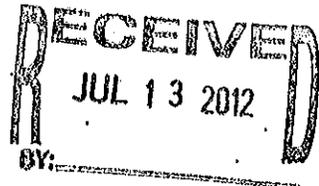


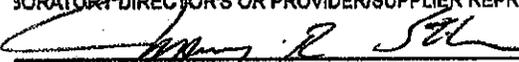
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185446</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/22/2012</b>
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  <b>BLUEGRASS CARE &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3576 PIMLICO PARKWAY LEXINGTON, KY 40517</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  A Recertification Survey was initiated on 06/19/12 and concluded on 06/22/12 with deficiencies cited. The highest S/S was a "D". A Life Safety Code Survey was conducted on 06/27/12 with the highest Scope and Severity of a "D".	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS  The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined the facility failed to ensure one (1) of twenty (20) sampled residents, (Resident #7) remained free from physical restraints. Observations, on 06/20/12, revealed Resident #7 had a Posey Activity Apron on while in his/her wheel chair which was tied behind the wheel chair and restricted the resident from freedom of movement.  The findings include: Review of facility policy entitled " Physical Restraint Reduction Program ", dated 12/2010, revealed the facility's definition of physical restraint was any manual method or mechanical device, material or equipment attached adjacent to the resident's body that the individual could not remove easily which restricted freedom of movement or normal access to one's body.	F 221	 <p>F 221 <b>Immediate Corrective Action For Residents Found To Be Affected</b></p> <ul style="list-style-type: none"> <li>◆ The activity apron was removed from resident #1 immediately, thus eliminating the restraint.</li> </ul> <p><b>Identification of Other Residents With The Potential to be Affected</b></p> <ul style="list-style-type: none"> <li>◆ An audit for unapproved/non-care planned physical restraints of 100% of the resident population was completed on June 21 by DON (Director of Nursing), ADON (Assistant Director of Nursing), SDC (Staff Development Coordinator), RNM (Restorative Nurse Manager), NNM (Night Nurse Manager) or MDSN</li> </ul>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>L.A.N.A.</b>	(X6) DATE <b>July 13, 2012</b>
---	--------------------------	-----------------------------------

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.

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

PRINTED: 07/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/22/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
--	--

(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 221	<p>Continued From page 1</p> <p>Record review revealed Resident #7 was admitted to the facility, on 02/11/09, with diagnoses which included Dementia, Hypertension, Parkinson's, Atypical Psychosis, Alzheimer's Disease with Behavior Disturbance, Iron Deficiency Anemia, Dysphagia, Symbolic Dysfunction, and Difficulty Walking. Review of an Annual Minimum Data Set, dated 05/17/12, revealed the facility assessed Resident #7 to have a Brief Interview Mental Status of one (1), indicating the resident was cognitively impaired. Further review of the MDS revealed Resident #7 required extensive assistance of two (2) staff for transfers and toilet use and extensive assistance of one (1) staff for ambulation and personal hygiene. Additional review of the MDS revealed Resident #7 utilized a wheelchair as a mobile device and utilized a trunk restraint daily.</p> <p>Review of Resident #7's Comprehensive Plan of Care related to risk for falls and physical restraints, reviewed 06/09/12, revealed Resident #7 was to have a Velcro alarm pelvic seatbelt and a clip alarm in place related to decreased trunk stability and decreased safety awareness. Review of the activities plan of care revealed Resident #7 was to be provided an activity apron as a diversional activity related to behaviors.</p> <p>Observations, on 06/20/12 at 9:50 AM, 10:50 AM and 2:00 PM, revealed Resident #7 was sitting in a wheel chair in a common area of the facility. Further observation revealed a Velcro alarm pelvic seatbelt was across the resident's lap and a clip alarm was alarm attached between the resident and the wheel chair. Additional observation revealed Resident #7 was wearing a</p>	F 221	<p>(Minimum Data Set Nurse) with no additional residents identified.</p> <p><b>Measures Taken To Assure There Will Not Be a Recurrence</b></p> <ul style="list-style-type: none"> <li>◆ All nursing staff will be educated by the SDC, DON, ADON, RNM, NNM or MDSN from June 20 through July 10, 2012, as well as to any stakeholder returning from leave or inactive during these times or during on-boarding for new staff beginning July 11, 2012 regarding the facility policy on restraints.</li> <li>◆ Physical restraint utilization shall be reviewed in the weekly at-risk meeting beginning on June 28, 2012 for policy compliance.</li> </ul> <p><b>Monitoring Changes To Assure Continuing Compliance</b></p> <ul style="list-style-type: none"> <li>◆ Reports of the weekly at risk meetings will be presented to the</li> </ul>	

