

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185174</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FLORENCE PARK CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>6975 BURLINGTON PIKE</b> <b>FLORENCE, KY 41042</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  An offsite revisit was conducted and based on the acceptable Plan of Correction (POC) the facility was deemed to be in compliance as alleged on 03/14/14.	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042	
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F 000	INITIAL COMMENTS  A Recertification Survey was initiated on 02/8/14 and concluded on 02/20/14. Deficiencies were cited with the highest Scope and Severity of an "E".	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by observation during initial tour of the facility's shower rooms revealed cracked, broken or missing tiles; one (1) of the shower stalls on the Long Term Care (LTC) Unit had a wash cloth tied around the shower head which was dripping; two (2) shower stalls had the drain cover off of the drain; dark brownish black substance in grout of tiles; cracked and peeling caulking with areas which were dark brown in color around the toilet base; a torn and cracked bath mat; and a non-fitting toilet tank cover in the bathroom adjacent to the Rehabilitation Shower.  The findings include:  Review of the facility's policy titled, "Procedure for Cleaning Bathing Facilities", undated, revealed staff were to remove dirty linens and trash; use	F 253	P 253 483.15(h)(2) Housekeeping and Maintenance Services  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.  1. There were no negative outcomes to any resident as a result of the shower rooms having cracked, broken or missing tiles; shower heads leaking; shower drain covers missing; a dark brownish black substance in grout of tiles in shower rooms; cracked and peeling caulking with areas which were dark brown in color around the toilet base; a torn and cracked bath mat, and a non-fitting toilet tank cover.  2. A house-wide in-service on reporting of the need for maintenance or service repairs was conducted on 03/03/14 and 03/04/14, with all nursing staff, environmental services staff, activities and dietary staff.  b. Damaged shower mat was replaced on 2/20/2014;  c. All toilets noted were fixed/replaced 2/20/2014;  d. Cracked/Broken/Missing tiles were replaced 2/20/2014;  e. Shower Stall drain covers fixed/replaced 2/20/2014;	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*[Signature]*

TITLE

Administrator

(X6) DATE

04/01/14

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

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F 253	<p>Continued From page 1</p> <p>approved chemicals to clean and sanitize all porcelain surfaces which included tub and shower walls, sink and toilet. Continued review of the policy revealed staff were to clean and sanitize all metal surfaces in bathing areas; clean and sanitize any equipment, such as, bath mats and shower beds; and sweep and mop the floor. Additionally, review of the policy revealed the procedure for cleaning the bathing facility included to report any needed repairs.</p> <p>Review of the facility's policy titled, "Reporting required repairs/updates on equipment and/or surrounding environment", dated 02/25/13, revealed all equipment utilized for residents by staff was to be in good working condition. Review of the policy revealed the resident's surroundings were to be in good repair without safety hazards. Further review revealed any staff could report a concern; and front desk personnel or the supervisor/charge nurse was to log the work order into the log book and e-mail the Director of Environmental Services with the request.</p> <p>Observation on 02/18/14 at approximately 12:10 PM of the Long Term Care Unit Shower room during initial tour, revealed floor and wall tiles in the shower room to be cracked, broken or missing; and discolored dark brownish/black substance in the grout surrounding the tiles. Observation revealed the shower table mat to be cracked and torn; and one (1) of the three (3) shower stalls to have a wet wash cloth tied around the shower head with water leaking from it. Continued observation revealed the drains not covered in two (2) of the three (3) shower stalls with a reddish brown substance surrounding the drain. Observation revealed cracked and peeling caulking around the toilet base which had areas</p>	F 253	<p>f. Leaking shower-heads fixed/replaced 2/20/2014;</p> <p>g. Exhaust fans cleaned 2/20/2014;</p> <p>h. Housekeeping staff inservice on proper procedure/frequency of cleaning routines for resident areas 3/3/2014;</p> <p>i. Shower rooms thoroughly cleaned 2/20/2014;</p> <p>j. QAs for continuously monitoring cleanliness and orderliness of Shower Rooms and Maintenance required/performed shall be performed by the Environmental Services Director or Designee with the following schedule:</p> <ul style="list-style-type: none"> <li>i. Daily for months 1-2;</li> <li>ii. Weekly for months 3-6 and;</li> <li>iii. Quarterly thereafter forever.</li> <li>iv. QA shall be reported to the Administrator by the Environmental Services Director and kept on file. The audits will be reviewed by the QA committee at the end of each month and analyzed by the committee at the quarterly QA meeting.</li> </ul> <p>Alleged Date of Compliance: 03/14/2014</p>	

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F 253	<p>Continued From page 2</p> <p>of discoloration dark brown in color. Further observation revealed the floors had a brownish build up in the corners and along the walls; and the exhaust fan and a portable fan had a white substance on the blades and cover of the fan.</p> <p>Observation on 02/18/14 at 12:00 PM of the Memory Care Unit Shower during initial tour, revealed floor and wall tiles in the shower room to be cracked or missing; and to have missing grout in areas and discolored dark brownish/black substance in the grout. Continued observation revealed cracked and peeling caulking around the toilet base which had areas of a dark brown discoloration. Observation revealed the floors had a brownish substance in the corners and along the walls. Further observation revealed the exhaust fan and a portable fan had a white substance on the blades and cover of the fan.</p> <p>Observation on 02/18/14 at 12:27 PM of the Rehabilitation Unit Shower during initial tour, revealed the floor and wall tiles were cracked or missing and had a brownish/black substance in the grout. Continued observation revealed the floors had a brownish substance in the corners of the room and along the base of the walls. Further observation revealed the toilet in the shower room had a dark substance around the base of the toilet; and discolored and missing caulking. Additionally, observation of the bathroom adjacent to the shower room had a dark substance around the base of the toilet; discolored and missing caulking with a blackish substance on the floor behind the toilet; and a non-fitting porcelain tank cover.</p> <p>Interview with Housekeeping Staff #1 on 02/19/14 at 10:30 AM, revealed it was Housekeeping's</p>	F 253		

