

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

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185242 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 06/28/2013 |
| NAME OF PROVIDER OR SUPPLIER WINDSOR CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 125 STERLING WAY MOUNT STERLING, KY 40353 | | |
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| F 000 | INITIAL COMMENTS A Standard Recertification Survey was conducted on 06/25/13 through 06/28/13 with deficiencies cited. The highest Scope and Severity was a "G", with the facility having an opportunity to correct before remedies would be recommended for imposition. | F 000 | The following constitutes the facility's response to the findings of the Department for Health Services and does not constitute an admission of the facts alleged or conclusions set forth on the summary statement of deficiencies. | | |
| F 226 SS=D | 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure alleged violations involving misappropriation of resident property were reported immediately to the Administrator of the facility and State Agencies in accordance to state law. Group Interview conducted, on 06/25/13 at 3:00 PM revealed complaints with missing items such as clothing, jewelry, and Resident #20 revealed he/she had money, five (5) dollars and ten (10) dollars in quarters, missing which happened about a month ago. Interview with Social Worker #1 revealed the facility had not been made aware of some of the missing items reported in group, but had investigated Resident #20's missing money. The facility failed to notify the Office of Inspector General (OIG) within | F 226 | This plan of correction is prepared as required by the provisions of the Health Safety code, 42 CFR and constitutes the facility's written credible allegation of compliance. F 226 - BY: _____ Resident # 20 was not harmed by the alleged deficient practice. No other residents were determined to have been harmed by the alleged deficient practice. The facility will report all confirmed claims of missing items to the appropriate agencies. Once staff is made aware of the missing items, an attempt to locate the missing items will be made by staff and it will be reported to the administrator and social services director who is the designated person to initiate complaint investigations. If the | RECEIVED AUG 14 2013 | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rebecca Cooley TITLE: Administrator (X6) DATE: 8/14/13

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

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twenty-four (24) hours after the missing money had been reported as per the facility's policy.

The findings include:

Review of the facility's policy titled: "Abuse Prevention", revised date 05/2011, revealed outside entities, including regulatory agencies and protective services, will be notified and involved as appropriate to the situation. Review of the policy's investigation section revealed the facility would investigate and report incidents or occurrences in accordance with federal and state regulations and guidelines. Review of the policy's Reporting/Response section revealed all alleged violations and all substantiated incidents were reported to the State Agency and to all other required agencies.

Interview with Licensed Practical Nurse (LPN) #5, on 06/28/13 3:10 PM, revealed if residents reported things missing they were to tell the Social Worker, Director of Nursing or Administrator. The LPN stated the Social Worker filled out a missing items forms and it went to all the areas of the facility. Further interview revealed they would ask if anyone had seen the items.

Group Interview, on 06/25/13 at 3:00 PM, revealed Resident #20 reported approximately a month ago he/she had money missing, a five (5) dollar bill and ten (10) dollars in quarters, from his/her room and reported it to the facility.

Review of the facility's Missing/Damaged Items Report, dated 05/13/13, revealed Resident #20 reported five (5) dollars missing and a bag of

F 226 items are immediately located, then we will not report the items to the office of inspector general, ombudsman, adult protective services, or the police. If the items are not located in the required time frame to make the initial report, then it will be reported and the facility will continue their investigation of the missing items and will report their findings within five (5) days as required by regulations and facility policy on Abuse.

Staff re-education began on 7-01-13 and will be completed by 7-31-13 on reporting requirements and processes to locate missing items.

Resident's and family members will be re-educated through the facility newsletter in August about making sure resident's personal effects are labeled, that money is placed in resident trust fund accounts, and importance of reporting timely when something is missing.