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

PRINTED: 07/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/22/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3676 PIMLICO PARKWAY LEXINGTON, KY 40517
--	--

(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 221	<p>Continued From page 2</p> <p>Posey Activity Apron across his/her abdomen and chest and the ties were tied behind the wheel chair.</p> <p>Observation, on 06/20/12 at 12:50 PM, revealed Resident #7 was sitting in a wheel chair at a restorative table in the dining area. Further observation revealed Resident #7 was wearing a Posey Activity Apron across his/her abdomen and chest and the ties were tied behind the wheel chair.</p> <p>Review of the facility's Physical Restraint Elimination Assessment, with a review date of 05/18/12, revealed Resident #7 continued to get up and unbuckled seat belt. Additional review of the assessment revealed the activity apron was utilized to attempt to divert this behavior.</p> <p>Review of the facility's Behavioral Assessment/Psychotropic Medication/Management Plan for Resident #7, with a review date of 05/18/12, revealed staff were to provide Resident #7 with an activity apron to decrease the resident's anxiety.</p> <p>Review of Manufacture's Recommended Use for the Posey Activity Apron, downloaded and printed by facility on 06/20/12, revealed the activity apron was to be secured around the waist.</p> <p>During an interview with State Registered Nursing Assistant (SRNA) #1 who provided direct care to Resident #7, on 06/20/12 at 2:20 PM, SRNA #1 demonstrated how she applied the Posey Activity Apron while Resident #7 was not in the wheel chair. SRNA #1 stated she would apply the Posey Activity Apron to the resident with the apron on</p>	F 221	<p>quarterly Quality Assurance Committee for review and follow up until at such time consistent substantial compliance has been achieved as determined by the committee.</p> <p><b>Date of Completion:</b></p>	07-10-12

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

PRINTED: 07/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/22/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3676 PIMLICO PARKWAY LEXINGTON, KY 40517
--	--

(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 221	<p>Continued From page 3</p> <p>the resident's lap and chest with the ties around the chest and tied to the back of the wheel chair. As SRNA #1 tied the ties of the Posey Activity Apron to the back of the wheel chair she stated she would not tie it tight. Additional interview with SRNA #1, on 06/20/12 at 2:46 PM, revealed SRNA #1 had not seen the Posey Activity Apron until a couple months ago and she had not received training on the use of the apron.</p> <p>Interview with Assistant Director of Nursing (ADON), on 06/20/12 at 2:20 PM, revealed the proper placement of the ties for the Posey Activity Apron should be behind the resident's back. The ADON indicated she regularly checked the placement of the activity apron and had not noticed any problems. She stated she thought SRNA #1 had been nervous and had not tied the apron correctly. Further interview with the ADON revealed if the Activity apron was tied behind the wheel chair then it would be considered a restraint. The ADON was unaware staff had been trained on proper usage of the activities apron.</p>	F 221	<p><b>F 441</b></p> <p><b>Immediate Corrective Action For Residents Found To Be Affected</b></p> <ul style="list-style-type: none"> <li>Residents #5 &amp; 7 were assessed by the DON/ADON on June 22 and weekly thereafter through July 6, 2012 with no negative affect from this alleged deficient practice.</li> <li>Unsampled resident #A was monitored by the ADON for a 24 hour period beginning June 19, upon notification by surveyor, with no negative affect from this alleged deficient practice.</li> </ul>	
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <ol style="list-style-type: none"> <li>Investigates, controls, and prevents infections in the facility;</li> <li>Decides what procedures, such as isolation,</li> </ol>	F 441	<p><b>Identification of Other Residents With The Potential to be Affected</b></p> <ul style="list-style-type: none"> <li>An interview of 100% of the licensed nursing staff was completed on June 21 by DON, ADON, SDC, RNM, NNM or MDSN to ascertain if any additional nurses had performed skin assessments in the manner identified, with no additional residents identified.</li> </ul>	

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

PRINTED: 07/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/22/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3676 PIMLICO PARKWAY LEXINGTON, KY 40517
--	--

