Continued From page 10<br>supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and review of the facility's contractual agreement, it was determined the facility failed to ensure pharmaceutical services obtained by the facility provided consultation on all aspects of the provision of pharmacy services in the facility. On 03/19/12, two Zithromax 250 milligram (mg) tablets had been removed to administer to a resident in the facility; however, an observation, on 03/22/12 at 11:00 AM, revealed the Emergency Drug Kit (EDK) expired on 09/11. The expired EDK box remained in the facility and available for use.<br><br>Findings include:<br><br>A review of the contractual agreement signed by the consultant pharmaceutical service, on 01/06/11, revealed "In consideration of the mutual agreements and promises hereinafter set forth, | F 425 | F425<br>1. The expired emergency drug kit (EDK) was removed on 3/22/12 by the Assistant Director of Nursing.<br><br>2. Current EDK boxes were audited for use on 3/22/12. No other expired boxes were identified and no residents were identified to be affected.<br><br>3. The Pharmacy Technician has been reeducated on 3/22/12 about the responsibility to maintain EDKs with current expiration dates every 2 months by the Administrative Pharmacy Consultant.. Licensed nurses and Certified Medication Aides will be reeducated on the proper use of the Emergency Drug Kits including exchange of boxes once opened and checking medications pulled for use for expiration dates by the Assistant Director of Nursing on 4/13/12.<br><br>4. The Director of Nursing or Assistant Director of Nursing will monitor the expiration date of EDK boxes weekly for 3 months. Identified issues will be corrected upon discovery. The Director of Nursing will report results to the Performance Improvement Committee which consists of the Director of Nursing, Assistant Director of Nursing, Administrator, MDS Coordinator, Dietary Manager, House Supervisor, Social Services, Activities, Maintenance Director, Medical Director and Pharmacist for further recommendations x 3 months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185362 | | 03/22/2012 |

NAME OF PROVIDER OR SUPPLIER
COUNTRYSIDE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
47 MARGO AVENUE
BARDWELL, KY 42023