The Social Worker and or the Quality Assurance Nurse will conduct random audits of resident reports of missing items monthly x 3 months and quarterly x 3 quarters to

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quarters. Review of the report's follow-up section revealed as of 06/18/13 the money had still not been found. Continued review of the Report revealed no documented evidence the missing items had been reported to the Stage Agency.

interview, on 06/27/13 at 11:25 AM and on 06/28/13 at 5:15 PM, with Social Worker (SW) #1 revealed, Resident #20 had reported the money missing on 05/13/13 and she (SW) asked the resident where he/she had been and followed up on 06/18/13 and the money had not been found. The SW stated, based on an inservice she and the Administrator attended, misappropriation of property was defined as money or other property taken intentionally without consent. The SW stated when items were reported missing they investigated to see if it was a misappropriation of property event or a lost item. SW #1 further stated they only considered it a misappropriation of property event, if the item was specifically reported as "stolen" or was observed being taken, otherwise it was a missing item and they did not report to the State Agency. She also stated she would not ask residents if an item was stolen because she didn't want to influence them and instead let them tell her what happened. She further stated residents rarely reported an item as stolen and a lot of times said it was missing or they did not know what happened to it. Continued interview with SW #1 Worker regarding how the facility ensured all alleged misappropriation of property was reported appropriately if the resident was not sure what happened to the item revealed they probably needed to discuss as a team if the event needed to be reported.

F 226 ensure continued compliance of investigating and reporting missing items. 8-2-13

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Interview, on 06/28/13 at 6:00 PM, with the Administrator revealed misappropriation of a resident's property could be defined as someone who knowingly took from the resident or used the resident's property for personal use. The Administrator reported that in the case of residents missing items, she would be notified as well as the Director of Nursing and the SW. She stated the investigation process would then begin. The Administrator stated the SW would notify the resident's family to determine if the resident had the item that was identified as missing. The Administrator reported that if a resident stated to her that an item was taken or stolen, then the State Agencies such as the Office of Inspector General (OIG), Adult Protective Services (APS), the Ombudsman, and the police would be contacted. She reported the facility would conduct their own investigation to determine what happened to the lost items. The Administrator added that most of the time, the residents would tell staff if someone was found in their room and staff would be questioned. The Administrator stated residents were told upon admission that they (the facility) would not be responsible for lost items and encouraged residents to label all of their clothing. In regards to money missing, stolen, or taken, the Administrator stated she would probably give the resident the money back, out of her pocket. She further revealed that in the case of Resident #20's fifteen dollars (\$15.00), she was not aware of Resident #20's missing money. The Administrator added that 06/28/13, was the first time she had heard of it and was not for sure why she had not been informed. She stated Resident #20's missing fifteen dollars (\$15.00) should have been reported.

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F 241 483.15(a) DIGNITY AND RESPECT OF

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SS=G INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, it was determined the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of their individuality for four (4) sampled residents (Residents #2, #16, #18 and #19) and two (2) unsampled residents (Unsampled Residents C and D).

Group Interview, on 06/25/13 at 3:00 PM, revealed some residents complained there were bathroom lines, after lunch, on the Wisteria Unit and that some of the residents cried and fussed when in line. Interviews with Residents #2, #16, #18, and #19 and Unsampled Residents C and D revealed they preferred to use the bathrooms in their own rooms, but were taken to the common bathroom, beside the nurse station, to be toileted. They stated they sometimes had to wait a long time and as a result soiled themselves making them feel bad.

The findings include:

Interview, on 06/28/13 at 6:05 PM, with the Director on Nursing (DON) revealed it was the

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Resident C request to use the bathroom in the hallway and care plan has been updated to reflect resident's preference. Resident #2, #18, #19 and resident D were interviewed and all wish to use the bathrooms in their rooms.

All residents can be considered at risk for the alleged deficient practice, however Dignity audits completed by QA Nurse and DON 7/1/13 through 7/3/13, No dignity issues were found and no toileting issues noted on the other three units.

In-servicing on Dignity and asking residents preferences began 7/15/13 and will be completed by 8/1/13 by ADON.

Effective 7/1/13 staffs toileting routine on Wisteria was changed from two SRNA's toileting residents to all SRNA's toileting residents in bathrooms of choice.

Resident council minutes will continue to be reviewed monthly by DNS, QA Nurse and Social Services Director and issues addressed with follow up.

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residents choice to determine what bathroom they preferred to use, the common bathroom or the bathroom in their room. She further stated staff should not line up residents to use a bathroom, unless the resident stated they wanted to use the common bathroom.

At the Group Interview, on 06/25/13 at 3:00 PM, Resident #16 and Unsampled Resident H revealed there were bathroom lines, after lunch, on Wisteria and some of the residents cried and fussed when in the line. Residents at the group interview reported they thought all residents had bathrooms in their rooms.