(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	<p>Continued From page 4</p> <p>should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to 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 for two (2) of twenty (20) sampled residents (Residents #5 and #7), unsampled Resident A.</p>	F 441	<ul style="list-style-type: none"> <li>◆ All stakeholders involved in tray delivery and setup were interviewed by the SDC, DON, ADON, RNM, NNM or MDSN on June 22, 2012 to ascertain if any additional stakeholders had performed tray setup in the manner identified, with no additional residents identified</li> </ul> <p><b>Measures Taken To Assure There Will Not Be a Recurrence</b></p> <ul style="list-style-type: none"> <li>◆ All licensed nursing staff will be educated by the SDC, DON, ADON, RNM, NNM or MDSN from June 20 through July 09, 2012, as well as to any licensed stakeholder returning from leave or inactive during these times or during on-boarding for new staff beginning July 11, 2012 regarding Standard Precautions with specific focus to changing of gloves during skin assessments.</li> <li>◆ Beginning June 25, 2012, all skin assessments will be monitored by the SDC, DON, ADON, RNM, NNM or MDSN daily for 1 week then weekly for 4 weeks and</li> </ul>	

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

PRINTED: 07/06/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/22/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
--	--

(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	<p>Continued From page 5 The findings include:</p> <p>Review of the facility's Handwashing policy, dated 12/2012, revealed staff were to wash their hands before and after caring for each resident and before handling a resident's food or food tray.</p> <p>1. Observation, on 06/20/12 at 10:15 AM, of a skin assessment for Resident #5 revealed Licensed Practical Nurse (LPN) #2 assessed the resident's upper body, then proceeded to assess the resident's perineal area. LPN #2 did not remove the soiled gloves or sanitize her hands prior to proceeding to assess Resident #5's lower body, removing the dressings to his/her bilateral lower legs. She assessed the resident's legs and feet, adjusted the bed covers, and assisted with pulling Resident #5 up in bed without changing the soiled gloves or sanitizing her hands.</p> <p>2. Observation, on 06/20/12 at 2:40 PM, of a skin assessment for Resident #7 revealed Licensed Practical Nurse (LPN) #2 assessed the resident's upper body, then proceeded to assess the resident's perineal area which had a protective cream applied. LPN #2 did not remove the soiled gloves or sanitize her hands prior to re-dressing Resident #7's upper body and proceeding to assess Resident #7's lower body and feet. LPN #2 re-dressed the resident's lower body, and adjusted the bed covers without changing the soiled gloves or sanitizing her hands.</p> <p>Interview, on 06/20/12 at 2:55 PM, with LPN #2 revealed she should have removed her soiled gloves after touching Resident #5 and #7's perineal areas, sanitized her hands, and</p>	F 441	<p>monthly thereafter until compliance is achieved per direction of the QA Committee.</p> <ul style="list-style-type: none"> <li>◆ All stakeholders involved in tray delivery and setup will be educated by the SDC, DON, ADON, RNM, NNM or MDSN from June 20 through July 09, 2012, as well as to any licensed stakeholder returning from leave or inactive during these times or during on-boarding for new staff beginning July 11, 2012 regarding Standard Precautions with specific focus on appropriate tray setup, utilization of gloves and sanitation procedures.</li> <li>◆ Beginning June 25, 2012 SDC, DON, ADON, RNM, NNM, MDSN or Administrator shall monitor a minimum of 1 meal daily for 1 week, then weekly for 4 weeks and monthly thereafter until compliance is achieved per direction of the QA Committee. Discrepancies will be reported in the daily stand up meeting.</li> </ul>	

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

PRINTED: 07/06/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/22/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
--	--

(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	<p>Continued From page 6</p> <p>reapplied new gloves before proceeding with the skin assessments.</p> <p>3. Observation, on 06/19/12 at 12:22 PM, of delivery of lunch tray to unsampled Resident A, revealed CNA #2 open a sandwich wrapper with her bare hands. Further observation revealed CNA #2 proceeded to hold the sandwich at the top while cutting the sandwich without gloves.</p> <p>Interview, on 06/21/12 at 9:35 AM, with CNA #2 revealed she cut the sandwich in half without donning gloves prior to meal setup. Further interview revealed she should have worn gloves when directly touching resident's food to protect Unsampled Resident A from germs and for sanitation purposes.</p>	F 441	<p><b>Monitoring Changes To Assure Continuing Compliance</b></p> <ul style="list-style-type: none"> <li>◆ Reports of the skin assessment monitoring will be reported in the weekly at risk meeting beginning June 26, 2012.</li> <li>◆ Reports of the weekly at risk meetings will be presented at the quarterly Quality Assurance Committee for review and follow up until at such time consistent substantial compliance has been achieved as determined by the committee.</li> <li>◆ Reports of the tray delivery monitoring will be presented to the quarterly Quality Assurance Committee for review and follow up until at such time consistent substantial compliance has been achieved as determined by the committee.</li> </ul> <p><b>Date of Completion:</b></p>	07-10-12