| (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 425 | Continued From page 11 the sufficiency and adequacy of which are hereby acknowledged, the parties hereto agree and covenant as follows: 1. Responsibilities of Pharmacy, 1.1 (a) provide Pharmacy products to the facility and its' residents in a prompt and timely manner in accordance with applicable law; (1.2) E-Kits: If permitted by applicable law and requested by the facility, Pharmacy shall provide, maintain and replenish, in a prompt and timely manner, an emergency drug supply ("E-Kit"). E-Kits shall be the property of Pharmacy as prescribed by applicable law."<br><br>Observation of the medication room with the Assistant Director of Nursing Service (ADNS), on 03/22/12 at 11:00 AM, revealed there were two emergency drug kits stored on top of the refrigerator. A review of the second EDK revealed there was a label on top of the box, dated 09/11. An interview with the ADNS revealed the label indicated when the box expired. Further observations revealed the following medications were expired: Nitroglycerin 0.2 milligrams (mg)/hr patch, Nitrostat 0.4 mg taps, Lovenox 40 mg syringe, Lovenox 30 mg syringe, Bacitracin ointment tube 500 units/gram (gm), Tobramycin Opth. Solution 0.3% (5 milliliters (ml), Guaifenesin Oral solution 100 ml/5 ml, Ipratropium Bromide (Atrovent) .02% solution, SPS Suspension (Kayexalate) 15 g/60 ml, Nitrofurantion Mac Mono (Macrobid)100 mg capsule, Sterile Water 10 ml vial, Cetazidime (Fortaz) 1 gm intravenous (IV), Furosemide (Lasix) 20 mg tablet, Fluconazole (Diflucan) 150 mg tablet, Cefaclor (Ceclor) 250 mg capsule, Cefadroxil (Duricef) 500 mg capsule, Ampicillin TR 250 mg capsule, Amox TR-K CLV (Augmentin) 250 mg tablet, Methylprednisolone | F 425 | 5. Date of Completion: | 4-13-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 425 | Continued From page 12<br>Sodium 62.5 mg/1 ml injectable, Vitamin K 10 mg/ml injectable, Prochlorperazine (Compazine) 5 mg/ml injectable, Loperamide (Imodium) 2 mg capsule, Lisinopril 5 mg tablet, Clonidine 0.1 mg tablet, Omeprazole (Prilosec) 20 mg capsule, Mephyton (Vitamin K) 5 mg tablet, Mirtazapine (Remeron) 15 mg tablet, Multivitamin tablet, Therapeutic Multivitamin table, Haloperidol 1 mg tablet, Chlorpromazine (Thorazine) 25 mg tablet, Risperidone 0.5 mg tablet, Haloperidol 5 mg/ml injectable, Chlorpromazine (Thorazine) 25 mg/ml injectable, Citalopram HBR (Celexa) 10 mg tablet, Ciprofloxacin (Cipro) 250 mg tablet and Insta Glucose 31 gm.<br><br>An interview with a consultant pharmacist in the facility, on 03/22/12 at 11:45 AM, revealed the EDK boxes were automatically replaced. When an EDK box was delivered to the facility, then a EDK box was removed. She was expected to physically visualize the EDK boxes when she was in the facility to ensure the box was not expired. She revealed the EDK box was expired and had expired in September of 2011. She could not explain how the expired EDK box was still available for use, although it was expired.<br><br>A phone interview with the pharmacist, 03/22/12 at 5:15 PM, revealed he was the consultant pharmacist for the facility. The EDK box with the "out" date was sent to the facility on 07/11. The process was when an EDK box was sent out, a driver picked up another EDK box. The EDK box was stuck in a place we did not know about. Everyday, Monday through Saturday, the boxes were to be exchanged out, and Box #109 (outdated EDK box) was thought to be destroyed. The other consultant pharmacist came to the | F 425 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 425 | Continued From page 13<br>facility every two months and part of her responsibilities were to check the EDK boxes and ensure they were up-to-date. She does not do a 100% check on everything, but does check the dates of the kits within the facility. The other consultant pharmacist came once a month and reviewed the medication regimen of the resident. These were representatives of the pharmacy and they addressed issues or got them to the people who could address their concerns. He revealed he had not had this problem before and could not explain how the EDK box remained available for use.<br><br>An interview with the Director of Nursing (DON), on 03/22/12 at 5:35 PM, revealed the consultant pharmacist was in the facility, on 03/21/12, and there was a pharmacist in the building currently. The DON pointed out in the contractual agreement that it was the pharmacy's responsibility to maintain and replenish the EDK boxes for the facility. Nursing staff only checked the EDK box and the medication when they removed it for the residents, otherwise it was pharmacy's responsibility to monitor the EDK boxes. | F 425 | | |
| F 441<br>SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it - | F 441 | F441<br><br>1. Resident # 14 was assessed by licensed nurse on 3/22/12 and 3/23/12 and no signs and symptoms of infections were noted to insulin injection or accu-check site. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 441 | Continued From page 14<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of the Lippincott Manual Procedure Guidelines, it was determined the facility failed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection for one resident (#14), not in the selected sample, related | F 441 | 2. RN #1 was re-educated on 3/22/12 and was observed performing accu-checks with proper infection control technique to include wearing gloves on 3/23/12 by the Director of Nursing. Current licensed nurses have been reeducated regarding accu-check and insulin administration procedure including infection control technique to wear gloves by 3/30/12. This education will be provided by the Assistant Director of Nursing.<br><br>3. Current licensed nurses will perform return demonstration of accu-checks and insulin administration utilizing proper infection control technique to include wearing gloves by 4/11/12. To be observed by the House Supervisor and/or the Assistant Director of Nursing.<br><br>4. The licensed nurse will perform weekly accu-check and insulin administration observation audits to verify gloves are worn x 1 month, then monthly x 2 months. Identified issues will be corrected upon discovery. The Director of Nursing will report results to the Performance Improvement Committee which includes the Administrator, Director of Nursing, Assistant Director of Nursing, House Supervisor, MDS Coordinator, Dietary | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 441 | Continued From page 15<br>to staff using gloves while conducting an accucheck and administering a subcutaneous injection of insulin. On 03/20/12 at 3:52 PM, Registered Nurse (RN) #1 was observed doing an accucheck without gloves. Additionally, RN #1 administered an injection of insulin to Resident #14 without gloves on.<br><br>Findings include:<br><br>An interview with the Director of Nursing (DON), on 03/22/12 at 5:40 PM, revealed the facility utilized the Lippincott Manual, and the Potter and Perry Manual, for staff guidance on nursing skills.<br><br>A review of the Lippincott Manual Procedure Guidelines for "Blood Glucose Monitoring Techniques" revealed the staff prepared the resident's finger to be lanced by having the resident wash his/her hands with soap and warm water. Dry thoroughly, and for convenience, an alcohol wipe may be used to cleanse the finger. Alcohol must dry thoroughly before the finger is lanced. Put on disposable gloves.<br><br>A record review revealed the facility admitted Resident #14 on 12/05/11 with diagnoses to include Diabetes Mellitus Type II, Depressive Disorder and Chronic Airway Obstruction.<br><br>Observation during a medication pass, on 03/20/12 at 3:52 PM, revealed RN #1 pierced the resident's finger with a lancet and obtained a sample of blood on the test strip without putting on a pair of gloves. At 3:58 PM, RN #1 administered a subcutaneous injection of insulin into the resident's abdomen without putting on a pair gloves. | F 441 | Manager, Social Services, Activities Director, Maintenance Director, Medical Director and Pharmacist for further recommendations x 3 months.<br><br>5. Date of Completion: | 4-13-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 441 | Continued From page 16<br><br>An interview with RN #1, on 03/22/12 at 3:09 PM, revealed she was trained to wear gloves when completing an accucheck on a resident, and trained to wear gloves when she administered insulin to the residents. She acknowledged she did not wear gloves when she completed the accucheck, or when she administered the insulin to Resident #14. She revealed she had gotten into a bad habit of not wearing gloves while working at an acute care hospital and continued the practice in the facility. She was unsure of the facility's policy, but she knew she should have worn gloves when she completed the accucheck as well as during administration of the insulin.<br><br>An interview with the DON, on 03/22/12 at 5:40 PM, revealed she was not aware the nurses were conducting accuchecks without putting on a pair of gloves. The nurses were checked periodically to ensure they were completing the accuchecks correctly and the nurses were observed to wear gloves at the time they were "checked off" for the skill. The nurses were expected to wear gloves when they completed accuchecks and during administration of insulin to e resident. | F 441 | | |