Record review of the April 15, 2013 "Windsor Care Resident Council Minutes" under "New Business" revealed residents reported the lines for the bathroom were starting to get long. The residents did not appreciate the lines for the bathroom and felt they were undignified. Review of the documented responds from the facility revealed the bathroom lines were to be immediately discontinued and the facility apologized for any emotional distress felt by the residents. Further review of the meeting minutes revealed the facility put out a "ward" conference to staff related to the bathroom lines. However, observation on 06/27/13 from 9:15 AM until 9:30 AM revealed residents lined up in the hall waiting to use the common bathroom on the Wisteria Unit.

1. Review of Unsampled Resident C's medical record revealed the facility admitted the resident on 02/25/11 with diagnoses which included Hypertension, altered mental status, malaise and fatigue. Further record review revealed Resident

F 241 Dignity audits (see attached) will be conducted 2 x's weekly x 4 weeks, then weekly x4 weeks, then monthly by the QA Nurse, DNS, ADON, Unit Managers, or Social Services utilizing the QA dignity audit tool. The completed audits will be reviewed through the QA process weekly x's 2 months and then monthly by the QA Sub-Committee which consist of the QA Nurse, DNS, ADON, unit managers and Social Services.

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C was assessed by the facility as having a Brief Interview of Mental Status (BIMS) score of eight (8) out of fifteen (15) indicating the resident was moderately impaired in cognition.

Interview, on 06/27/13 at 9:50 AM, with Unsampled Resident C revealed he/she was toileted in the community bathroom. Resident C reported he/she could not walk, thus he/she depended on staff to assist him/her with toileting. Resident C further stated he/she had waited in line for more than thirty (30) minutes. Resident C added that many residents had to wait in line to be toileted and had waited longer than he/she had. Resident C stated he/she has been told by staff that he/she should wear briefs. Resident C revealed he/she had urinated on self while waiting to be toileted. Resident C added this made him/her feel like "hell" or "dirty" when he/she had peed on self.

2. Review of Resident #2's medical record revealed the resident was admitted by the facility on 11/10/11 with diagnoses which included functional decline, weakness and Insulin Dependent Diabetes. Review of the 10/30/12 admission Minimum Data Set (MDS) Assessment revealed the facility assessed the resident as being cognitively intact. In addition, the resident was assessed as required extensive assistance of two (2) staff for toileting.

Interview, on 06/27/13 at 9:15 AM, with Resident #2 revealed the resident was regularly toileted in the community bathroom. Resident #2 stated he/she had to wait in line for an hour to an hour and a half before he/she could be toileted. Resident #2 stated it made him/her feel bad to

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have to wait in line and reported he/she would like to be toileted in his/her bathroom versus the community bathroom. Resident #2 was observed to have a bathroom in his/her room and it appeared to be in working condition as evidenced by flushing the toilet.

Observation, on 06/27/13 from 9:15 AM until 9:30 AM, revealed Resident #2 was in line, at the community bathroom, waiting to be toileted. Resident #2 was observed sitting in his/her wheelchair, for fifteen (15) minutes, behind two (2) other residents. Resident #2 stated, "I have to go to the restroom".

3. Record review revealed the facility admitted Resident #19 on 08/28/12 with diagnoses which included Renal Failure, Edema, Depression and Obesity. Review of the latest Quarterly MDS Assessment revealed the facility assessed the resident as being moderately impaired in cognition.

Observations, on 06/27/13 from 9:15 AM until 9:30 AM, revealed Resident #19 waited in line in the hallway outside of the common bathroom to be toileted.

Observation, on 06/28/13, at 3:50 PM, of Resident #19's room revealed a toilet chair to the left side of the bed against the wall and a shared toilet area located in the room. Further observation of the toilet chair revealed personal items piled on top of the toilet chair against the wall.

Interview, on 06/28/13 at 3:50 PM, with Resident #19 revealed he/she had to wait in line to use the

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bathroom and had accidents of urine while waiting. Resident #19 also revealed the accidents made him/her feel bad.

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4. Review of Resident #18's medical record revealed the facility admitted the resident on 04/11/13 with diagnoses which included Altered Mental Status, Kidney Injury and Urinary Tract Infection. Review of the Admission MDS Assessment, dated 04/15/13, revealed the facility assessed Resident #18 as having a BIMS score of eight (8) out of fifteen (15) indicating moderate impairment in cognition.

