

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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
(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 standard health survey was conducted on 09/18-20/12 and a Life Safety Code survey was conducted on 09/18/12 with deficiencies cited at the highest scope and severity at an "F". The facility had the opportunity to correct the deficiencies before imposition of remedies would be recommended.	F 000	This Plan of Correction is submitted under Federal and State Regulation and status applicable to Long Term Care Providers. This Plan of Correction does not constitute an admission of liability on the part of the facility as such liability is hereby denied. The submission of this Plan does not constitute an agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Furthermore, we request this Plan of Correction service as our credible allegation of compliance.	
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.	F 156	Please note that anywhere that poc states Interim Director of Nursing that it will change to Director of Nursing when the facility officially fills the position of Director of Nursing. F 156 1. CORRECTIVE ACTION TAKEN FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The Activity Director informed Resident #3 verbally on 9-19-12 that he could go outside without supervision when he wanted to do so. A written copy of Resident Rights was reviewed with and given to Resident # 3 on	10/25/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____
Kara M. Meredith Executive Director 10-24-12

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.

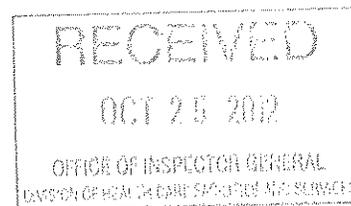
DK

RECEIVED
OCT 25 2012
OFFICE OF INSPECTOR GENERAL
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

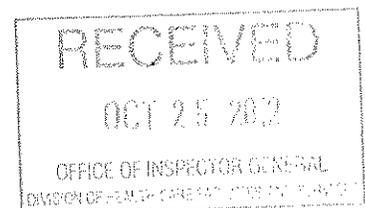
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004		
(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 156	<p>Continued From page 1</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements</p>	F 156	<p>10-9-12 to ensure that he is aware of all of his rights by an Assistant Activity Director. A resident council meeting was held on 9/19/12 by the Activity Director to address that alert and oriented residents could go outside without supervision when they want to do so. An additional residents council meeting was held on 10/22/12 to address that all other residents could go outside upon request with supervision. A written copy of resident rights was reviewed and given to all current residents, and mailed or given to responsible parties, family members and/or POA's to ensure that he/she is aware of all of his/her rights by the Activity Director or an Assistant Director on or by 10/22/12.</p> <p>2. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All alert and oriented residents with a BIM score of 13 or greater were made aware by the Activity Director verbally on 9-19-12 and a resident council meeting was held on 9/19/12 by the Activity Director to address that alert and oriented residents could go outside without supervision when they want to do so. An additional residents council meeting was held on 10/22/12 to address that all other residents could go outside upon request with supervision. A written copy of Resident Rights was reviewed with</p>	



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

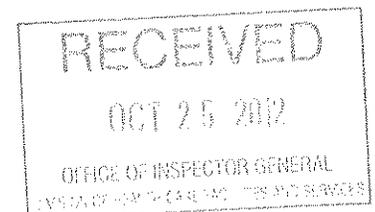
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
(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 156	<p>Continued From page 2</p> <p>specified in subpart l of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and review of the facility's Resident Council meeting minutes, it was determined the facility failed to inform residents in writing when the facility amended the rules regarding residents' access to the outside of the facility. The facility stopped abruptly, and without written notice, allowing residents access to the front porch without staff supervision.</p> <p>The findings include:</p>	F 156	<p>and given to all current Residents with a BIM score of 13 or greater by 10-9-12 to ensure that he/she is aware of all of his/her rights by the Activity Director or an Assistant Activity Director. A written copy of resident rights was reviewed and given to all current residents, and mailed or given to responsible parties, family members and/or POA's to ensure that he/she is aware of all of his/her rights by the Activity Director or an Assistant Director on or by 10/22/12.</p> <p>3. MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Any amendments to current facility rules will be addressed verbally and in writing by the Activity Director (or the Social Services Director in her absence) during the Resident Council and/or individually with residents, responsible parties, family members and/or POA's prior to changes being implemented. All staff will be re-educated on resident rights by the Social Services Director on or by 10-24-12.</p> <p>4. FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED: The Social Services Director (or the Executive Director in her absence) will address the Residents Council monthly</p>



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

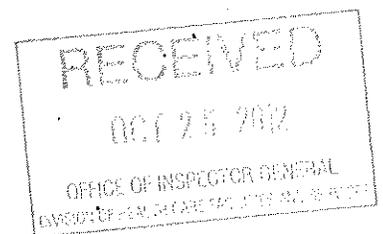
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
(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 156	<p>Continued From page 3</p> <p>Review of the Resident Council minutes, dated 06/27/12, revealed residents in attendance were requesting to go outside for awhile each week- at least once. The response from the activity department was given on 08/16/12 that indicated they would schedule a group activity outdoors at least one time a week. The Activity Coordinator wrote in the minutes the residents could go outside with her; however, they would have to request a time.</p> <p>Interview with the resident group, on 09/18/12 at 2:00 PM, revealed Resident #3 wanted to be able to sit outside on the front porch. Further interview revealed the facility would not allow the resident (who the facility identified with no cognition impairment) to sit outside on the front porch without staff supervision. The resident stated he/she loved to sit outside for extended periods of time and with the required staff supervision, the resident could not stay outside as much as they would like. The resident revealed he/she use to sit outside on the front porch for hours and converse with visitors coming into the facility.</p> <p>Interview with the five (5) residents in attendance of the group meeting five (5) revealed they too would like to go outside whenever they wanted; however, they could not due to the facility rule that staff had to always supervise residents outside. The residents stated they just stopped asking to go outside.</p> <p>Interview with the Executive Director (ED), on 09/19/12 at 2:15 PM, revealed she had only been at the facility for two months and was unaware of any rule that residents could not go outside without staff supervision. She stated if a resident</p>	F 156	<p>times 3 months and then quarterly times 2 quarters to determine if any residents with a BIM score of 13 or greater are requesting to go outside unsupervised are being permitted to do so and that residents requiring supervision are being taken outside upon request or with planned activities. The plan of correction will be integrated into the facility's Performance Improvement process where results will be reviewed and monitored by the Performance Improvement Committee to ensure on-going compliance over the next 3 months and quarterly times 2 quarters thereafter. If at any time concerns are identified during this process; the Performance Improvement Committee will be convened to analyze and recommend any further interventions deemed appropriate.</p> <p>5. Compliance date 10/25/2012.</p>



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
(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 156	Continued From page 4 was not an elopement risk, they had the freedom to come and go from the facility. The ED stated there was no policy regarding the new rule. Interview with the Activity Coordinator, on 09/19/12 at 2:30 PM, revealed sometime in the past, the prior ED made that decision. The ED had all the rocking chairs removed from the front porch and told the residents (verbally) that they could not go outside without staff. To her knowledge there were no Policy and Procedures developed and no written notice was given to the residents.	F 156		10/25/12
F 170 SS=C	483.10(l)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interview and review of the admission packet information, it was determined the facility failed to ensure all residents received and was able to send mail on Saturday. The facility had stopped the mail from being delivered and the Postal Service did not pick up mail from the facility on Saturday. The findings include: Review of the admission packet information, dated 2002 and given to each resident and family representative upon admission to the facility, revealed the Bill of Rights were included. Under	F 170	F 170 1. CORRECTIVE ACTION TAKEN FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No specific resident was identified. It was stated that during the group meeting on 9/18/12 revealed that residents did not receive mail on Saturdays. No adverse effect was found related to residents not receiving mail on Saturdays. The BOM notified the Post Office on 9/19/12 to initiate mail delivery on Saturday's beginning 9/22/2012. 2. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this practice. The BOM notified the Post Office on 9/19/12 to initiate mail delivery on Saturday's beginning on 9/22/12. The Interim Director of Nursing notified the Post Office on 9/22/2012 to ensure the mail delivery was scheduled for Saturdays and would be delivered beginning 9/22/2012. 3. MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT	