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

PRINTED: 04/05/2012
FORM APPROVED
OMB NO. 0938-0391

RECEIVED JUN 2012 OFFICE OF INSPECTOR GENERAL

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

NAME OF PROVIDER OR SUPPLIER
COUNTRYSIDE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
47 MARGO AVENUE
BARDWELL, KY 42023

| (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 |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>CFR: 42 CFR 483.70(a)<br><br>BUILDING: 01<br><br>PLAN APPROVAL: 1992<br><br>SURVEY UNDER: 2000 Existing<br><br>FACILITY TYPE: SNF/NF<br><br>TYPE OF STRUCTURE: One (1) story, Type V (111)<br><br>SMOKE COMPARTMENTS: Four (4) smoke compartments<br><br>FIRE ALARM: Complete fire alarm system with smoke detectors<br><br>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.<br><br>GENERATOR: Type II generator. Fuel source is diesel.<br><br>A standard Life Safety Code survey was conducted on 03/22/12. Countryside Care and Rehab was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for fifty three (53) beds with a census of fifty three (53) on the day of the survey.<br><br>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire) | K 000 | "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Countryside Care & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."<br><br>K025<br>1. On 3/23/12 the Maintenance Director (MD) conducted a review of the accessibility to the attic for smoke barriers. On 4/6/12 MD made available an alternate attic access for easier accessibility to inspect smoke barriers. Smoke barriers were repaired to ensure resistance of smoke between the smoke compartments by the MD per NFPA standards on 4/11/12. | |

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: D Karon Cagle
TITLE: Administrator
(X6) DATE: 4/12/12 6-20-12

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing 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 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

| TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 |
|---|---|---|---|---|
| K 000 | Continued From page 1 | K 000 | | |
| | Deficiencies were cited with the highest deficiency identified at "F" level. | | 2. On 3/23/12, MD inspected other fire walls and no other smoke barriers required repair. | |
| K 025<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 | K 025 | 3. The MD was re-educated 3/23/12 by the Administrator on conducting routine checks of fire walls to ensure they are to NFPA 101 standards.<br><br>4. The MD will conduct reviews of the facility fire walls on a quarterly basis for 6 months and report to the Performance Improvement committee for 6 months for further recommendations.<br><br>5. Date of Correction | 4-12-12 |
| | This STANDARD is not met as evidenced by:<br>Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for fifty three (53) beds with a census of fifty three (53) on the day of the survey.<br><br>The findings include:<br><br>Observations, on 03/22/12 between 9:00 AM and 12:00 PM, with the Maintenance Director revealed the smoke partitions, extending above the ceiling, located throughout the facility to be | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 |
|---|---|---|---|---|
| K 025 | Continued From page 2<br>inaccessible to the surveyor to confirm their integrity. Access doors were located a great distance from the barriers, and feasibly checking the barriers by the surveyor, or the Maintenance Staff would prove to be a safety issue as no walk ways were provided, and duct work blocked every travel path.<br><br>Interview, on 03/22/12 between 9:00 AM and 12:00 AM, with the Maintenance Director revealed he was aware of the difficulty in negotiating the attic to check the smoke barriers for penetrations.<br><br>Reference: NFPA 101 (2000 Edition).<br><br>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:<br>(a) The space between the penetrating item and the smoke barrier shall<br>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or<br>2. Be protected by an approved device designed for the specific purpose.<br>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall<br>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or<br>2. Be protected by an approved device designed for the specific purpose.<br>(c) Where designs take transmission of vibration | K 025 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