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F 253	<p>Continued From page 3</p> <p>responsibility to clean the shower rooms. Housekeeping Staff #1 stated the process for cleaning the shower room included spraying the shower stalls with cleaner and wiping them down; and cleaning the toilet, toilet seat and the floor around the toilet. Continued interview revealed she reported all issues to the Maintenance/Housekeeping Director. She indicated the facility utilized work orders to request services. Further interview revealed she had reported the cracked, broken and missing tiles to the Maintenance/Housekeeping Director approximately one month ago; however was unsure of the exact date.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #2 on 02/19/14 at 3:51 PM, revealed she was responsible for giving residents showers; and was not aware the shower table mat was torn. SRNA #2 stated residents were placed directly on the shower table mat; and as it was torn this was a safety issue related to residents possibly receiving skin tears. SRNA #2 indicated placing residents on the torn shower table mat could also be an infection control issue due to the cracks in the mat.</p> <p>Interview with SRNA #3 and SRNA #5 on 02/20/14 at 3:58 PM, revealed they both were responsible for showering residents. The SRNA's stated they did not know how long the shower table mat had been torn. Continued interview revealed they should not have been placing residents on the torn shower table mat due to infection control and safety of residents. Further interview with the SRNA's revealed the torn shower table mat should have been reported to maintenance for replacement.</p>	F 253		

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F 253	<p>Continued From page 4</p> <p>Interview with Registered Nurse (RN) #2, on 02/19/14 at 4:06 PM, revealed the cracked, broken, and missing tiles in the shower rooms, as well as, the torn shower table mat were infection control and safety issues for residents. RN #2 stated the wash cloth tied on the shower head was an infection control issue. The RN stated the cracked, broken and missing tiles and the torn shower table mat should have been reported to maintenance for repair.</p> <p>Interview with the Maintenance/Housekeeping Director on 02/18/14 at 12:55 PM, revealed he was responsible for maintenance and housekeeping. The Director stated the fans in the shower rooms were cleaned each month; however he had not documented the cleaning. An additional interview on 02/19/14 at 3:20 PM, with the Maintenance/Housekeeping Director revealed the floors and around the toilets in the shower rooms needed to be cleaned more effectively. He stated the toilet and caulking in the Rehabilitation Shower room should have been removed and reset. Continued interview revealed he thought the brownish black substance in the grout in the shower rooms was mold or mildew. The Director stated the brownish black substance should not have been in the grout. He stated the broken, cracked and missing files should have been replaced; and the shower head which leaked should have been repaired or replaced. The Maintenance/Housekeeping Director stated the toilet tank cover which did not fit the toilet should not have been placed on the toilet. Further interview revealed the rubber shower/bath mat should have been replaced when there was a tear observed in it. He stated there should not have been cracked and peeling caulking around the toilet base. According to the</p>	F 253	

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F 253	<p>Continued From page 5</p> <p>Maintenance/Housekeeping Director, he did not feel this was a home-like environment for residents; and repairs of the identified issues should have been completed for the safety of residents and for infection control issues.</p> <p>Interview with the Director of Nursing (DON) on 02/20/14 at 4:06 PM, revealed the brownish black substance in the grout, brownish substance on the floors in the corner and along the base of the wall, white dust like substance on the fan and the brownish substance and discoloration along the base of the toilets were not reflective of a sanitary and homelike environment and could have been an infection control issue for residents.</p> <p>Interview with the Administrator on 02/20/14 at 4:06 PM, revealed the Maintenance/Housekeeping Director was responsible for maintaining the building inside and out to ensure it was in good repair. The Administrator indicated the Maintenance/Housekeeping Director should have made all repairs necessary in the shower rooms to ensure residents had a sanitary environment in those areas. According to the Administrator, this would have included all the concerns identified, such as, cleaning and repairing the tiles; and repairing or replacing the shower head, toilet and shower/bath mat.</p>	F 253	
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p>	F 280	<p>F280 Right to Participate Planning Care-Revise CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p>