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

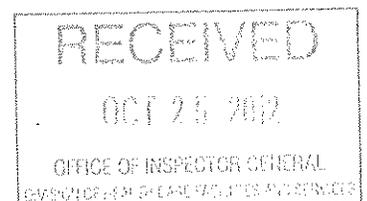
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
(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 170	Continued From page 5 the Bill of Rights (#20), the resident has the right to send and receive mail promptly that was unopened. During the group resident meeting, on 09/18/12 at 2:00 PM, the residents revealed they did not receive mail on Saturday. Interview with the front desk receptionist, on 09/19/12 at 1:50 PM, revealed mail was delivered to the facility Monday-Friday. She stated she had worked at the facility for a year and mail had never been delivered on Saturday. She did not know why but would call the Post Office. Interview with the Business Officer Manager, on 09/19/12 at 2:15 PM, revealed she had spoken with the local Post Office to ask why mail was not delivered to the facility on Saturday. She stated the Post Office personnel informed her that sometime in the past, someone from the nursing facility requested Saturday mail be held. She could not say who or when that occurred. The facility Administrator was present during the interview and stated she was unaware there was no Postal Services for the residents on Saturday.	F 170	F 170 RECUR: The post office was called on 9/19/12 by the BOM and informed that the facility would like to ensure that mail would be delivered to the facility on Saturdays effective 9/22/2012. The Interim Director notified the Post Office on 9/22/2012 to ensure the mail delivery was scheduled for Saturdays and would be delivered beginning 9/22/2012. The Activity Director educated her assistants on 9-21-12 that mail was to be delivered to residents by them on Saturdays effective 9/22/2012. The Manager on Duty Assignments for the weekends now includes a form to ensure that resident's mail is delivered on Saturdays. The Manager on Duty forms addresses mail delivery on Saturdays. The mail delivery forms will be reviewed every Monday morning by the Executive Director to ensure that mail was delivered to residents on the previous Saturday.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of	F 241	4. FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED; The Activity Director (or the Social Services Director in her absence) will address the Residents Council monthly times 3 months and then quarterly times 2 quarters to ensure mail is being delivered	

F 170

when received on Saturdays to residents. The Executive Director will continue to review the Manager on Duty forms addressing mail delivery to ensure that mail was delivered on Saturdays monthly times 3 months and then quarterly times 2 quarters and the plan of correction will be integrated into the facility's Performance Improvement process where results will be reviewed and monitored by the Performance Improvement Committee to ensure on-going compliance over the next 3 months and quarterly times 2 quarters thereafter. If at any time concerns are identified during this process, the Performance Improvement Committee will be convened to analyze and recommend any further interventions deemed appropriate.

5. Compliance Date: 10/25/2012.

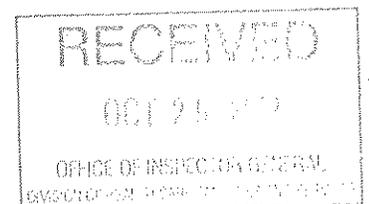
Page 6A



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
(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 241	Continued From page 6 the facility's policy, it was determined the facility failed to promote the care of a resident in a manner that maintained or enhanced the residents dignity and respect for one (1) of sixteen (16) sampled residents and one unsampled resident. Resident #6 and unsampled Resident B. Staff was observed pulling Resident #6 by both hands forward in a wheelchair with saliva drooling down the resident's face through the hallway to the dining room. Unsampled Resident B stated staff spoke to her/him in a disrespectful tone that hurt the resident's feelings and made the resident cry. The resident stated she/he was afraid of retaliation and tries to stay away from the staff member. The findings include: Review of the facility's policy titled dignity, revised on 06/17/2008, revealed the policy includes the federal regulation statement. In addition, the policy stated treating residents with dignity and respect maintains and enhances each resident's self worth and improves his/her psychosocial well-being and quality of life. Procedure included: assisting residents in daily care in a dignified manner and speaking to residents in a friendly and patient manner. 1. Interview during a group meeting conducted, on 09/18/12 at 2:00 PM, revealed three (3) of five (5) residents in attendance felt if they informed the surveyor of any problems, they would be retaliated against from the facility. The residents stated they did not feel comfortable complaining because they were afraid they would not receive care, i.e. pain medication, toileting assistance from staff. Further interview revealed unsampled	F 241	F 241 1. CORRECTIVE ACTION TAKEN FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The Director of Nursing at the time of the referenced survey is no longer employed at the facility effective 9/20/2012. FYI: An Interim Director of Nursing was put in place on 9/20/2012. Resident #6 was observed on 9/21/12 by Executive Director and exhibited no visible indicators of dignity concerns at this time i.e. monitored for hair clean and combed, oral mouth care completed, shaved, proper foot ware, clothing free from stains and tears, clothing free from food debris, nails clean and groomed, free from odors, staff speaking to resident in dining room sitting at eye level, etc... Resident #6 was reviewed on 10/4/2012 by the Executive Director and exhibited no visible indicators of dignity concerns at this time i.e. monitored for hair clean and combed, oral mouth care completed, shaved, proper foot ware, clothing free from stains and tears, clothing free from food debris, nails clean and groomed, free from odors, staff speaking to resident in dining room sitting at eye level, etc... The Social Services Director observed Resident #6 on 10/8/12 and he was wandering about the facility and being redirected by staff as needed. Staff	10/25/12



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

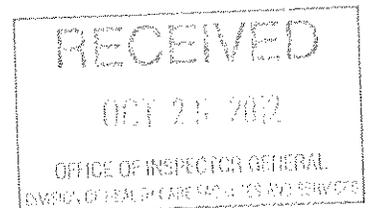
PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004		
(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 241	<p>Continued From page 7</p> <p>Resident B had an incident recently where the Director of Nursing (DON) had spoken to the resident in a manner that hurt the resident's feelings and made the resident cry.</p> <p>Interview with unsampled Resident A, on 09/19/12 at 1:15 PM, revealed the resident does not feel like he/she had protection when reporting a problem. The resident stated most staff treated him/her with respect; however, the DON had a short, curt tone to her voice and did not take seriously the problems reported. The resident indicated he/she felt comfortable speaking to the administrator but not the DON.</p> <p>Review of unsampled Resident A's clinical record revealed a quarterly assessment, dated 07/06/12, with a BIMS score of 15, no cognition deficit. The facility assessed the resident to have no mood or behaviors.</p> <p>Another interview with unsampled Resident B, on 09/19/12 at 4:30 PM, revealed the DON, accompanied by the housekeeping supervisor, came to the resident's room to talk with the resident regarding the temporary change of rooms while the resident's room was being renovated. The resident stated the DON started demanding the resident get rid of some personal items in the resident's room. The resident indicated the DON spoke sharp and made the resident cry. The resident said the DON made him/her angry and the resident yelled at the DON to leave the room. The resident indicated he/she had been retaliated against before when the resident reported a certified nursing assistant (CNA) for telling the resident, "We can't stand here and watch you peel!" The resident said staff</p>	F 241	<p>were paying attention to Resident #6. Therapy was working with Resident #6 for positioning and for tightness in trunk and legs. The Social Services Director also observed Resident #6 on 10/18/12 and noted that the resident was appropriately dressed and appeared more comfortable in his new wheelchair.</p> <p>Resident A was interviewed on 9/21/12 by the Social Services Director. Resident A denies any concerns with eating/sleeping or feelings of depression. She is very active in facility life and enjoys all activities. Her son and daughter-in-law take her on outings regularly.</p> <p>Resident B was observed by the Social Worker on 9/28/12 up and participating with therapy laughing and talking with staff. Social Worker also noted that she assisted Activities in a soup/chili sale to raise money for the Alzheimers Association. Social Worker visited Resident B on 10/17/12 and Resident B was tearful and stated that she was not crying about anything going on here—everyone is treating me fine; but asked for prayer for a family member. Resident B stated that "the mood has seemed to improve here over the past few weeks ever since the previous DON left—</p>		