Interview with Resident #18, on 06/28/13 at approximately 1:45 PM, revealed Resident #18 was toileted in the community bathroom. Resident #18 stated he/she did not know how long he/she had to wait for the bathroom, but reported it had been about thirty (30) minutes or so and added, "You are lucky to get in then". Resident #18 revealed he/she had problems with his/her bladder, but reported it was better now that he/she had been placed on bladder control medication. Resident #18 reported he/she had urinated on self while waiting to be toileted. Resident #18 stated, "it did not make him/her feel good to wait in line". Resident #18 reported he/she felt terrible when he/she was unable to hold his/her bladder while he/she waited in line.

5. Review of Unsampled Resident D's medical record revealed the facility admitted the resident on 03/11/13 with diagnoses which included Cerebrovascular Disease, Diabetes Mellitus, Urinary Tract Infection, and Arthritis. Review of the Admission MDS Assessment, dated 03/15/13, revealed the facility assessed Unsampled

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Resident D as having a BIMS score of eight (8) out of fifteen (15) indicating the resident was moderately impaired in cognition.

Interview, on 06/27/13 at 11:00 AM, with Unsampld Resident D revealed he/she was regularly toileted in the community bathroom. Resident D reported he/she had to wait in line for an hour or longer. Resident D added that often times, residents were still behind him/her after he/she had been toileted. Resident D stated there were no set times in which the line for toileting occurred, "it happened throughout the day", reported Resident D. Resident D stated he/she depended on staff to toilet him/her and had urinated on self while waiting to be toileted. Resident D reported he/she would rather go to his/her own bathroom for toileting. Resident D revealed it made him/her feel "awful" to have to wait in line to be toileted.

Observation, on 06/27/13 at 10:58 AM, revealed unsampled Resident D had a private bathroom and it appeared to be working as evidenced by a flushed toilet.

6. Record review of Resident #16's medical record revealed the facility admitted the resident on 11/29/07 with diagnoses which included Urinary Frequency, Generalized Weakness, Congestive Heart Failure and Hypertension (high blood pressure). Review of the 05/09/13 Quarterly Minimum Data Set (MDS) Assessment revealed the facility assessed the resident as being moderately cognitively impaired.

Interview, on 06/28/13 at 1:40 PM, with Resident #16 revealed he/she had seen residents lined up

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| F 241 | <p>Continued From page 10</p> <p>to be taken to the bathroom by the nurse station and thought the residents had to wait awhile, but could not recall how many residents were lined up.</p> <p>Interview, on 06/28/13 at 2:43 PM, with Certified Nursing Assistant (CNA) #7 revealed residents on the Wisteria Unit lined up to use the common bathroom, by the nursing station, after they ate. The CNA stated, on Wisteria, they typically had two (2) CNAs assist residents who were in the bathroom line and two (2) CNAs who would answer room call lights after meals. She stated there were a bunch of residents who lined up to use the public restroom after eating, but the residents were used to doing that. She stated, she thought residents preferred the public bathroom because it was bigger and was not aware of any resident complaints. The CNA revealed it took awhile to get all the residents through the line, but it was easier taking them to the public bathroom. She stated some residents had accidents when waiting to use the public bathroom and got upset, but they tried to get to them as fast as they could.</p> <p>Interview with CNA #8, on 06/28/13 at 3:30 PM, revealed the residents on Wisteria line themselves up at the public bathroom across from the nurse station after meals. The CNA stated she was unsure why residents didn't use the bathroom in his/her room, but the public bathroom was bigger and it was difficult to get two (2) people and a wheelchair in the bathroom in the residents' rooms. CNA #8 revealed she didn't ask the resident's what bathroom they preferred to use. She stated one time a resident had soiled themselves waiting in the line, the</p> | F 241 | | | |