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F 280	<p>Continued From page 6</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to revise the Comprehensive Care Plan for one (1) of twenty-four (24) residents (Resident #13).</p> <p>Record review revealed Resident #13 had been care planned to wear glasses when he/she was up out of bed. However, observation revealed Resident #13 had no glasses on. Family interview revealed Resident #13 no longer required the use of glasses due to him/her being legally blind.</p> <p>The findings include:</p> <p>Interview, on 02/20/14 at 3:50 PM, with the RN Supervisor Unit Manager revealed she was had looked for a facility policy regarding revising care plans; however was unable to locate a policy</p>	F 280	<ol style="list-style-type: none"> <li>1. Resident #13 showed no ill effects from the alleged deficient practice.</li> <li>2. Resident #13 care plan was reviewed by the IDT and after receiving input from the resident's family on 2/20/2014 the LTC unit manager revised resident #13 care plan. All care plans were reviewed, residents monitored and/or consulted and IDT consulted to ensure accuracy and compliance, by the DON and the Unit managers. All care plans were reviewed for deficient practices based on F Tag 280, by the DON or the Unit Managers. The residents were reviewed by the IDT team to make sure they were in compliance with their own plan of care.</li> <li>3. A facility wide audit was conducted on 2/21, 2/24 and 2/25/2014 by the DON and Unit Managers, whereas all care plans were reviewed, residents monitored and IDT consulted to ensure no other residents were affected by any alleged deficient practice. All care plans were reviewed for deficient practices based on F Tag 280, by the DON or the Unit Managers. The residents were reviewed by the IDT team to make sure they were in compliance with their own plan of care.</li> <li>4. All the members of the IDT (Unit Managers, Dietary Director, Activity Director and MDS nurses) were in-serviced on the facility policy regarding</li> </ol>

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F 280	<p>Continued From page 7</p> <p>related to this. The RN Supervisor Unit Manager indicated it was the expectation of the facility for residents' care plans to be revised as needed.</p> <p>Review of Resident #13's medical record revealed the facility admitted the resident on 05/03/13, with diagnoses which included Anxiety, Alzheimer's Dementia, Behaviors, and Low Vision in one eye. Review of the Quarterly Minimum Data Sheet (MDS) dated 01/24/14, revealed the facility had assessed Resident #13 to have short term and long term memory problems; and to be severely impaired with daily decision making.</p> <p>Review of Resident #13's Comprehensive Care Plan revealed a care plan for vision impairment related to low visual acuity and blindness, with an initiated date of 05/03/13. Continued review of the vision impairment care plan revealed a goal for Resident #13 to maintain optimal vision with the use of glasses which had a target date of 04/17/14. Further review of the care plan revealed interventions which included staff to ensure the resident was wearing clean glasses free from scratches and in good repair when up out of bed.</p> <p>Observations, on 02/18/14 at 5:05 PM and 6:10 PM, of Resident #13 revealed the resident to be sitting in a high backed wheel chair with no glasses on. Additional observations on 02/19/14, at 9:10 AM, 9:40 AM, 10:53 AM and 3:17 PM revealed Resident #13 sitting in a high back wheel chair with no glasses on.</p> <p>Interview, on 02/19/14 at 3:17 PM, with State Registered Nursing Assistant (SRNA) #1; and at 3:20 PM, with SRNA #2 revealed Resident #13 had glasses in a drawer in his/her room which</p>	F 280	<p>revising care plans by the DON on 3/7/2014.</p> <p>5. A QA will be conducted by DON or designee on 3 residents a week for 12 weeks to ensure prompt revision of care plans; this will be accomplished by reviewing the care plans, observation of the resident and/or consulting with the resident and/or family and consulting the IDT to ensure the care plan is accurate and interventions are being followed as advised.</p> <p>6. The Administrator will ensure compliance, by checking and monitoring the audits at the end of each month. The Administrator will bring the QA to the QA committee quarterly for further review. At which time the information from the QA conducted by the DON or designee will be reviewed, analyzed and utilized to ensure compliance.</p> <p>Alleged Date of Compliance: March 14<sup>th</sup>, 2014</p>	