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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

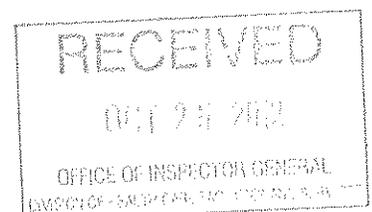
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
(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 241	<p>Continued From page 8 treated her/him different after that.</p> <p>Review of the clinical record for unsampled Resident B revealed the resident had resided at the nursing facility since May 2011. Review of the annual assessment conducted, on 9/12/12, revealed the resident had no cognition impairment with a Brief Interview for Mental Status (BIMS) score of fifteen (15). The assessment of the resident revealed the staff was told he/she felt down and depressed most days. No behaviors were identified. The facility assessed the resident to need extensive assist with bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. The care plan developed on 01/13/12 for Depression with interventions for staff to observe for tearfulness. Review of nurses notes dated 03/09/12 through 07/31/12 revealed no documentation of the resident crying.</p> <p>Interview with the Housekeeping Supervisor, on 09/20/12 at 8:15 AM, revealed she accompanied the DON to speak with unsampled Resident B sometime in July. She stated they were instructed in the morning meeting to speak with the resident regarding the impending move to another room. When they went in to speak with the resident, the DON did most of the talking, "I only observed." The DON told the resident that he/she had too much stuff and due to renovation, would have to get rid of some of the personal items. The housekeeping staff stated the resident began to cry and the DON said to the resident, "Why are you crying?" "You know we have to do this." She stated the resident continued to cry and the housekeeping supervisor was uncomfortable with the tone of the DON's voice. The housekeeping</p>	F 241	<p>everybody just seems happier" Resident B also went on a facility outing on 10/16/12 and has been active in facility activities.</p> <p>2. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents would have the potential to have been affected.</p> <p>All residents are to be cared for in an environment that maintains and enhances their dignity and respect in full recognition of the individual. Residents were observed to ensure for hair clean and combed, oral mouth care completed, men shaved/women free of facial hair, proper foot ware, clothing free from stains and tears, clothing free from food debris, nails clean and groomed, free from odors/ladies with lipstick etc., staff speaking to resident in dining room sitting at eye level, etc by the Executive Director, Interim Director of Nursing, Dietary Manager, Housekeeping Supervisor, Maintenance Director, BOM, Social Services Director, Rehab Manager, Activities Director, HIM and MDS Nurse(s) to ensure that dignity and respect were maintained by staff during care on 9-25-12.</p> <p>3. MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE</p>



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

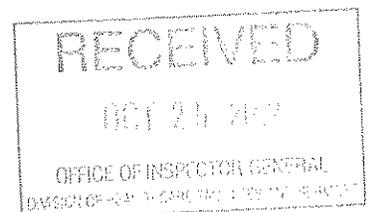
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004		
(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 241	<p>Continued From page 9</p> <p>supervisor said she did not think the DON meant to harm the resident, but she spoke in a curt, sharp tone and she doesn't realize the effect it may have on the residents. She revealed she returned to the resident's room later to comfort the resident. She acknowledged the resident cried again.</p> <p>Interview with the DON, on 09/20/12 at 2:55 PM, revealed she did go and speak with unsampled Resident B regarding the move to another room during renovation of the resident's room. The DON said she told the resident to get things packed up for the move. She indicated she wanted to help the resident get rid of clothing that didn't fit anymore and the resident got angry and told her to box up the clothing and give it to Goodwill. The DON revealed the resident started crying and said, "Do what you want." The resident wouldn't look at us, was crying, and told them to get rid of it all. We left the room because the resident was done with us. The DON stated she did not mean to upset the resident and did not feel she had been mean, rude or disrespectful. The DON did not recall saying to the resident, your not going to start crying are you? She acknowledged the resident was upset when she left the room and she did not go back and check on the resident. She indicated the resident was depressed, takes everything to heart, and cries easily. However, she revealed she had not seen the resident cry before and she failed to document the resident's behavior in the clinical record. In addition, she had not informed the Director of Social Services of the resident's behaviors.</p> <p>Observation of unsampled Resident B, on</p>	F 241	<p>DEFICIENT PRACTICE WILL NOT RECUR:</p> <p>The Director of Nursing at the time of the referenced survey is no longer employed at the facility effective 9/20/2012. FYI: An Interim DON was put in place on 9/20/2012.</p> <p>All staff will receive education regarding dignity and respect of residents by Social Services on or by 10/24/12 or prior to their next scheduled shift.</p> <p>Residents residing in the facility were educated on the Concerns and Comment Program and how to use the cards during a Resident Council Meeting held on 10/12/12 by the Executive Director and the Social Services Director.</p> <p>All staff will be in-serviced on or by 10/24/12 or prior to their next scheduled shift by the Executive Director or the Social Services Director on the Concerns and Comment Program and all new hires will be educated on the Concerns and Comments Program upon hire by the Social Services Director, Interim Director of Nursing, Assistant Director of Nursing or Executive Director. All residents families, responsible parties, POA's were educated about the Concerns and Comments Program by a letter dated 10/11/12 that was mailed/given on 10/12/12 on how to use the Cards for</p>		



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

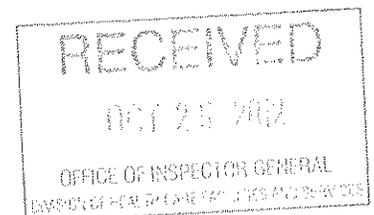
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004		
(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 241	<p>Continued From page 10</p> <p>09/20/12 at 4:00 PM, revealed the resident sitting on side of the bed writing on cards. Additional interview with the resident revealed he/she did not consider the DON actions to be abusive but disrespectful. The resident told the surveyor that the DON had hurt his/her feelings and made him/her very upset. "I cried, then I got angry and lashed out." I told the DON to get out of my room. I yelled this two times because she would not leave at first. The resident restated it was not what the DON said but how she said it. The resident stated again that he/she was afraid of retaliation and staff would not provide for the resident's needs. The resident stated he/she was dependent on staff for assistance.</p> <p>Interview with the Social Worker, on 09/20/12 at 5:05 PM, revealed the housekeeper supervisor had reported the resident was upset later, on the day of the occurrence. When she went to talk with the resident, the resident told her, the DON was harsh. She then informed the administrator of what the resident had told her. The Social Worker stated she had not known the resident had cried. If she had been told, she would have questioned the resident different. She did not talk with the DON.</p> <p>Review of a written statement provided by the Executive Director regarding a conversation with the DON on 07/26/12 that revealed a resident had a concern about the way the DON had spoken to her/him. The Executive Director advised the DON to be aware of the way she spoke and the need to speak in a professional and respectful manner.</p>	F 241	<p>Concerns and Issues, and it will also be addressed at the Family Council Meeting scheduled for 10/24/12 by the Executive Director or Social Services Director and upon admission effective 10/12/12. All residents not in the Residents Council meeting on 10/12/12 were educated about the Concerns and Comments Program by being given/read a copy of the letter dated 10/11/12 by the Social Services Director and the Director of Sales and Marketing on 10/22/12.</p> <p>A Concern and Comment Program has been put in place. Concern and Comment Cards have been placed at each nursing station and the front entrance of facility, for easy access to residents, staff, visitors, and family to have a way of reporting any issues such as: dignity, resident care, etc. The Concern and Comment Cards will be placed in boxes provided outside the Executive Director's door and the front lobby for a quick response the next business day. The Executive Director will follow up daily (Monday – Friday) to ensure any concerns or issues are addressed appropriately. In the Executive Director's absence the Social Services Director will follow up. In the absence of the Social Services Director and Executive Director the Executive Director will designate someone to provide follow up. The Executive Director's cell phone is also written in the letter so she can be</p>	