NAME OF PROVIDER OR SUPPLIER: COUNTRYSIDE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 47 MARGO AVENUE, BARDWELL, KY 42023

| (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 025 | Continued From page 3 into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. | K 025 | | |
| K 027 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7<br><br>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross -corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for fifty three (53) beds with a census of fifty three (53) on the day of the survey.<br><br>The findings include:<br><br>Observation, on 03/22/12 at 11:16 AM, with the Maintenance Director revealed the cross-corridor doors located in the 200 Hall did not seal when tested, leaving a gap larger than ¾ of an inch at the top. | K 027 | K027<br>1. The smoke barrier to the 200 hall doors will be repaired by K R Associates by 4/30/12 to ensure the doors are resistant to the passage of smoke per the NFPA 101 standards.<br><br>2. The MD completed the inspection of the cross corridor doors on 3/23/12 to verify no other doors required repairs.<br><br>3. The MD has been re-educated on the requirements for door openings in smoke barriers by the Administrator on 3/23/12.<br><br>4. The MD will conduct quarterly audits for 6 months of the cross corridor doors and report the findings to the Performance Improvement Committee for further recommendations for 6 months.<br><br>5. Date of Completion: | 5-1-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 |
|---|---|---|---|---|
| K 027 | Continued From page 4<br><br>Interview, on 03/22/12 at 11:16 AM, with the Maintenance Director revealed they were unaware the doors did not seal properly.<br><br>Reference: NFPA 101 (2000 edition)<br><br>8.3.4.1* Doors in smoke barriers shall close the opening leaving<br>only the minimum clearance necessary for proper operation<br>and shall be without undercuts, louvers, or grilles. | K 027 | | |
| K 029<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff | K 029 | K029<br>1. The door was equipped with self closing device on 3/28/12 by the MD<br><br>2. The MD conducted rounds of the facility and no other doors were identified requiring a self closure device.<br><br>3. The MD was re-educated on 3/23/12 by the Administrator on use of self closing door devices in relation to dry storage areas. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 03/22/2012 |

NAME OF PROVIDER OR SUPPLIER
COUNTRYSIDE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
47 MARGO AVENUE
BARDWELL, KY 42023

| (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 029 | Continued From page 5<br>and visitors.<br><br>The findings include:<br><br>Observation, on 03/22/12 between 9:00 AM and 12:00 PM, with the Maintenance Director revealed the door to the dry storage room did not have a self closing device. The room contains an excess of cardboard boxes which are combustible.<br><br>Interview, on 03/22/12 between 9:00 AM and 12:00 PM, with the Maintenance Director revealed they were not aware the doors were required to be self closing if the rooms were being used as hazardous storage.<br><br>Reference:<br><br>NFPA 101 (2000 Edition).<br><br>19.3.2 Protection from Hazards.<br>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:<br>(1) Boiler and fuel-fired heater rooms<br>(2) Central/bulk laundries larger than 100 ft2 | K 029 | 4. The MD will monitor doors with closers monthly for 2 months and will report results to Performance Improvement Committee x 2 months.<br><br>5. Date of Completion: | 3-29-12 |

| TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

| IAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 029 | Continued From page 6<br>(9.3 m2)<br>(3) Paint shops<br>(4) Repair shops<br>(5) Soiled linen rooms<br>(6) Trash collection rooms<br>(7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies<br>and equipment in quantities deemed hazardous by the authority having jurisdiction<br>(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.<br>Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied<br>protective plates extending not more than 48 in. (122 cm) above the bottom of the door. | K 029 | | |
| K 038<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiencies had the potential to affect four (4) of four (4) smoke compartments, residents, staff | K 038 | K038<br>1. The Delayed Egress signs were replaced on all exit doors by the MD on 4/10/12 by the MD with 1 inch lettering and contrasting backgrounds to meet size requirements.<br><br>2. The MD completed a review on 3/23/12 of the facility to identify delayed egress doors to verify and place signs to meet size requirements<br><br>3. The MD and Administrator were reeducated on 3/22/12 by Regional Director of Operations on the requirements of the Delayed Egress signs. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 03/22/2012 |

NAME OF PROVIDER OR SUPPLIER
COUNTRYSIDE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
47 MARGO AVENUE
BARDWELL, KY 42023