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F 280	<p>Continued From page 8</p> <p>were not prescription glasses. SRNA/KMA #1 and SRNA #2 indicated Resident #13 did not wear his/her glasses; he/she would remove the glasses if staff put them on him/her. They indicated after the resident removed the glasses he/she would "play" with them.</p> <p>Interview, on 02/19/14 at 3:30 PM, with Registered Nurse (RN) #1 revealed Resident #13 took his/her glasses off and played with them. She indicated Resident #13's family had taken the glasses home as the resident no longer required them.</p> <p>Interview, on 02/20/14 at 3:55 PM, with Resident #13's daughter revealed she had taken the resident's glasses home with her because the glasses were broken. According to the resident's daughter, Resident #13 had cataracts, was legally blind and did not require the use of glasses anymore. She indicated the resident's glasses had been reading glasses, not prescription glasses.</p> <p>Interview, on 02/19/14 at 3:40 PM, with the RN Supervisor/Unit Manager revealed Resident #13's daughter had taken the resident's glasses home with her as he/she played with the glasses which were now broken. She stated she did not know why the glasses were an intervention on Resident #13's care plan as the resident did not require them any longer, and they were no longer at the facility for the resident's use. She indicated she thought Resident #13's care plan had been revised in regards to this. After reviewing the care plan, she indicated it should have been revised to include the information that Resident #13 no longer used his/her glasses and they were no longer at the facility for the resident to use.</p>	F 280		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure services were provided in accordance with each resident's written Plan of Care for one (1) of twenty-four (24) sampled residents (Resident #8).</p> <p>Resident #8's Comprehensive Care Plan revealed a care plan for vision impairment related to the resident's diagnosis of Glaucoma. Interventions included staff to ensure Resident #8 had his/her glasses on when up out of bed; to assist the resident to wear the glasses; and assist with the care and repair of the glasses. However, observations during the survey revealed Resident #8 was not wearing his/her glasses.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Advance Care Planning", undated, revealed staff were required to follow the care plan as documented. Review revealed if staff were unable to follow the care plan the reason why was to be documented in the resident's medical record.</p> <p>Observations of Resident #8 in the dining room/television area on 02/18/14 at 3:59 PM, 4:29 PM and 4:43 PM; on 02/19/14 at 9:20 AM,</p>	F 282	<p>F282 Services by Qualified Persons/Per Care Plan</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan or care.</p> <ol style="list-style-type: none"> <li>1. Resident #8 showed no ill effects from the alleged deficient practice.</li> <li>2. Resident #8 glasses were immediately located on 2/20/2014 and staff assisted resident #8 to don her eye glasses.</li> <li>3. LPN #5 and STNA #8 were in serviced by Memory Care Unit Manager on 2/20/2014 on the facility's policy "advanced care planning" and following the care plan.</li> <li>4. A facility wide audit was conducted on 2/21, 2/24 and 2/25/2014 by the DON and Unit Managers, whereas all care plans were reviewed, residents monitored and IDT consulted to ensure all care plan Interventions were implemented and no other residents were affected by the alleged deficient practice.</li> </ol>	
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F 282	<p>Continued From page 10</p> <p>9:30 AM, 10:10 AM, 10:50 AM, 11:00 AM, 11:40 AM, 12:30 PM, 12:45 PM, 1:10 PM, and 3:20 PM; and on 02/20/14 at 10:46 AM and 11:00 AM revealed the resident to be up in his/her wheelchair with no glasses on. Continued observation at those times revealed no observation of staff assisting the resident to wear his/her glasses.</p> <p>Interview with Resident #8 at 12:30 PM on 02/19/14, revealed he/she stated he/she did not know where his/her glasses were. Resident #8 stated he/she needed the glasses for reading.</p> <p>Review of Resident #8's medical record revealed diagnoses which included Dementia, Alzheimer and Glaucoma. Further review of the record revealed no documented evidence of why Resident #8 was not wearing his/her glasses. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 12/14/13, revealed the facility assessed the resident to have short term and long term memory impairments; and to be severely impaired in daily decision making. Further review of the MDS revealed the facility assessed Resident #8 to have impaired vision and to require corrective lenses (glasses).</p> <p>Review of Resident #8's Comprehensive Care Plan, revealed a care plan for vision impairment related to a diagnosis of Glaucoma, with an initiated date of 04/21/12, which had a goal of the resident to have had no decline in his/her visual function. Review of the interventions revealed staff were to ensure the resident had his/her glasses on when up out of bed; to assist the resident with wearing the glasses; and assist with the care of his/her glasses as needed.</p>	F 282	<p>5. All nursing staff was In-serviced on following the care plans by DON, LTC, Rehab and MC Unit Managers and Supervisors on 3/7, 3/8, 3/9 and 3/10/2014.</p> <p>6. A QA will be conducted by DON or designee on 3 residents a week for 12 weeks to ensure all interventions are implemented and staff are following resident's written care plan. This will be accomplished by reviewing the care plans, observations of the resident and/or consulting the resident and/or family and consulting the IDT to ensure the care plan is accurate and interventions are being followed as advised.</p> <p>7. The Administrator will ensure compliance, by checking and monitoring the audits at the end of each month. The administrator will bring the QA to the AQ committee quarterly for further review. At which time the information from the QA conducted by the DON or designee will be reviewed, analyzed and utilized to ensure compliance.</p> <p>Alleged Date of Compliance: March 14<sup>th</sup>, 2014</p>		

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NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6976 BURLINGTON PIKE FLORENCE, KY 41042	

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F 282	<p>Continued From page 11</p> <p>Review of Resident #8's "Kardex Report" dated 02/19/14 revealed staff were to ensure the resident was wearing his/her glasses when up out of bed.</p> <p>Interview with the Long Term Care (LTC) Unit Manager on 02/20/14 at 11:32 AM revealed the KARDEX Report was utilized to ensure nursing staff were aware of residents' care needs. She indicated the "Kardex Report" was based on residents' Comprehensive Care Plans. According to the LTC Unit Manager, the information on the "Kardex Report" was provided to the Charge Nurse who made the nursing assistants aware of the care plan information to ensure residents' care needs were met.</p> <p>Interview with the Memory Care Unit Manager on 02/20/14 at 2:32 PM, revealed the "Kardex Report" was based off information located on residents' Comprehensive Care Plans. She stated the care plans assigned an area of focus; and the "Kardex Report" system tracked the information to ensure residents' care needs were met per the care plan.</p> <p>Interview with SRNA #8 on 02/19/14 at 12:15 PM, who provided care for Resident #8, revealed she could not locate the resident's glasses; and did not know why the resident was not wearing his/her glasses. SRNA #8 indicated Resident #8's "Kardex Report" revealed the resident was care planned to have his/her glasses on with assistance from staff.</p> <p>Interview with LPN #5 on 02/19/14 at 12:20 PM, who provided care for Resident #8, revealed she had been employed at the facility since May 2013, and was unaware Resident #8 was to wear</p>	F 282		