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

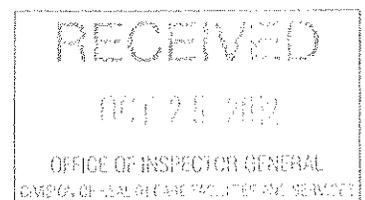
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
(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 241	<p>Continued From page 11</p> <p>2. Observation of Resident #6, on 09/18/12 at 12:04 PM, revealed the Director of Nursing (DON) pulling Resident #6 by both arms while in his/her wheelchair, down a long hall while the resident had a long strand of drool coming from the corner of his/her mouth.</p> <p>Interview with the DON, on 09/18/12 at 12:13 PM, revealed Resident #6 did not like for staff to be behind him/her when transporting.</p> <p>Record review of Resident #6, revealed he/she was admitted on 01/25/10 with a medical history of Alzheimer Disease, osteomyelitis and amputee of the toes. Resident #6's BIMS score was a 0, which meant the resident was not interviewable.</p> <p>Record review of the Safety and Transfers in-service training provided by the Therapy department, on 06/29/12 revealed to never pull on residents arms, and to take your time with transfers.</p> <p>Interview with the DON, on 09/19/12 at 2:50 PM, revealed there were multiple in-services the day the Safety and Transfer in-service was given. The DON helped present some of the in-services to staff; however, she did not attend the Safety and Transfer in-service that was provided.</p> <p>Record review of the Safety and Transfer in-service signature sheet for attendance revealed no DON signature.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 09/19/12 at 1:58 PM, revealed Resident #6 was wheeled to the dining room. CNA #3 stated</p>	F 241	<p>reached day or night should a concern arise that is not met to their satisfaction. Executive Director and/or Director of Social Services will audit a combined total of 6 staff members from all departments (Nursing, Dietary, Housekeeping, Laundry, Maintenance, Activities, Administrative Personnel, Therapy, Medical Records, Marketing and Admissions, Social Services, --includes all department managers and the Executive Director and Director of Nursing) daily (Mon-Friday) x 4 weeks, weekly x4 weeks, monthly x 2 months performing resident care or services to ensure dignity and respect are being provided to residents. Potential areas considered when observing for dignity concerns: hair clean and combed, oral mouth care completed, men shaved/women free of facial hair, proper foot ware, clothing free from stains and tears, clothing free from food debris, nails clean and groomed, free from odors/ladies with lipstick etc., staff speaking to resident in dining room sitting at eye level, tone of employee voice, patience of employee, emotions observed (i.e. crying, sad, happy), did interaction between resident and employee appear comfortable and engaged, etc... In the event that the Executive Director and/ or Social Services Director is out of the facility they will designate someone to perform their audits in their absence (Monday-Friday). Any/all concerns identified will be addressed</p>



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

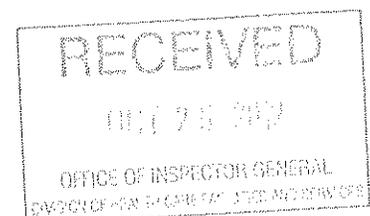
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004		
(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 241	<p>Continued From page 12</p> <p>she would talk to Resident #6 and ask him/her if he/she could pick up his/her feet, Resident #6 would then respond and CNA #3 would then push Resident #6 in the wheelchair. CNA #3 also stated sometimes she escorted Resident #6 by taking one hand and walking along side of Resident #6 backwards. CNA #3 stated she had witnessed staff pulling both arms while escorting Resident #6 down the hall, and that it was not appropriate to transfer Resident #6 like that. CNA #3 stated if staff pulled on him/her it would be against his/her will and felt this was a dignity issue. CNA #3 stated all you had to do was talk to Resident #6 to get him/her to transfer.</p> <p>Interview with CNA #2, on 09/19/12 at 1:42 PM, revealed she knew staff were not to transfer Resident #6 by both arms. CNA #2 stated that if Resident #6 was being transferred by both arms, she would then say the resident was being pulled in the wheelchair.</p> <p>Interview with the Rehab Services Manager, on 09/19/12 at 9:26 AM, revealed she did not encourage staff to use both his/her hands while in the wheelchair. The Rehab Services Manager stated she did not think it was appropriate for staff to pull Resident #6 by both of his/her arms. The Rehab Services Manager stated she had instructed staff to push him/her when he/she was encouraged to put his/her feet up and to give Resident #6 cue's on days when he/she did not want to put his/her feet up. She stated we encourage staff to use one hand when trying to encourage Resident #6 to move in his/her wheelchair. The Rehab Services Manager stated she had provided three (3) in-services in the last five (5) months. She stated she would not want</p>	F 241	<p>immediately by the Executive Director or the Social Services Director or the person designated by the Executive Director in the absence of the Executive Director and Social Services Director as dictated by the situation. If a concern is identified pertaining to the Executive Director the Social Services Director will report the concern to the Director of Nursing and the Regional Vice President and it will be addressed as dictated by the situation. The results of the audits will be brought to the monthly Performance Improvement meeting for review and further recommendation if needed.</p> <p>4. FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED: Executive Director and/or Director of Social Services will audit a combined total of 6 staff members from all departments (Nursing, Dietary, Housekeeping, Laundry, Maintenance, Activities, Administrative Personnel, Therapy, Medical Records, Marketing and Admissions, Social Services, --includes all department managers and the Executive Director and Director of Nursing) daily (Mon-Friday) x 4 weeks, weekly x 4 weeks, monthly x 5 months performing resident care or services to ensure dignity and respect are being provided to residents. Potential areas considered when observing for dignity concerns: hair clean and</p>		



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

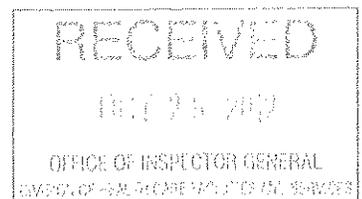
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004		
(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 241	Continued From page 13 someone pulling her in a wheelchair and felt it was not only a safety issue but a dignity issue as well. The Rehab Services Manager stated she educated staff on the spot when she witnessed staff pulling the resident by both arms. Interview with the DON, on 09/19/12 at 2:50 PM, revealed she denied pulling Resident #6 by the arms. The DON stated she was holding both of his/her hands and Resident #6 pedaled his/her feet. The DON stated she was not aware she was not to hold both hands while transferring Resident #6 in the wheelchair. The DON stated she would not want someone to pull her to cafeteria with drool coming down from her mouth. She did not think to wash Resident #6's face before escorting Resident #6 to the dining room. The DON stated because the resident had drool coming from his/her mouth, this could affect Resident #6's dignity.	F 241	F 241 combed, oral mouth care completed, men shaved/women free of facial hair, proper foot ware, clothing free from stains and tears, clothing free from food debris, nails clean and groomed, free from odors/ladies with lipstick etc., staff speaking to resident in dining room sitting at eye level, tone of employee voice, patience of employee, emotions observed (i.e. crying, sad, happy), did interaction between resident and employee appear comfortable and engaged, etc... In the event that the Executive Director and/ or Social Services Director is out of the facility they will designate someone to perform their audits in their absence (Monday-Friday). Any/all concerns identified will be addressed immediately by the Executive Director or the Social Services Director as dictated by the situation. If a concern is identified pertaining to the Executive Director the Social Services Director will report the concern to the Director of Nursing and the Regional Vice President and it will be addressed as dictated by the situation. The results of the audits will be brought to the monthly Performance Improvement meeting for review and further recommendation if needed. 5. Compliance date 10/25/2012.		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure a medication error rate of five (5) percent or less. Observation during the medication pass revealed a medication error rate of 13.043 percent. These errors occurred on one unit, one shift, and with one nurse.	F 332			