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

PRINTED: 07/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  06/19/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY, 40517
--	---

(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  Building: 01  Plan Approval: 6/15/77  Survey under: NFPA 101 (2000 Edition)  Facility type: SNF/NF  Type of structure: Type V (111) Unprotected  Smoke Compartment: Four (4)  Fire Alarm: Complete Fire alarm System  Sprinkler System: Complete Sprinkler System (Dry).  Generator: Type II Diesel and Type II Natural Gas  A standard Life Safety Code survey was conducted on 06/19/12. Bluegrass Care and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred twenty-four (124) beds and the census the day of survey was ninety-nine (99). <b>NFPA 101 LIFE SAFETY CODE STANDARD</b>	K 000		
K 143 SS=D	Transferring of oxygen is:  (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;  (b) In an area that is mechanically ventilated,	K 143	<b>K 143</b>  <b>Immediate Corrective Action For Residents Found To Be Affected</b>  ◆ The alleged deficiency was relative to an oxygen storage area and did not include a specific resident.	

RECEIVED  
JUL 13 2012  
BY: \_\_\_\_\_

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE 07/13/2012

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.

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

PRINTED: 07/06/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185448</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/19/2012</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BLUEGRASS CARE &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3876 PIMLICO PARKWAY LEXINGTON, KY 40517</b>
---	--

(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 143	<p>Continued From page 1 sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) In an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the transferring of liquid oxygen was being performed in a suitable location as set forth by NFPA standards.</p> <p>The findings include:</p> <p>During the Life Safety Code survey, on 6/19/12 between 10:00 AM and 2:00 PM, with the Director of Maintenance, a liquid oxygen storage room used for transferring liquid oxygen located in the southwest hall was noted to have tile floor covering over concrete. The floor must have concrete or ceramic tile flooring to meet code requirements. The tile and adhesive under the tile would accelerate flame spread and would reduce the protection time in event of fire.</p> <p>An interview with the Maintenance Director, on 6/19/12 at 2:00 PM, revealed he was not aware of liquid oxygen transferring or construction requirements.</p>	K 143	<p><b>Identification of Other Residents With The Potential to be Affected</b></p> <ul style="list-style-type: none"> <li>The alleged deficiency was limited specifically to the oxygen storage areas and did not affect the resident areas thus no other specific resident was identified.</li> </ul> <p><b>Measures Taken To Assure There Will Not Be a Recurrence</b></p> <ul style="list-style-type: none"> <li>Maintenance Director removed tile flooring in both oxygen storage rooms immediately after inspection on June 25, 2012.</li> </ul> <p><b>Monitoring Changes To Assure Continuing Compliance</b></p> <ul style="list-style-type: none"> <li>Maintenance Director or Maintenance Assistant will review rooms monthly with report presented to the quarterly Quality Assurance Committee for review and follow up until such time consistent substantial compliance has been achieved as determined by the committee.</li> </ul>	

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

PRINTED: 07/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  06/19/2012
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3676 PIMLICO PARKWAY LEXINGTON, KY 40517	
(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 143	Continued From page 2  8-6.2.5 Gases in Cylinders and Liquefied Gases in Containers.  8-6.2.5.1 Transferring Cylinders. a. Mixing of compressed gases in cylinders shall be prohibited. b. Transfer of gaseous oxygen from one cylinder to another shall be in accordance with CGA Pamphlet P-2.5, Transferring of High Pressure Gaseous Oxygen to Be Used for Respiration. Transfer of any gases from one cylinder to another in patient care areas of health care facilities shall be prohibited.  8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: a. Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistant construction; and b. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and c. The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted. Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transferring of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures.	K 143	Date of Completion:	07-10-12

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

PRINTED: 07/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  188446	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  06/19/2012
NAME OF PROVIDER OR SUPPLIER  BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
(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 143	Continued From page 3 The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.	K 143			