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F 282	Continued From page 12 glasses. LPN #5 stated she had not ever seen Resident #8 wearing glasses since she had been working at the facility. She indicated she was not aware the resident was care planned to wear glasses.  Interview with the Memory Care Unit Manager on 02/19/14 at 12:21 PM, revealed Resident #8 used to have glasses; however she was not aware of where the glasses were at that time. The Memory Care Unit Manager reviewed the Resident #8's care plan and stated it indicated the resident was to wear glasses when up out of bed. An additional interview with the Memory Care Manager on 02/19/14 at 12:35, revealed she had contacted Resident #8's family, and the resident's family had informed her the resident's glasses were there at the facility. She indicated however she had been unable to locate the resident's glasses and had completed a "missing item" report. According to the Memory Care Unit Manager, Resident #8 should have had his/her glasses on as per the care plan.  Interview with RN #3 on 02/20/14 at 10:51 AM, revealed Resident #8 was to wear glasses as per the care plan. RN #3 stated Resident #8 was not wearing glasses per his/her care plan as he/she was a Dementia resident and sometimes removed his/her glasses. According to RN #3, the nursing assistants had to assist Resident #8 to put his/her glasses back on when he/she removed them. RN #3 indicated she was not aware of why Resident #8 was not wearing his/her glasses.	F 282			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371			

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F 371	<p>Continued From page 13</p> <p>The facility must -</p> <ul style="list-style-type: none"> <li>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</li> <li>(2) Store, prepare, distribute and serve food under sanitary conditions</li> </ul> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and review of the facility's policy and documents, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by food ingredient bins observed during initial tour of the facility to be visibly soiled on the outside with greasy lids; and the Long Term Care (LTC) Unit's kitchenette/nourishment room observed to have undated and unlabeled food products in the refrigerator and storage areas.</p> <p>The findings include:</p> <ul style="list-style-type: none"> <li>1. Review of the facility's policy titled, "General Sanitation", dated 11/27/11, revealed the food service area was to be maintained in a clean and sanitary manner.</li> </ul> <p>Observation, on 02/18/14 at 11:15 AM, during the initial kitchen tour revealed food ingredient bins which were visibly soiled and had greasy lids.</p> <p>Review of the Dietary Department cleaning schedule revealed food ingredient bins were not on the schedule to be cleaned; or assigned on</p>	F 371	<p>F 371 483.35(j) Food Procure, Store/Prepare/Serve-Sanitary</p> <p>The facility must procure food from sources approved or considered satisfactory by federal, state or local authorities and store, prepare, distribute and serve food under sanitary conditions</p> <ul style="list-style-type: none"> <li>1. There were no negative outcomes to any resident due to the food ingredient bins exterior surface being soiled and having "greasy lids".             <ul style="list-style-type: none"> <li>a. Inservice of dietary staff on 3/7/2014 regarding cleaning of food ingredient bins being added to "Dietary Department Cleaning Schedule".</li> <li>b. Cleaning of ingredient bins added to Daily cleaning routine.</li> <li>c. Dietary Director or designee to perform QA on "Dietary Cleaning Schedule" completion with the following schedule:                 <ul style="list-style-type: none"> <li>i. Daily for 1 month;</li> <li>ii. Weekly for Months 2-3;</li> <li>iii. Quarterly thereafter forever.</li> </ul> </li> <li>d. QA results shall be reported to the QA Committee quarterly by the Dietary Director or Designee, and kept on file.</li> <li>e. Dietary Director or Designee shall oversee all department functions to maintain compliance with regulations.</li> </ul> </li> <li>2. There were no negative outcomes to any resident due to the LTC Refrigerator containing undated/unlabeled popsicles, whipped cream type salad, oreo cookie packs, oranges in a plastic bag, saltine crackers in a plastic bag. There were no negative outcomes to any resident due to a "dried yellow liquid" on the bottom of the refrigerator.             <ul style="list-style-type: none"> <li>a. Inservice of dietary staff on 3/7/14 regarding proper labeling and dating of food items for distribution and storage to include:                 <ul style="list-style-type: none"> <li>i. Facility provided items</li> </ul> </li> </ul> </li> </ul>	

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F 371	<p>Continued From page 14</p> <p>the weekly Dietary Sanitation Routine Cleaning Schedule.</p> <p>Interview, on 02/20/14 at 10:10 AM, with the Dietary Manager revealed food ingredient bins and lids were to be wiped off daily. He indicated it appeared this had not been done. He stated the food ingredient bins were scheduled to be pressured washed when the weather improved.</p> <p>2. Review of the facility's policy titled, "Nourishments" undated, revealed nourishments were to contain the date prepared, the expiration date, and the food item's name or marking which identified what the product was. Continued review of the policy revealed in general, resident-personal items had a shelf life of three days, the date of refrigeration plus two (2) additional days. Nourishments were to be rotated using the FIFO (First In/First Out) method to ensure maintenance of product freshness. Additionally, review of the policy revealed nourishments were to be removed from the servable-stock upon the date of expiration and discarded.</p> <p>Review of the facility's document titled, "New Hire Orientation Packet Dietary Department", updated 07/28/11, revealed all resident food items which required refrigeration might be placed in kitchenette refrigerators, however these food items were to be labeled with the resident's name, the date placed in the refrigerator, and contain an expiration date of three (3) days after the date the food was saved.</p> <p>Observation, on 02/18/14 at 12:50 PM, of the kitchenette/nourishment room on the LTC Unit, revealed the refrigerator/freezer was observed to</p>	F 371	<ul style="list-style-type: none"> <li>ii. Resident/Family provided items.</li> <li>b. Inservice of Nursing Staff on 3/10/14 regarding correct labeling/dating and storage of resident items.</li> <li>c. Dietary Director or designee to perform QA on Kitchenette Refrigerators and food storage to check for proper labeling/dating of food products and cleanliness with the following schedule:             <ul style="list-style-type: none"> <li>i. Daily for 1 month;</li> <li>ii. Weekly thereafter forever;</li> </ul> </li> <li>d. QA results shall be reported to the QA Committee quarterly by the Dietary Director or Designee, and kept on file.</li> <li>e. Dietary Director or Designee shall oversee all department functions to maintain compliance with regulations.</li> </ul> <p style="text-align: right;">Alleged Date of Compliance: March 14, 2014</p>	