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
(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 332	<p>Continued From page 14 The findings include:</p> <p>Review of the medication administration policy, revised 10/2004, revealed all medications are administered safely and appropriately to help residents overcome illness, relieve/prevent symptoms, and help in diagnosis. Initial each medication in the correct box on the Medication Administration Record (MAR) after the medication is given.</p> <p>Observation during the medication pass, on 09/18/12 at 10:00 AM, revealed unsampled Resident C received eleven (11) pills and an Inhaler medication Spriva. LPN #1 stated this was the last resident for the morning medication pass. She took the medication cart to the nurses desk and walked away.</p> <p>Review of unsampled Resident C's clinical record (physician orders to reconcile the medications) revealed six medications: Aspirin low-EC 81 mg, Wellbutrin SR 150 mg, Plavix 75 mg, Aricept 10 mg, Cymbalta 60 mg, and Lisinopril 20 mg was ordered but omitted during the medication pass observation. Further review of the (MAR) revealed the facility had scheduled those medications to be given during the morning medication pass.</p> <p>Interview with LPN #1, on 09/19/12 at 10:30 AM, revealed the nurse had completed the morning medication pass. Review of the MAR and the most current physician orders with the nurse revealed she had omitted a whole sheet of medications from the medication pass. The nurse stated she must have flipped through the MAR and had just missed that page. The medications</p>	F 332	<p>F 332 10/25/12</p> <p>1. CORRECTIVE ACTION TAKEN FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE</p> <p>LPN # 1 received an education acknowledgement on 9/29/2012 by the Interim Director of Nursing regarding following the medication administration policy. A medication pass observation was completed on 10/8/12 upon return of LPN # 1 from vacation by the Unit Manager to ensure safe and complete medication administration as it relates to the policy.</p> <p>Please note that the resident had no adverse effect related to LPN # 1 missing a sheet of medications on the MAR. The medications were administered upon notification to the LPN by the surveyor as ordered by the physician.</p> <p>2. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents would have the potential to have been affected.</p> <p>A 100% review of all resident's MAR/TAR's was completed on 10/10/12 by the Interim Director of Nursing, Unit Managers and MDS Nurse(s) for the last</p>



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

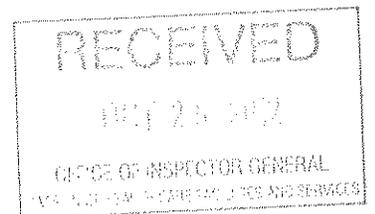
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004		
(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 332	Continued From page 15 were then given to the resident after surveyor intervention. Interview with the Director of Nursing, on 09/20/12 at approximately 10:30 AM, revealed pharmacy performs medication pass observation for the facility on all nurses. LPN #1 had been observed by pharmacy and found to have problems with technique not missing medications and retraining was provided.	F 332	30days to ensure all residents were receiving all prescribed medications during medication pass. Any issues identified were addressed immediately. A 100% of nurses will be observed during a medication pass by the Interim Director of Nursing, Unit Managers or MDS Nurse(s) on or by 10/24/12 to ensure all residents were receiving all prescribed medications during medication pass.		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS Review of the pharmacy medication pass quality assurance evaluation revealed on 07/18/12, LPN #1 had five (5) medication errors with med error rate of 20%. On 08/01/12, the nurse was observed again by pharmacy with a medication error rate of 22%. On 09/05/12, the Assistant Director of Nursing observed LPN #1 and found no medication errors. 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	3. MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: An in service was initiated on 10-2-12 and will be completed on or by 10-24-12 by the Interim Director of nursing related to medication administration. Any licensed nursing personnel not receiving this in service prior to 10-24-12 will receive the in-service prior to their next scheduled shift. Pharmacy consultants will conduct medication pass observations of 2 nurses quarterly. The Interim Director of Nursing, Assistant Director of Nursing, Unit Coordinators and MDS Nurse(s) will conduct medication pass observations daily (Monday-Friday) of 4 nurses times 4 weeks, 4 medication passes weekly times 4 weeks, 4 medication pass observations monthly times 3 months, upon hire effective 10/24/12, annually and PRN.		



4. FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED:

4 Medication pass observations will be conducted daily (Monday-Friday) x 4 weeks, 4 medication pass observations will be conducted weekly x 1 month and then 4 medication pass observations monthly times 3 months by the Interim Director of Nursing, Assistant Director of Nursing, Unit Coordinators and MDS Nurse(s) to ensure all medications are administered during medication administration pass times. The results of the audits will be brought to the monthly Performance Improvement meeting for review and further recommendation if needed.

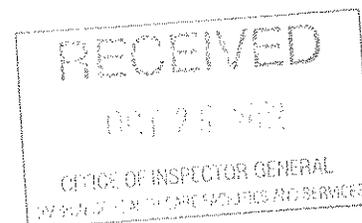
5. Compliance date: 10-25-12



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

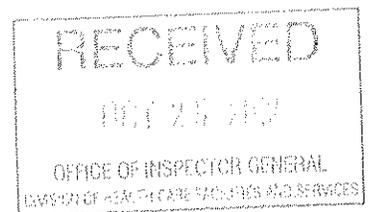
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 16 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. 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 staff washed their hands when moving from a dirty area to a clean area for two (2) of sixteen (16) sampled residents, Resident #5 and #7. Staff members were observed going from a dirty area to a clean area without washing hands and removing gloves while conducting a skin assessment on Resident #5. The facility staff was also observed to practice improper hand hygiene while conducting a skin assessment for Resident #7. The findings include:	F 441	F 441 1. CORRECTIVE ACTION TAKEN FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #5 was assessed by a charge nurse on 9/30/12 during a skin assessment and resident #7 was assessed during wound rounds by the wound care physician on 9/24/12 both with no adverse effects noted related to LPN # 1 and Director of Nursing not washing hands or changing gloves. LPN # 1 was re-educated by the Interim Director of Nursing on 10-8-12 after returning from vacation regarding appropriate infection control guidelines that are to be utilized when providing care to residents or performing skin assessments. 2. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by the practice. A 100% observation of all nurses will be completed by the Interim Director of Nursing, Unit Managers and MDS Nurse(s) on or by 10-24-12 to ensure compliance of all nurses when providing care to residents or performing skin assessments.	10/25/12