| (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 038 | Continued From page 7<br>and visitors. The facility is licensed for fifty three (53) beds with a census of fifty three (53) on the day of the survey.<br><br>The findings include:<br><br>Observation, on 03/22/12 between 9:00 AM and 12:00 PM, with the Maintenance Director revealed the delayed egress doors located throughout the facility to have delayed egress, and the signs posted did not meet the size requirements in accordance with NFPA standards.<br><br>Interview, on 03/22/12 between 9:00 AM and 12:00 PM, with the Maintenance Director revealed they were not aware of the size requirements for delayed egress signage.<br><br>Reference:<br><br>NFPA 101 (2000 edition)<br><br>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress<br>locks shall be permitted to be installed on doors serving<br>low and ordinary hazard contents in buildings protected<br>throughout by an approved, supervised automatic fire detection<br>system in accordance with Section 9.6, or an approved,<br>supervised automatic sprinkler system in accordance with Section<br>9.7, and where permitted in Chapters 12 through | K 038 | 4. The MD will monitor exit doors with delayed egress monthly for 3 months to ensure that the signage remains posted. The results will be reported to the Performance Improvement Committee x 3 months . . Thereafter, will monitor each month.<br><br>5. Date of Completion: | 4-11-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 038 | Continued From page 8<br>42, provided<br>that the following criteria are met.<br><br>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance<br>with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors<br>of an approved, supervised automatic fire detection system in<br>accordance with Section 9.6.<br><br>(b) The doors shall unlock upon loss of power controlling<br>the lock or locking mechanism.<br><br>(c) An irreversible process shall release the lock within 15<br>seconds upon application of a force to the release device<br>required in 7.2.1.5.4 that shall not be required to exceed 15 lbf<br>(67 N) nor be required to be continuously applied for more<br>than 3 seconds. The initiation of the release process shall activate<br>an audible signal in the vicinity of the door. Once the<br>door lock has been released by the application of force to the<br>releasing device, relocking shall be by manual means only.<br>Exception: Where approved by the authority having jurisdiction, a delay<br>not exceeding 30 seconds shall be permitted.<br><br>(d) *On the door adjacent to the release device, | K 038 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 038 | Continued From page 9<br>there<br>shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows:<br>PUSH UNTIL ALARM SOUNDS<br>DOOR CAN BE OPENED IN 15 SECONDS<br><br>7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows:<br>NO<br>EXIT<br>Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.<br><br>7.5.2.2* Exit access and exit doors shall be designed and<br>arranged to be clearly recognizable. Hangings or draperies | K 038 | | |
| K 050<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 | K 050 | K050<br>1. A fire drill was conducted at random on 4/6/12 at 8:13 a.m. by the MD.<br><br>2. Fire drills will be held at unexpected times under varying conditions at least quarterly on each shift by the MD. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

NAME OF PROVIDER OR SUPPLIER
COUNTRYSIDE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
47 MARGO AVENUE
BARDWELL, KY 42023

| (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 |
|---|---|---|---|---|
| K 050 | Continued From page 10<br><br>This STANDARD is not met as evidenced by:<br>Based on Fire Drill record review and interview, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for fifty three (53) beds and the census was fifty three (53) on the day of the survey.<br><br>The findings include:<br><br>Fire Drill record review, on 03/22/12 at 9:48 AM, with the Maintenance Director revealed the fire drills were not being conducted at unexpected times under varied conditions. First shift fire drills were being conducted at 1:25 PM, and Second shift was being conducted between 3:03 PM and 3:38 PM.<br><br>Interview, on 03/22/12 at 9:48 AM, with the Maintenance Director revealed he was unaware the fire drills were not being conducted as required.<br><br>Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts. | K 050 | 3. The MD has been reeducated by the Administrator on 3/23/12 on the fire drill policy and drills being conducted at varying times and randomly.<br><br>4. Fire drills will be audited by the Administrator monthly for 6 months to verify they are conducted at unexpected times under varying conditions. The results will be brought to the Performance Improvement Committee by the MD monthly for 6 months for further recommendations.<br><br>5. Date of Completion: | 4-7-12 |
| K 051<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>A fire alarm system with approved components, | K 051 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 |
|---|---|---|---|---|
| K 051 | Continued From page 11<br>devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview it was determined the facility failed to ensure the building fire alarm system was installed as required by NFPA standards. The deficient practice has the potential to affect four (4) of four (4) smoke compartments, staff, and the residents. The facility is licensed for fifty three (53) beds with a census of fifty three (53) on the day of the survey. | K 051 | K051<br>1. An annunciator panel was installed across from the nurses station to allow staff ability to hear a trouble signal if occurs on 3/30/12 by Vanguard Alarm Systems.<br><br>2. The MD reviewed the facility to ensure proper placement of the annunciator panel near the nurses station outside the mechanical room.<br><br>3. The MD was re-educated on 3/23/12 by the Administrator on the requirements of the annunciator panel per the NFPA standards.<br><br>4. The annunciator panel will be monitored by the MD for usage by the staff monthly for 3 months. The results will be reported to the Performance Committee x 3 months.<br><br>5. Date of Completion: | 3-31-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 051 | Continued From page 12<br><br>The findings include:<br><br>Observation, on 03/22/12 at 11:53 AM with the Maintenance Director revealed the Fire Alarm Control Panel (FACP) Annunciator was located in the Mechanical Room. The annunciation panel could not be heard by staff if a trouble signal were to occur.<br><br>Interview, on 03/22/12 at 11:53 AM with the Maintenance Director revealed he was not aware the panel must be in an area that it can be monitored by staff.<br><br>Reference: NFPA 72 (1999 Edition).<br><br>1-5.4.4 Distinctive Signals.<br>Fire alarms, supervisory signals, and trouble signals shall be distinctively and descriptively annunciated.<br><br>1-5.4.6 Trouble Signals.<br>Trouble signals and their restoration to normal shall be indicated within 200 seconds at the locations identified in 1-5.4.6.1 or 1-5.4.6.2. Trouble signals required to indicate at the protected premises shall be indicated by distinctive audible signals. These audible trouble signals shall be distinctive from alarm signals. If an intermittent signal is used, it shall sound at least once every 10 seconds, with a minimum duration of 1/2 second. An audible trouble signal shall be permitted to be common to several supervised circuits. The trouble signal(s) shall be located in an area where it is likely to be heard.<br>5-2.6.1.4<br>Upon receipt of trouble signals or other signals | K 051 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 051 | Continued From page 13<br>pertaining solely to matters of equipment maintenance of the fire alarm systems, the central station shall perform the following actions:<br>(1) *Communicate immediately with persons designated by the subscriber<br>A-5-2.6.1.4(1)<br>The term immediately in this context is intended to mean "without unreasonable delay." Routine handling should take a maximum of 4 minutes from receipt of a trouble signal by the central station until initiation of the investigation by telephone.<br><br>5-5.3.2.1.6.2<br>The following requirements shall apply to all combinations in 5-5.3.2.1.6.1:<br>(1) Both channels shall be supervised in a manner approved for the means of transmission employed.<br>(3) The failure of either channel shall send a trouble signal on the other channel within 4 minutes.<br>(8) Failure of telephone lines (numbers) or cellular service shall be annunciated locally.<br><br>3-8.1* Fire Alarm Control Units.<br>Fire alarm systems shall be permitted to be either integrated systems combining all detection, notification, and auxiliary functions in a single system or a combination of component subsystems. Fire alarm system components shall be permitted to share control equipment or shall be able to operate as standalone subsystems, but, in any case, they shall be arranged to function as a single system. All component subsystems shall be capable of simultaneous, full load operation without degradation of the required, overall system | K 051 | | |

| TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

| IAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 051 | Continued From page 14<br>performance. | K 051 | | |
| K 056<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview it was determined the facility failed to ensure the building had a complete automatic sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for fifty three (53) beds with a census of fifty three (53) on the day of the survey.<br><br>The findings include:<br><br>Observation, on 03/22/12 between 11:00 AM and 11:40 AM, with the Maintenance Director revealed | K 056 | K056<br>1. Sprinkler heads will be installed at 100 hall exit, porch outside of dining room, back corner of the receiving area by Premier Fire Protection by 4/30/12.<br><br>2. The facility was inspected by the MD on 3/23/12 to identify any other areas in need of sprinkler heads. Three additional sprinkler heads were identified at that time to include resident rooms' showers.<br><br>3. The MD has been reeducated by the Administrator on 3/23/12 on the sprinkler system requirements.<br><br>4. Sprinkler heads will be monitored by the MD monthly for 3 months. The MD will report results to the Performance Committee x 3 months.<br><br>5. Date of Completion: | 5-1-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 056 | Continued From page 15<br>the facility had combustible porches that extended out four (4) foot or greater and were not sprinkler protected. The porches were located outside the dining room, the back corner of the receiving area, and the outside exit at the end of the 100 Hall.<br><br>Interview, on 03/22/12 between 11:00 AM and 11:40 AM, with the Maintenance Director revealed they were not aware the porches needed to be sprinkler protected.<br><br>Observation, on 03/22/12 at 11:50 AM, with the Maintenance Director revealed the men ' s and women ' s shower rooms to not have complete sprinkler coverage.<br><br>Interview, on 03/22/12 at 11:50 AM, with the Maintenance Director revealed he had not noticed the sprinklers coverage was not adequate.<br><br>Reference: NFPA 13 (1999 Edition) 5-13 8.1<br><br>Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.<br>Reference: NFPA 13 (1999 Edition) 5-13 8.1<br><br>Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.<br>Actual NFPA Standard: NFPA 101, 19.3.5.1.<br>Where required by 19.1.6, health care facilities | K 056 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 03/22/2012 |

NAME OF PROVIDER OR SUPPLIER
COUNTRYSIDE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
47 MARGO AVENUE
BARDWELL, KY 42023

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 056 | Continued From page 16<br>shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.<br>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.<br>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:<br>(1) Sprinklers installed throughout the premises<br>(2) Sprinklers located so as not to exceed maximum protection area per sprinkler<br>(3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. | K 056 | | |
| K 062<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained as required. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for fifty three (53) beds with a census of fifty three (53) on the day of the survey. | K 062 | K062<br>1. All items were removed within 18 inches of the sprinkler head in the medication room and activity storage closet on 3/23/12 by the MD. Insulation found on the sprinkler heads located in the attic was removed 4/11/12 by the MD. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 03/22/2012 |