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F 371	Continued From page 15 have twenty (21) loose popsicles which were undated and unlabeled; a whipped cream type salad in a clear bowl in a plastic bag undated and not identified as to what the food item was; eight (8) Oreo snack packs undated; a plastic bag of three (3) oranges in a drawer labeled with a resident name, however undated; and a dried yellow liquid on the bottom of the refrigerator. Continued observation of the kitchenette/nourishment room revealed saltine crackers in a plastic zip lock bag which was undated.  Interview, on 02/19/14 at 4:20 PM, with the Dietary Manager revealed specific dietary staff members were assigned the refrigerator/freezer in the nourishment rooms who were to record the temperatures and rotate the stock. He stated the snacks items should have been dated with the date of preparation and an expiration date. Continued interview revealed he or another staff member checked the kitchenette/nourishment room areas periodically for cleanliness and to ensure food items were labeled and dated as per facility policy. He indicated the food items observed on 02/18/14, by the Surveyor should have been identified by name, dated and labeled. He stated Housekeeping was responsible for cleaning those areas.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431		

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F 431	<p>Continued From page 16</p> <p>controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure drugs and biologicals were labeled in accordance with currently accepted professional principles, and included the expiration date when applicable as evidenced by observation of the emergency crash carts revealed expired items available for resident use; and two (2) of the emergency crash carts were</p>	F 431	<p>F431 Drug Records, Label/Store Drugs &amp; Biologicals</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <ol style="list-style-type: none"> <li>No residents were adversely affected from the alleged deficient practice.</li> <li>LTC, Rehab and Memory Care Unit crash carts were audited by the Unit Managers on 2/20/2014 to assure that no out dated supplies, expired medications or any medications were being stored in the crash cart.</li> <li>Central supply room and all medication/supply closet were audited on 2/20/2014 by DON, LTC, Rehab and MC Unit Managers and Central Supply employee to assure no out dated supplies or medications were being stored as well as no medications were being stored inappropriately.</li> </ol>

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F 431	<p>Continued From page 17</p> <p>unlocked and observed to contain expired Heparin Lock Flush solutions.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Crash Cart Policy", dated 02/18/14, revealed the central supply clerk or designee was responsible for removing discontinued, unnecessary or expired items from the facility's crash carts.</p> <p>Review of the facility's policy titled, "Medication Storage", dated 03/01/10, revealed expired, outdated, contaminated or deteriorated medications were to be immediately withdrawn from stock. Further review revealed the facility would not use discontinued, outdated, or deteriorated drugs or biologicals; and these medications were to be returned to the dispensing pharmacy or destroyed. Continued review revealed compartments containing drugs and biologicals were to be locked when not in use.</p> <p>Observation on 02/18/14 at 12:10 PM, of the Long Term Care (LTC) Unit emergency crash cart, revealed it was unlocked and contained the following expired or outdated contents: a basic spill clean up kit opened with an expiration date of November 2008; two (2) bottles of 100 milliliter (ml) Normal Saline (NS) with a manufacturer expiration date of May 2013; an Intravenous (IV) Start Kit with a manufacturer expiration date of July 2012; four (4) pair of size large sterile gloves with a manufacturer expiration date of October 2014; and three (3) Heparin Lock Flush Syringes with a manufacturer expiration date of 02/15/13.</p> <p>Observation on 02/18/14 at 4:30 PM, of the</p>	F 431	<p>4. Unit Manager and Central supply were in-serviced by the DON on 2/20/2014 on the Crash Cart Policy and the medication storage policy.</p> <p>5. All RNs and LPNs were in-serviced on 3/7, 3/8, 3/9 and 3/10/2014 by the DON and the LTC, Rehab and MC Unit Managers on the crash cart</p> <p>policy and medication storage policy.</p> <p>6. A QA will be conducted by DON or designee on one supply or medication storage, including narcotic storage, area a week for 12 weeks to ensure no expired supplies or medications or inappropriately stored medications as well as medications/supplies are labeled correctly and monitor for compliance for entire F tag 431.</p> <p>7. The Administrator will ensure compliance by checking and monitoring the audits at the end of each month. The Administrator will bring the QA to the QA committee quarterly for further review. At which time the information from the QA conducted by the DON or designee will be reviewed, analyzed and utilized to ensure compliance.</p> <p>Alleged Date of Compliance: March 14<sup>th</sup>, 2014</p>	

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NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042	