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

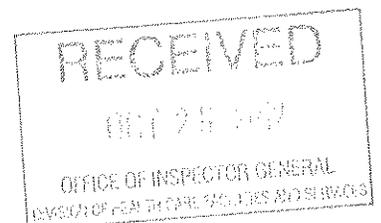
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 17 Review of the Infection Control Policy, revised 02/06/06, revealed the facility would implement strategies to achieve a facility wide hand hygiene program that complied with CDC hand hygiene guidelines and National Patient Safety Goals. Review of the Hand Hygiene Policy, revised 05/21/2004, revealed the purpose of the policy was to decrease the risk of transmission of infection by appropriate hand hygiene. Hand washing/hand hygiene was generally considered the most important single procedure for preventing nosocomial infections. Wear appropriate gloves when it can be reasonably anticipated that there may be hand contact with blood or other potentially infectious materials and when handling or touching contaminated items or surfaces; replace gloves if contaminated or if their ability to function as a barrier has been compromised. 1. Observations made of Licensed Practical Nurse (LPN) #1 and the Director of Nursing (DON) completing a head to toe skin assessment for Resident #5 on, 09/18/12 at 2:33 PM, revealed LPN #1 and the DON standing around Resident #5 across from each other, checking Resident #5's body from both sides. As LPN #1 assessed the Resident #5's feet, legs and buttocks on the left side of the body, the DON was observed assessing Resident #5's feet, legs and buttocks on the right side of the body. LPN #1 then assessed the back, arms and head of Resident #5's left side of the body and the DON then assessed the back, arms and head of Resident #5's right side of the body. Both LPN and DON were observed to not remove their	F 441	3. MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: All staff will receive re-education by the Interim Director of Nursing on or by 10-24-12 regarding the Infection Control Policy, facility wide hand hygiene program, CDC's Infection Control Guidelines and National Patient Safety Goals to prevent the development and transmission of disease and infection. Any personnel not receiving this in service on or by 10-24-12 will receive the in-service prior to their next scheduled shift. Education will be provided by the Interim Director of Nursing, Assistant Director of Nursing and Unit Managers and MDS Nurse(s) upon hire, annually, and as needed. All nurses will have successfully completed handwashing competencies on or by 10/24/12 or prior to their next scheduled shift. All nurses will also complete hand washing competencies upon hire effective 10/24/12. Facility Rounds will be completed daily (Mon-Friday) by Executive Director, Interim Director of Nursing, Assistant Director of Nursing, Housekeeping Supervisor, Maintenance Director, BOM, Social Services Director, Rehab Manager, Activities Director, HIM and MDS Nurse(s). Any Infection Control		



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

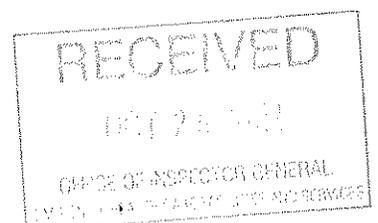
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 18 gloves or wash their hands when moving from the feet to the head of the resident during the assessment. Interview with LPN #1, on 09/18/12 at 2:33 PM, revealed she should have washed her hands after assessing Resident #5's peri area. LPN #1 stated staff should wash their hands to prevent the spread of infection as she had been trained to do.	F 441	Issues identified will be discussed during the Daily Standup Meeting and will be followed up by the department manager responsible for infection control issues identified. 4. FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED:		
	Interview with the DON, on 09/19/12 at 2:50 PM, revealed though she watched LPN #1 conduct a skin assessment on Resident #5, she could not recall assisting LPN #1 with the skin assessment. The DON further stated she could not recall LPN #1 not washing her hands or changing her gloves. The DON stated she could not recall touching Resident #5's peri area and once LPN #1 had touched the peri area she should have removed her gloves and washed her hands. The DON finally stated when you move from dirty to clean you could transfer infection to another part of the body. Interview with the Infection Control Nurse, on 09/20/12 at 4:07 PM, revealed she conducted infection control in-services upon hire and annually, with opportunities to conduct educations quarterly. The Infection Control Nurse stated she and the DON conducted a mandatory in-service on infection control last quarter and all staff were to attend. The Infection Control Nurse stated staff needed to wash their hands when they removed their gloves. She stated she would have suggested that the DON and LPN #1 remove their gloves when going from dirty to clean. The Infection Control Nurse stated they wash their		The Interim Director of Nursing, Assistant Director of Nursing, Unit Managers and MDS Nurse(s) will perform Infection Control Surveillance Rounds throughout facility daily (Mon-Friday) x30 days, weekly x4 weeks, then monthly x7 months. The audits will be conducted to ensure compliance, in all areas, with the facilities and CDC's Infection control guidelines. The results of the audits will be brought to the monthly Performance Improvement meeting for review and further recommendation if needed. 5. Compliance Date: 10/25/2012		



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

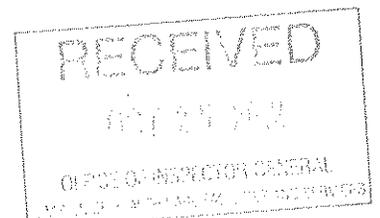
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
(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 19</p> <p>hands so that E-coli would not be carried to other parts of the body.</p> <p>2 Review of the facility's hand hygiene policy, dated 05/21/2004, revealed a six (6) step process for hand washing. Step five (5) stated faucets should be turned off with a paper towel which would then be discarded.</p> <p>Observation, on 09/18/12 at 2:15 PM, revealed both LPN #1 and the DON did not use paper towels to turn off the sink's faucet handles after washing their hands during the skin assessment for Resident #7.</p> <p>Interview, on 09/20/12 at 1:00 PM, with LPN #1 revealed she should have turned off the faucet handles with a paper towel, which she thought she did because her routine was to also clean up the sink with a paper towel after drying her hands.</p> <p>LPN #1 stated the problem with not observing all the steps in the hand washing process in the facility's policy would be the potential for re-soiling her hands and spreading infection to the residents and staff members. LPN #1 stated she attended an infection control in-service one year ago as a new employee to the facility.</p> <p>Interview with the DON, on 09/19/12 at 3:25 PM, revealed she typically used her elbow or a paper towel to turn off the faucet handles after washing her hands, and the problem with not consistently observing all the steps outlined in the facility's hand washing policy would be the potential for</p>	F 441	



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

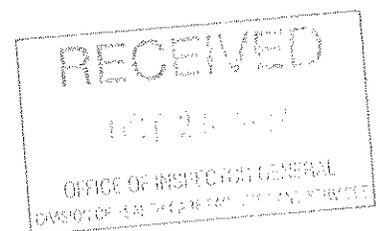
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 20 spreading infection to residents and staff members. The DON stated she and the infection control nurse led the infection control/hand washing in-services and all employees were required to attend the in-service annually. The DON stated a formal system for monitoring infection control compliance among direct-care staff was not in place at this time. Interview, on 09/20/12 at 4:10 PM, with the Assistant Director of Nursing (ADON) revealed she was responsible for ensuring all employees attended an infection control in-service at least annually. The ADON stated staff should wash their hands after giving direct care to residents and that proper hand washing technique included turning off faucet handles with a paper towel to prevent recontamination of clean hands. The ADON stated an All-Staff Infection control in-service was conducted on 05/18/12. However, review of the all-staff infection control attendance roster revealed LPN #1, and the DON had not signed the attendance roster for this in-service.	F 441			
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's policy and review of the glucometer log, it was determined the facility failed to conduct quality control testing for Glucose Glucometers for two (2) of four (4) meters involving one of two units.	F 456	F 456 1. CORRECTIVE ACTION TAKEN FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were found to have been affected by the glucose logs not up to date. 2. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this practice. A Glucose Control Test was performed by a Unit Manager on both units on 10-1-12 to ensure all glucose monitors in use tested accurately. No issues were identified. A 100% review of all Diabetic resident glucose readings were reviewed on 10-9-12 by Interim Director of Nursing and East Unit Manager to ensure all Diabetic residents had glucose levels logged on Medication Administration Record. All glucose levels were recorded with no discrepancies in glucose levels noted. 3. MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: All Licensed staff will be in-serviced on or by 10-24-12 or prior to their next scheduled	10/25/12	