NAME OF PROVIDER OR SUPPLIER
COUNTRYSIDE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
47 MARGO AVENUE
BARDWELL, KY 42023

| (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 062 | Continued From page 17<br>The findings include:<br><br>Observation, on 03/22/12 at 10:54 AM, with the Maintenance Director revealed the sprinkler heads located in the attic were obstructed by insulation. The insulation had blown up and become attached to the sprinkler head.<br><br>Interview, on 03/22/12 at 10:54 AM, with the Maintenance Director revealed he was not aware the sprinklers in the attic were blocked by insulation.<br><br>Observation, on 03/22/12 at 11:02 AM, with the Maintenance Director revealed storage within 18 inches of a sprinkler head located in the 300 Hall Med Room, also in the Activities Storage Closet.<br><br>Interview, on 03/22/12 at 11:02 AM, with the Maintenance Director revealed he was aware items could not be stored within 18 inches of a sprinkler head, but not sure who placed the items so close.<br><br>Reference: NFPA 13 (1999 Edition)<br><br>5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development.<br>5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.<br><br>2-2.1.1* Sprinklers shall be inspected from the | K 062 | 2. The MD inspected the facility for 18 inch clearance of the sprinkler heads and other compartments requiring sprinkler heads per NFPA standards on 3/23/12. No other sprinkler heads were found to be obstructing.<br><br>3. The MD was re-educated on 3/23/12 by the Administrator on the requirements of the sprinkler system per NFPA standards.<br><br>4. The MD will conduct inspections of the sprinkler heads to verify clearance and maintain as required on a quarterly basis for 6 months and will report to the Performance Improvement Committee for 6 months for further recommendations.<br><br>5. Date of Completion: | 4-12-12 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 062 | Continued From page 18<br>floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.<br>hydraulic design basis, the system area of operation shall be<br>permitted to be reduced without revising the density as indicated<br>in Figure 7-2.3.2.4 when all of the following conditions<br>are satisfied:<br>(1) Wet pipe system<br>(2) Light hazard or ordinary hazard occupancy<br>(3) 20-ft (6.1-m) maximum ceiling height<br>The number of sprinklers in the design area shall never be<br>less than five. Where quick-response sprinklers are used on a<br>sloped ceiling, the maximum ceiling height shall be used for<br>determining the percent reduction in design area. Where<br>quick-response sprinklers are installed, all sprinklers within a<br>compartment shall be of the quick response type.<br>Exception: Where circumstances require the use of other than ordinary<br>temperature-rated sprinklers, standard response sprinklers shall be<br>permitted to be used. | K 062 | | |
| K 064<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 | K 064 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 064 | Continued From page 19<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, it was determined that the facility failed to maintain the installation of portable fire extinguishers in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for fifty three (53) beds with a census of fifty three (53) on the day of the survey.<br><br>Findings include:<br><br>Observations, on 03/22/12 at 11:28 AM, with the Maintenance Director revealed the wall mounted, portable fire extinguisher in the Activities Room was blocked by stacked boxes of storage.<br><br>Interview, on 03/22/12 at 11:28 AM, with the Maintenance Director revealed they routinely stored items in front of the extinguisher due to lack of storage space.<br><br>Reference: NFPA 10<br>6.2.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected, manually or by electronic monitoring, at more frequent intervals when circumstances require.<br>6.2.2* Procedures. Periodic inspection of fire | K 064 | K064<br>1. Stacked boxes were removed from access to fire extinguisher on 3/22/12 by the Activity Director.<br><br>2. The MD inspected the facility for safe access to all fire extinguishers on 3/23/12, no other issues were identified.<br><br>3. The Activity Director was reeducated by the MD on the fire drill policy including quick and easy access to the fire extinguishers.<br><br>4. An audit will be done monthly for 6 months by the MD to ensure easy access to fire extinguishers and will be presented to the Performance Improvement Committee monthly for 6 months for further recommendations.<br><br>5. Date of Completion: 3/23/12 | 3-24-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 03/22/2012 |

NAME OF PROVIDER OR SUPPLIER
COUNTRYSIDE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
47 MARGO AVENUE
BARDWELL, KY 42023

| (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 |
|---|---|---|---|---|
| K 064 | Continued From page 20<br>extinguishers shall include a check of at least the following items:<br>(1) Location in designated place<br>(2) No obstruction to access or visibility<br>(3) Operating instructions on nameplate legible and facing outward<br>(4)* Safety seals and tamper indicators not broken or missing<br>(5) Fullness determined by weighing or " hefting "<br>(6) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle<br>(7) Pressure gauge reading or indicator in the operable range or position<br>(8) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units)<br>(9) HMIS label in plac | K 064 | | |
| K 066<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Smoking regulations are adopted and include no less than the following provisions:<br><br>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.<br><br>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.<br><br>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.<br><br>(4) Metal containers with self-closing cover | K 066 | K066<br>1. Ashtrays of noncombustible material and safe design have replaced other ashtrays in the smoking areas on 3/28/12 by the MD.<br><br>2. The MD inspected the facility designated smoking areas for ashtrays that did not meet NFPA standards and none were found on 3/28/12.<br><br>3. The MD was reeducated on 3/23/12 by the administrator on the required ashtrays for designated smoking areas. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | | 03/22/2012 |