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F 431	<p>Continued From page 18</p> <p>Memory Care Unit emergency crash cart revealed two (2) Heparin Lock Flush Syringes with a manufacturer expiration date of 02/15/13.</p> <p>Observation on 02/20/14 at 2:25 PM, of the Rehabilitation Unit emergency crash cart revealed a Yankauers Suction Tip Catheter with a manufacturer expiration date of November 2012.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 02/20/14 at 2:47 PM, revealed night shift staff was responsible for restocking the emergency crash cart. She stated she did not know how often the emergency crash cart was checked for accuracy and expired items. Continued interview revealed the expired items should not have been on the emergency crash carts available for resident use.</p> <p>Interview with the LTC Unit Manager on 02/20/14 at 2:53 PM, revealed Central Supply was responsible for the accuracy of the contents of the emergency crash cart. The LTC Unit Manager stated expired items were not to be on the emergency crash cart available for resident use. Further interview revealed the Heparin Lock Flushes should not have been on the emergency crash cart; those items should have been stored in a locked container.</p> <p>Interview with the Central Supply Coordinator on 02/20/14 at 3:48 PM, revealed the accuracy of the emergency crash cart was his responsibility. He stated the emergency crash carts were checked at least once a month for accuracy and expired products. He indicated the emergency crash carts had been last checked the week of 01/27/13. The Central Supply Coordinator stated expired items should have been removed from</p>	F 431		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/20/2014
NAME OF PROVIDER OR SUPPLIER  FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042		
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F 431	Continued From page 19 the emergency crash carts and not available for resident use. Further interview revealed Heparin Lock Flushes should not have been stored in the emergency crash carts.  Interview with the Director of Nursing (DON) on 02/20/14 at 4:08 PM, revealed Central Supply was responsible for accuracy of the emergency crash cart to include checking for expired products/medications. The DON stated expired items should have been removed from the emergency crash carts. According to the DON, the expired items should not have been available for resident use due to the inability to ensure the integrity of the item past the manufacturer's expiration date. Further interview revealed Heparin Lock Flushes should not have been stored in the emergency crash carts. The DON indicated the Heparin Lock Flushes should have been stored in a locked area.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	F441 Infection Control, Prevent Spread, Linens  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  1. No residents were adversely affected from the alleged deficient practice.		

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F 441	<p>Continued From page 20</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens 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 review of the facility's policy, it was determined the facility failed to maintain an Infection Control Program in order to provide a safe, sanitary and comfortable environment and to help prevent, recognize and control, to the extent possible, the onset and spread of infection within the facility.</p> <p>Observation during initial tour of the community bathroom on the Long Term Care (LTC) Unit, revealed the shower table mat to have tears in the foam rubber.</p> <p>The findings include:</p>	F 441	<ol style="list-style-type: none"> <li>The torn shower bed was removed from the shower room and placed in storage on 2/19/2014 and the shower table mat was removed and a new shower table mat was ordered on 2/19/2014 and placed on the shower bed on 2/20/2014.</li> <li>SRNA #2 was educated on 2/19/2014 on reporting any needed repairs by the LTC Unit Manager.</li> <li>A facility wide audit was conducted by DON, Maintenance Director and LTC, Rehab and MC Unit Manager on 2/21/2014 through rounds to observe equipment, staff providing resident care and on all equipment to assure all equipment was functional and free from tears or damage. A facility wide audit was conducted on 2/21, 2/24 and 2/25/2014 by the DON, Maintenance Director and LTC, Rehab and MC Unit Managers through rounds to observe equipment, environment and staff providing care to assure no infection control issues were noted.</li> <li>All staff was in-serviced on 3/7, 3/8, 3/9 and 3/10/2014 by the DON and the LTC, Rehab and MC Unit Managers on reporting</li> </ol>	

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F 441	<p>Continued From page 21</p> <p>Review of the facility's policy titled Infection Control Program, undated, revealed the infection control committee monitored staff performance to ensure that infection control policies and procedures were properly implemented.</p> <p>Review of the facility's policy titled, "Procedure for Cleaning Bathing Facilities", undated, revealed staff were to clean and sanitize any equipment such as bath mats, shower beds and shower chairs. Continued review revealed staff should report any needed repairs.</p> <p>Observation on 02/18/14 at approximately 12:10 PM of the LTC Unit Shower room during initial tour, revealed the shower table foam rubber mat to have been torn and cracked.</p> <p>Interview with State Registered Nursing Aide (SRNA) #2 on 02/19/14 at 3:51 PM, revealed residents were placed directly on the torn shower table mat. She indicated however, she had not been aware it was torn. SRNA #2 stated the torn mat could be an infection control issue due to the cracks in the mat.</p> <p>Interview with the Maintenance/Environmental Service Director on 02/19/14 at 3:46 PM, revealed the the shower/bath table mat should not have been in service to be utilized for resident use due to a potential for contamination. He indicated it should have been replaced to prevent possible contamination.</p> <p>Interview with Registered Nurse (RN) #1 on 02/19/14 at 3:49 PM, revealed the bath/shower table mat with torn and cracked areas on it could be an infection control issue and should have been replaced.</p>	F 441	<p>any necessary repairs and the Infection control policy.</p> <p>6. A QA will be conducted by DON or designee by making rounds on 3 residents/resident areas 3 times a week for 12 week monitoring and observing environment, equipment and staff providing resident care to assure equipment is functional, free from cracks and/or tears and infection control policy is being followed.</p> <p>7. The Administrator will ensure compliance by checking and monitoring the audits at the end of each month. The Administrator will bring the QA to the QA committee quarterly for further review. At which time the information from the QA conducted by the DON or designee will be reviewed, analyzed and utilized to ensure compliance.</p> <p>Alleged Date of Compliance: March 14<sup>th</sup>, 2014</p>	

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F 441	Continued From page 22  Interview, on 02/20/14 at 4:06 PM, with the Director of Nursing (DON), who was filling in for the Infection Control Nurse who was not present at the time, revealed she was not aware the bath/shower table mat in the shower room was torn. The DON stated the bath/shower table mat with visible tears in the rubber material should not have been in the shower room for resident use as this was an infection control issue related to possible cross contamination. According to the DON, she had received no reports of negative outcome as a result of the torn bath mat; however indicated the potential was there.	F 441		