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

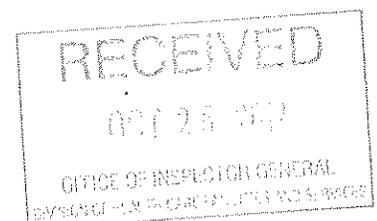
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
(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 456	Continued From page 21 (West Wing). The findings include: Review of the facility policy regarding Glucose Control Testing with the Optium EZ Blood Glucose Monitor, dated 08/10, revealed quality control testing must be performed a minimum once every twenty-four (24) hours. The policy directed staff to record results onto the Quality Control Results Log. Review of the Optium EZ Blood Glucose Quality Control Results log for two (2) glucometer on Medication cart #1 and #2 (on the West Wing) revealed the control test was not conducted every twenty-four (24) hours as indicated in the policy. The equipment was not tested on September 14-16, 2012. Interview with the Director of Nursing, on 09/19/12 at 11:00 AM, revealed the glucose control test should be conducted daily on the night shift. She revealed the facility recently had a JCAHO accreditation survey that identified the same problem; however, she had not provided follow-up training to the nurses. She stated she had pulled the old test logs and started with a new log for each glucometer on 09/12/12. She said she had planned on providing education to the nurses on how to conduct the glucose control test with a return demonstration required. However, she had not had time to conduct that training.	F 456	shift by Interim Director of Nursing regarding Glucose Control testing a minimum of every twenty-four hours and to record results onto the Quality Control Results Log. All Glucose Control Logs will be audited daily by on coming Charge Nurse with End of Shift Charge Nurse to ensure Glucose Controls have been obtained and logged. The Interim Director of Nursing, Assistant Director of Nursing, Unit Managers and MDS Nurse(s) will audit Glucose Logs Weekly x 1 month, Monthly x8 months. 4. FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED: All Glucose Control Logs will be audited daily by on coming Charge Nurse with End of Shift Charge Nurse to ensure Glucose Controls have been obtained and logged. The Interim Director of Nursing, Assistant Director of Nursing, Unit Managers and MDS Nurse(s) will audit Glucose Logs Weekly x 1 month, Monthly x8 months. The results of the audits will be brought to the monthly Performance Improvement meeting for review and further recommendation if needed.	
F 514 SS=D	483.75(f)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514	5. Compliance Date: 10/25/2012	



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

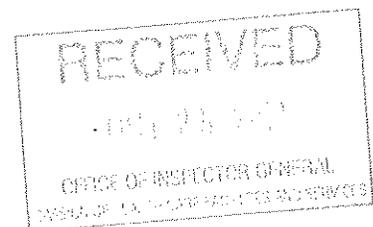
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
(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 514	Continued From page 22 The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure the clinical record was complete and accurately documented for one resident (unsampled Resident B) out of total sample of sixteen (16) residents. The clinical record did not include observation of the resident's behavior and tearfulness with staff interventions provided for an incident that occurred in July 2012. The findings include: The facility provided a Nursing Documentation policy, revised 03/11, however, the policy did not include procedures for documenting behaviors and interventions in the clinical record. Interview with unsampled Resident B, on 09/18/12 at 2:00 PM, during the group meeting revealed an incident where a staff member came into the resident's room and spoke disrespectful and made the resident cry. This was witnessed by	F 514	F514 1. CORRECTIVE ACTION TAKEN FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident B was observed by the Social Worker on 9/28/12 up and participating with therapy laughing and talking with staff. Social Worker also noted that she assisted Activities in a soup/chili sale to raise money for the Alzheimers Association. Social Worker visited Resident B on 10/17/12 and Resident B was tearful and stated that she was not crying about anything going on here—everyone is treating me fine; but asked for prayer for a family member. Resident B stated that “the mood has seemed to improve here over the past few weeks ever since the previous DON left—everybody just seems happier” Resident B also went on a facility outing on 10/16/12 and has been active in facility activities. 2. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this practice. Social Services Director interviewed residents with a BIMS score of 13 or more on 10/9/2012 to ensure psychosocial needs were being met. No psychosocial concerns were identified and no behaviors noted.	10/25/12



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
(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 514	Continued From page 23 another staff member. Follow-up interview with the resident, on 09/19/12 at 4:30 PM, revealed the staff member had made the resident angry and the resident told the staff member to get out of the room. Refer to F-241. Review of the clinical record's nurses notes, dated 03/09/12 through 07/31/12, revealed no documentation of the resident crying. Further review of the record, on 09/20/12, revealed 07/31/12 was the last entry in the nurses notes. Interview with the Director of Nursing (DON), on 09/20/12 at 2:55 PM, revealed she had observed unsampled Resident B become angry and cried during a conversation regarding a room change for the renovation of the resident's room. The DON stated she had failed to document the resident's behavior and tearfulness in the clinical record and she should have.	F 514	An observation of all residents was completed by East Unit Coordinator and Social Services Director on 10-9-12 to ensure no behaviors are being displayed without documentation and intervention for behavior observed. 3. MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: All staff will receive education regarding reporting and documenting behaviors to the Interim Director of Nursing, Unit Managers, Charge Nurse, and/or Social Services Director upon hire and annually by the Social Services Director, Interim Director of Nursing or Assistant Director of Nursing to ensure documentation and interventions are entered in the resident's clinical record. Residents residing in the facility will be educated on the Concerns and Comment Program and how to use the cards during a Resident Council Meeting was held on 10/12/12 by the Executive Director and the Social Services Director. Residents residing in the facility were educated on the Concerns and Comment Program and how to use the cards during a	



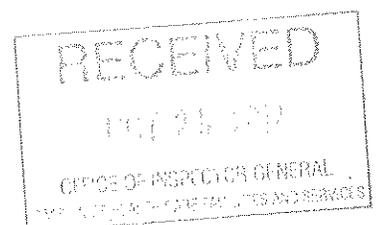
F 514

Resident Council Meeting held on 10/12/12
by the Executive Director and the Social
Services Director.

All staff will be in-serviced on or by
10/24/12 or prior to their next scheduled
shift by the Executive Director or the Social
Services Director on the Concerns and
Comment Program and all new hires will be
educated on the Concerns and Comments
Program upon hire by the Social Services
Director, Interim Director of Nursing,
Assistant Director of Nursing or Executive
Director. All residents families, responsible
parties, POA's were educated about the
Concerns and Comments Program by a
letter dated 10/11/12 that was mailed/given
to on 10/12/12 on how to use the Cards for
Concerns and Issues, and it will also be
addressed at the Family Council Meeting
scheduled for 10/24/12 by the Executive
Director or Social Services Director and
upon admission effective 10/12/12. All
residents not in the Residents Council
meeting on 10/12/12 were educated about
the Concerns and Comments Program by
being given/read a copy of the letter dated
10/11/12 by the Social Services Director
and the Director of Sales and Marketing on
10/22/12.