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| F 241 | <p>Continued From page 11</p> <p>resident had diarrhea, but it didn't seem to bother him/her.</p> <p>Interview, on 06/28/13 at 3:43 PM, with CNA #9, who worked on Wisteria, revealed after meals or activities residents put themselves over to the public bathroom because they would rather use the hall bathroom because it was bigger. CNA #9 stated it didn't seem to bother the residents to use the bathroom. The CNA further stated with residents who required two (2) assist to use the bathroom, they took them to the bigger bathroom to make it easier. She stated if the residents complained about using the hall bathroom they would take them to his/her own bathroom. She further stated they usually had two (2) CNAs who assisted the residents in the bathroom line and two (2) CNAs who assisted the residents to his/her own bathroom. The CNA stated she had not seen any residents who had accidents when waiting to use the public bathroom.</p> <p>Interview, on 06/28/13 at 2:30 PM, with CNA #10 revealed she was aware of the lines that formed outside of the community bathroom. CNA #10 stated she was not sure why the residents stood in line, but reported residents had always formed the lines since she has worked the unit beginning in January 2013. CNA #10 revealed she knew the residents had waited approximately ten (10) minutes before being toileted, but expressed residents had not waited longer than thirty (30) minutes. CNA #10 revealed residents had soiled themselves while waiting to be toileted. CNA #10 reported she had asked residents if they preferred to be toileted in their rooms and residents had indicated they would like to.</p> | F 241 | | |

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| | F 241 Continued From page 12 Interview, on 06/28/13 at 3:00 PM, with CNA #6 revealed staff tried to get to every resident as fast as they could but had noticed that some residents voided on themselves while waiting to be toileted. Interview with Licensed Practical Nurse (LPN) #5, on 06/28/13 at 3:10 PM, revealed the residents on Wisteria, would line up to use the public bathroom when they needed to go; it was mostly the alert and oriented residents. She stated that is just how they had done it, the bathroom was bigger and most of them liked to use it. She further stated she was unaware of any resident complaints about using the public bathroom. LPN #5 stated when residents lined up to use the public bathrooms they had two (2) CNAs assist them and two (2) CNAs answered room call lights. The LPN further stated she did observe a resident soiled in the line, but it was awhile ago and the resident had a weak bladder. Interview with Social Worker (SW) #1, on 06/27/13 at 11:25 AM, revealed they had lined up the residents after meals to use the bathroom in the hall because it was quicker. SW #1 stated residents had voiced concern to her about why they were being lined up to use the bathroom in the hall instead of their room. The SW further stated she had informed the residents staff was hoping to get to them quicker. She stated it was the residents' right to choose where they wanted to be toileted unless there was a medical reason for it and it could be a dignity issue if the residents preferred to use the bathroom in their room and had to wait in line. SW #1 stated she had spoken to the DON because it was a nursing issue. Continued interview with the DON, on 06/28/13 at | F 241 | |

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| F 241 | Continued From page 13 6:05 PM, revealed the Social Worker did discuss resident complaints about bathroom lines and the DON did an investigation of the bathroom lines and talked to staff and residents but had no documentation of her investigation. She stated she had felt the situation had improved since she had put out education. She further stated residents had chosen to line up to use the public bathroom because it was bigger and wanted to go there. The DON stated the expectation was residents had the right to use the bathrooms in their rooms if they wanted. The DON further stated it was a dignity issue if residents were taken to the public bathroom but the residents preferred to use the bathroom in their own rooms. The DON further stated it would be a dignity issue if a resident had an event in which they soiled themselves while waiting to be toileted by staff and the event was upsetting to the resident. | F 241 | | |

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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

Building: 01

Plan Approval: 1976, 1995, 2002, 2008

Survey under: 2000 Existing

Facility type: SNF/NF

Type of structure: One story Type V000 with partial basement.

Smoke Compartments: 5

Fire Alarm: Complete fire alarm system with new panel upgrade in 2008

Sprinkler System: Complete automatic (dry and wet) sprinkler system.

Generator: Type II 60 KW Natural gas generator installed in 1976, Type II 150 KW diesel generator installed in 2002.

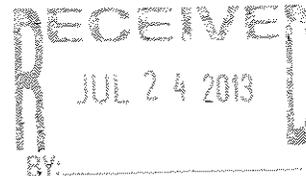
A Life Safety Code survey was conducted on 06/26/13. Windsor Care Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was one hundred thirty-six (136) residents. The facility is licensed for one hundred forty-four (144) residents.

The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).

K 000

The following constitutes the facility's response to the findings of the Department for Health Services and does not constitute an admission of the facts alleged or conclusions set forth on the summary statement of deficiencies.