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{K 000}	INITIAL COMMENTS  On 4/7/14 a desk review was completed of the facilities plan of correction and was found to be acceptable. The facility meets the requirements for participation in the Medicare and Medicaid program.	{K 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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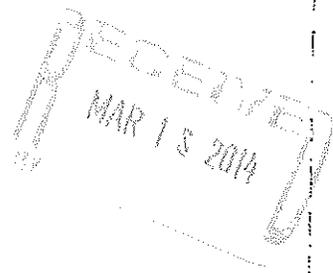
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type V (000)</p> <p>Smoke Compartment: Nine (9)</p> <p>Fire Alarm: Fire alarm with single station smokes in resident rooms</p> <p>Sprinkler System: Complete sprinkler system (wet and dry)</p> <p>Generator: Type II. Diesel installed 1999</p> <p>A standard Life Safety Code survey was conducted on 02/19/14. Florence Park 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-five (135). The facility is licensed for one hundred fifty (150).</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "E" level.</p>	K 000		
K 072 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant</p>	K 072		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *03/13/14*

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 072	Continued From page 1 use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with National Fire Prevention Association (NFPA) standards. The deficiency had the potential to affect two (2) smoke compartment, forty-four (44) residents, staff, and visitors. The facility is licensed for one hundred fifty (150) beds with a census of one hundred thirty-five (135) on the day of the survey.  The findings include:  Observation, on 2/19/14 between 8:00 AM and 12:00 PM with the Maintenance Director revealed two (2) computer keyboards mounted on a wall in a flip down tray. One (1) in B Wing Rehab Hall and one(1) in A Wing Short Hall. Means of egress must remain clear of all obstructions and impediments at all times in case of emergency or fire.  Interview, on 2/19/14 at 8:25 AM, with the Maintenance Director revealed he was not aware of this requirement.  Interview on 2/19/14 at 12:30 PM, with the Administrator revealed he would have the trays replaced with a spring loaded trays that would retract upright when not in use and would be compliant.	K 072	K 072 NFPA 101 Life S C Standard  Means of Egress are continuously maintained free of all obstructions and or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other Objects obstruct exits, access to, egress from or visibility of exits.  1. There were no negative outcomes to any resident due to the computer keyboards mounted in the hallways on a flip down tray, being in the downward position. a. The spring loaded trays are not available at this time: All staff were in-serviced by the DON, Maintenance Director, Unit Managers and the Clinical Coordinator on March 7 <sup>th</sup> , 8 <sup>th</sup> , 9 <sup>th</sup> and 10 <sup>th</sup> /2014 to push the flip trays back into the wall so that they don't protrude into the hallway and restrict access to the exits. b. A QA will be conducted by the Maintenance Director or his designee on a daily basis for one month and then weekly forever. c. This will be monitored by the DON and Administrator and they will ensure compliance.  Alleged Date of Compliance:03/14/2014	

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K 072	Continued From page 2  Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the facility had an adequate number of electrical receptacles to meet the needs of residents without the use of extension cords or multiple outlet adapters according to National Fire Protection Association (NFPA). The deficiency had the potential to affect one (1) smoke compartment, one (1) resident, staff and visitors.  The findings include:  Observation, on 2/19/14 at 9:00 AM, with the Maintenance Director revealed multi-outlet strip being used as permanent wiring. Medical equipment and phone charger were observed plugged into power strips in the Physical Therapy Department. In addition, extension cords and multi-outlet strips cannot be used as a substitute for permanent wiring.	K 147	K 147 NFPA 101 Life Safety Code Standard – Electrical wiring and equipment is in accordance with NFPA 70, National Electric Code 9.1.2  1. There were no negative outcomes to any resident due to the use of a multi-outlet power strip used as permanent wiring in the Physical Therapy Department. a. Physical Therapy Department Staff in-serviced on 2/24/2014 regarding the requirement that no multi-outlet power strips be used as permanent wiring. b. Multi-Outlet power strip was removed from the Physical Therapy Department on 2/24/2014 c. Environmental Services Director or Designee to perform QA to ensure no multi-outlet power strips are used in the Physical Therapy Department with the following frequency: i. Weekly for month 1; ii. Monthly for months 2-3 iii. Quarterly thereafter forever. iv. QA shall be reported to the Administrator and kept on file.  Alleged Date of Compliance:03/14/2014

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K 147	<p>Continued From page 3</p> <p>Interview, on 2/19/14, at 9:00 AM, with the Maintenance Director revealed he was unaware of the power strips being used in Physical Therapy.</p> <p>Interview on 2/19/14 at 12:30 PM with the Administrator revealed he would have the power strip removed immediately and would educate the Physical Therapy staff on the prohibited use of power strips in the facility.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-3.2.1.2 D</p> <p>2. 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.</p> <p>Reference: NFPA 70 (1999 Edition).</p> <p>400-8. Uses Not Permitted</p> <p>Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> <li>1. As a substitute for the fixed wiring of a structure</li> <li>2. Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</li> <li>3. Where run through doorways, windows, or similar openings</li> <li>4. Where attached to building surfaces</li> </ol> <p>Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8.</p> <ol style="list-style-type: none"> <li>5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped</li> </ol>	K 147		
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K 147	Continued From page 4 ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code.	K 147		
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