NAME OF PROVIDER OR SUPPLIER
COUNTRYSIDE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
47 MARGO AVENUE
BARDWELL, KY 42023

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 066 | Continued From page 21<br>devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for fifty three (53) beds with a census of fifty three (53) on the day of the survey.<br><br>The findings include:<br><br>Observation, on 03/22/12 at 11:37 AM, with the Maintenance Director revealed the ashtrays located at the rear employee smoking area were not of the unapproved type. They did not have a metal container with a self-closing lid to dump ashtrays.<br><br>Interview on 03/22/12 at 11:37 AM, with the Maintenance Director revealed he was not aware of the requirement for self-closing ashtrays.<br><br>Reference: NFPA Standard 101 (2000 Edition).<br><br>19.7.4 Smoking (4)<br>Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is | K 066 | 4. The MD will be responsible for monitoring monthly for 2 months the use of ashtrays in smoking areas to ensure only ashtrays meeting NFPA standards are used. The results will be reported to the Performance Improvement Committee.<br><br>5. Date of Completion: | 3-29-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 03/22/2012 |

NAME OF PROVIDER OR SUPPLIER
COUNTRYSIDE CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
47 MARGO AVENUE
BARDWELL, KY 42023

| (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 |
|---|---|---|---|---|
| K 066 | Continued From page 22<br>permitted. | K 066 | | |
| K 130<br>SS=E | NFPA 101 MISCELLANEOUS<br><br>OTHER LSC DEFICIENCY NOT ON 2786<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress in accordance with NFPA standards. The deficiency had the potential to affect two (2) of the four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for fifty three (53) beds with a census of fifty three (53) on the day of the survey.<br><br>The findings include:<br><br>Observation, on 03/22/12 between 9:00 AM and 12:00 PM, with the Maintenance Director revealed an unapproved hold open device (magnet on a chain) was installed on Laundry Room, the Men's and Woman's Shower rooms, and the cross corridor doors to the Dining Room.<br><br>Interview, on 03/22/12 between 9:00 AM and 12:00 PM, with the Maintenance Director revealed they were aware of the hold open devices installed on the doors; however, they were not aware they were not permitted unless they released with the activation of the fire alarm or sprinkler system. | K 130 | K 130<br>1. The hold open devices on the laundry room, men and women's shower rooms and the cross corridor doors to the dining room was removed by the MD on 3/23/12.<br><br>2. The MD inspected the facility for other hold open devices on 3/23/12 and no others were identified.<br><br>3. The MD was reeducated on 3/23/12 by the administrator regarding the requirement of not using hold open devices.<br><br>4. The MD will monitor the facility to ensure no hold open devices are used monthly x 3 months. Results will be reported to the Performance Improvement Committee x 3 months.<br><br>5. Date of Completion: | 3-24-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 130 | Continued From page 23<br>Reference: NFPA 101 (2000 Edition)<br><br>19.2.2.2.4<br>Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. | K 130 | | |
| K 147<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for fifty three (53) beds with a census of fifty three (53) on the day of the survey.<br><br>The findings include:<br><br>Observations, on 03/22/12 between 10:00 AM and 12:00 PM, with the Maintenance Director revealed:<br><br>1) Storage in front of electrical panels located in the rear mechanical room.<br>2) An extension cord attached to the wall to provide power to a permanently mounted fan located in the back receiving area. | K 147 | K 147<br>1. All items stored within 36" of electrical panels located in the rear mechanical room were moved on 3/27/12 by MD. The extension cord located in the back receiving area was removed on 3/27/12 by the MD.<br><br>2. The MD completed and an inspection of the facility on 3/23/12 to ensure that no extension cords were utilized in the facility and no other items were stored within 36" of electrical panels.<br><br>3. The MD was reeducated on 3/23/12 by Administrator on maintaining electrical wiring according to NFPA standards.<br><br>4. An audit will be done monthly for 6 months by the MD to verify electrical wiring is maintained to include no use of extension cords and no storage | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185382 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 03/22/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE CARE AND REHABILITATION CENTER | 47 MARGO AVENUE<br>BARDWELL, KY 42023 |

| (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 |
|---|---|---|---|---|
| K 147 | Continued From page 24<br>Interview, on 03/22/12 between 10:00 AM and 12:00 PM, with the Maintenance Director revealed they were not aware the extension cords were only for temporary use. They were also not aware of the storage in front of the electrical panels.<br><br>Reference: NFPA 99 (1999 edition)<br><br>3-3.2.1.2 D<br><br>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.<br><br>110-26. Spaces<br><br>About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. | K 147 | in front of electrical panels. Results will be brought to the Performance Improvement Committee for review for 6 months.<br><br>5. Date of Completion: | 3-28-12 |