This plan of correction is prepared as required by the provisions of the Health Safety code, 42 CFR and constitutes the facility's written credible allegation of compliance.



Continued on p 4

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rebecca Cooley</i> | TITLE <i>Administrator</i> | (X6) DATE <i>7/24/13</i> |
|--|-----------------------------------|---------------------------------|

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

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K 000 Continued From page 1
CFR: 42 CFR 483.70(a) K 000

Building: 02
Plan Approval: 1976, 1995, 2002, 2008
Survey under: 2000 Existing
Facility type: SNF/NF
Type of structure: One story Type V000 with partial basement.
Smoke Compartments: 5
Fire Alarm: Complete fire alarm system new panel upgrade in 2008
Sprinkler System: Complete automatic (dry and wet) sprinkler system.
Generator: Type II 60 KW Natural gas generator installed in 1976, Type II 150 KW diesel generator installed in 2002.
A Life Safety Code survey was conducted on 06/26/13. Windsor Care Center (Bluegrass Suites Wing) was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was one hundred thirty-six (136) residents. The facility is licensed for one hundred forty-four (144) residents.
The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).

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| K 073 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency had the potential to affect all smoke compartments, all residents, staff, and visitors. The facility is certified for one hundred forty-four (144) beds with a census of one hundred thirty-six (136) on the day of the survey. The facility failed to ensure decorations brought into the facility were being properly fire treated.</p> <p>The findings include:</p> <p>Observation, on 06/26/13 between 11:30 AM and 2:00 PM, with the Environmental Services Director, revealed wreaths were on doors throughout the facility to include the following rooms: 1, 2, 3, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 17, 101, 102, 104, 106, 108, 110, 111, 112, 113, 114, 117, 122, 125, 127, 129, 131, 135, 202, 205, 206, 207, 208, 210, 218, 219, 220, 227. The facility had no documentation of flame retardant being applied to the items.</p> <p>Interview, on 06/26/13 at 1:45 PM, with the Environmental Services Director revealed she was unaware decorations were required to be treated with a fire retardant spray but the facility did not allow the flammable decorations in the facility. She also stated that the facility did not</p> | K 073 | |

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| K 073 | <p>Continued From page 3</p> <p>have a policy on decorations.</p> <p>Interview, on 6/26/13 at 1:45 PM, with the Administrator revealed they would remove the decorations but thought that was part of a home-like environment.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.</p> <p>Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency had the potential to affect all smoke compartments, all residents, staff, and visitors. The facility is certified for one hundred forty-four (144) beds with a census of one hundred thirty-six (136) on the day of the survey. The facility failed to ensure decorations brought into the facility were being properly fire treated.</p> <p>The findings include:</p> <p>Observation, on 06/26/13 between 11:30 AM and 2:00 PM, with the Environmental Services Director, revealed wreaths were on doors throughout the facility to include the following rooms: 1, 2, 3, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 17, 101, 102, 104, 106, 108, 110, 111, 112, 113, 114, 117, 122, 125, 127, 129, 131, 135, 202, 205, 206, 207, 208, 210, 218, 219, 220, 227. The facility had no documentation of flame retardant being applied to the items.</p> | K 073 | <p>K073</p> <p>On 6/27/13 all wreaths were removed from resident doors and other service areas. Residents and family members were notified as to why they were being removed.</p> <p>A Decoration Policy was implemented on 7/1/13 and facility is in the process of notifying current residents, responsible family members and staff of the new policy in our August, 2013 edition of our facility newsletter. New admissions will be informed upon admission during the admission process.</p> <p>During daily rounds (Monday – Friday) the Environmental Services Director will monitor doors to ensure no one has brought in and added a wreath to the doors.</p> | 8-2-13 |

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K 073 Continued From page 4

Interview, on 06/26/13 at 1:45 PM, with the Environmental Services Director revealed she was unaware decorations were required to be treated with a fire retardant spray but the facility did not allow the flammable decorations in the facility. She also stated that the facility did not have a policy on decorations.

Interview, on 6/26/13 at 1:45 PM, with the Administrator revealed they would remove the decorations but thought that was part of a home-like environment.

Reference: NFPA 101 (2000 Edition)

19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.

K 073