A Concern and Comment Program has been
put in place. Concern and Comment Cards
have been placed at each nursing station and

Page 24 A



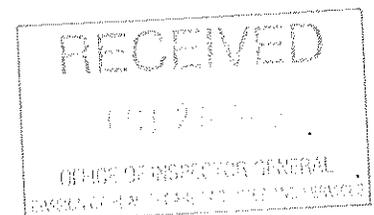
the front entrance of facility, for easy access to residents, staff, visitors, and family to have a way of reporting any issues such as: dignity, resident care, etc. The Concern and Comment Cards will be placed in boxes provided outside the Executive Director's door and the front lobby for a quick response the next business day. The Executive Director will follow up daily (Monday – Friday) to ensure any concerns or issues are addressed appropriately. In the Executive Director's absence the Social Services Director will follow up. In the absence of the Social Services Director and Executive Director the Executive Director will designate someone to provide follow up. The Executive Director's cell phone is also written in the letter so she can be reached day or night should a concern arise that is not met to their satisfaction.

4. FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED:

Interim Director of Nursing, Unit Manager, or Social Services Director will complete an audit of 5 resident's daily (Mon-Friday) x 4weeks, weekly x4 weeks, then Monthly x2 months observing for behaviors to ensure documentation and interventions for behaviors observed. The results of the audits will be brought to the monthly Performance Improvement meeting for review and further recommendation if needed.

5. Compliance Date: 10/25/2012

Page 24B



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004
---	---

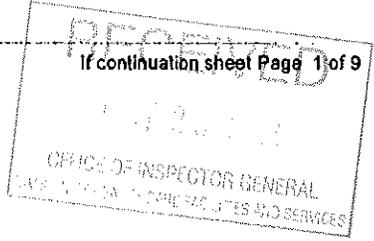
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1978 Original building, 2012 Building Addition.</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (000)</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic, dry sprinkler system.</p> <p>GENERATOR: Type II generator, 30 KW, fuel source is propane gas.</p> <p>A standard Life Safety Code survey was conducted on 09/18/12. Life Care Center of Bardstown was found not in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>This Plan of Correction is submitted under Federal and State Regulation and status applicable to Long Term Care Providers. This Plan of Correction does not constitute an admission of liability on the part of the facility as such liability is hereby denied. The submission of this Plan does not constitute an agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Furthermore, we request this Plan of Correction service as our credible allegation of compliance.</p>	
-------	--	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Karen M. Meredith</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>10-24-12</i>
---	------------------------------------	------------------------------

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

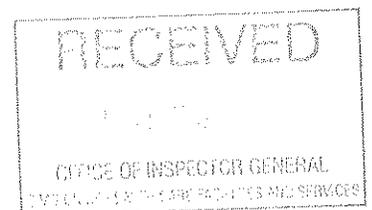
5A



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

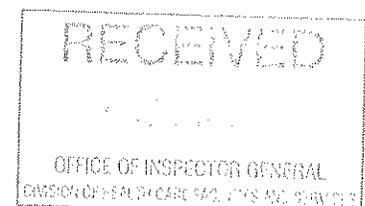
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
(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 000	Continued From page 1	K 000		
K 062 SS=F	<p>Deficiencies were cited with the highest deficiency identified at F level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure the sprinkler system was being maintained and tested in accordance with NFPA standards. The deficiency had the potential to affect each of the eight (8) smoke compartments, all residents, staff and visitors. The facility has one-hundred (100) certified beds and the census was eighty (80) on the day of the survey.</p> <p>The findings include:</p> <p>Record review, on 10/18/12 at 3:45 PM, with the Maintenance Director revealed the last interior pipe inspection for the automatic sprinkler system was unknown. This inspection must be done once every five years.</p> <p>Interview, on 10/18/12 at 3:45 PM, with the Maintenance Director revealed he was not aware the interior pipe inspection of the automatic sprinkler system had not been performed within the past five (5) years.</p>	K 062	<p>K 062</p> <p>Koorsen Fire & Security completed a 5 year internal pipe inspection on 9/28/12. Per service work order "no excess debris was found at this time". The Maintenance Director and Assistant Maintenance Director were re-educated by the Executive Director on 10/9/12 regarding K 062 NFPA 101 Life Safety Code Standard.</p> <p>All residents had the potential to be affected but there were no negative outcomes and no residents were affected.</p> <p>The Maintenance Director and Assistant Maintenance Director were re-educated on 10/9/12 by the Executive Director regarding K 062 NFPA 101 Life Safety Code Standard and a review of the 9/18/2012 Life Safety Code Deficiencies which details the requirement for an interior pipe inspection of the automatic sprinkler system every 5 years. The Maintenance Director will ensure that the interior pipe inspection is completed again within 5 years of 9/28/12. Annual calendars have been printed for 2013 thru 2017. The 2017 calendar has a reminder on the month of July to schedule the 5 year interior pipe inspection of the automatic sprinkler system to be completed in August of 2017. The month of August 2017 has a reminder to determine that the interior pipe inspection has been completed. The date of September 28, 2017 has been</p>	10/25/12



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

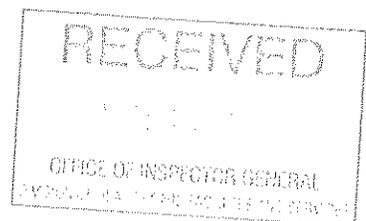
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 2 Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1	K 062	circled and a notation has been made that the last 5 year inspection was completed on September 28, 2012. The 5 year calendars dated 2013 thru 2017 will be maintained/monitored in the front of the Executive Director's Capital Planning Notebook and the front of the Maintenance Director's Preventative Maintenance Program Notebook. As each year passes the respective calendar will be removed, after the 2017 5 year interior pipe inspection has been completed prior to September 28, 2017 and an additional 5 years planning calendars will be printed and the process repeated. The above referenced process will be reviewed in the Performance Improvement Committee Meeting monthly for 6 months to ensure that the process remains in place. The Maintenance Director will bring the results of the 9/28/12 internal pipe inspection to the October Performance Improvement Committee Meeting for their review and further recommendations if deemed necessary. The Maintenance Director will ensure that the interior pipe inspection is completed again within 5 years of 9/28/12. Annual calendars have been printed for 2013 thru 2017. The 2017 calendar has a reminder on the month of July to schedule the 5 year interior pipe inspection of the automatic sprinkler system to be completed in August of 2017. The	



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

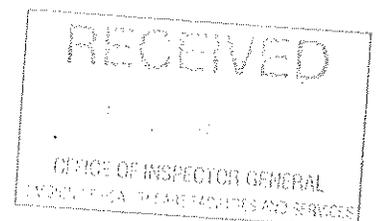
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 3 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections. 10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel. NFPA 101 LIFE SAFETY CODE STANDARD	K 062	month of August 2017 has a reminder to determine that the interior pipe inspection has been completed. The date of September 28, 2017 has been circled and a notation has been made that the last 5 year inspection was completed on September 28, 2012. The 5 year calendars dated 2013 thru 2017 will be maintained/monitored in the front of the Executive Director's Capital Planning Notebook and the front of Maintenance Director's Preventative Maintenance Program Notebook. As each year passes the respective calendar will be removed after the 2017 5 year interior pipe inspection has been completed prior to September 28, 2017 and an additional 5 years planning calendars will be printed and the process repeated. The above referenced process will be reviewed in the Performance Improvement Committee Meeting monthly for 2 months and quarterly for 2 quarters to ensure that the process remains in place. The Performance Improvement Committee will review the process and make recommendations if deemed necessary. Completion Date: 10/25/12	
K 069 SS=D		K 069		



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

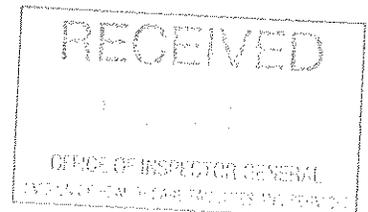
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004		
(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 069	Continued From page 4 Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the kitchen cooking appliances were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility has one-hundred certified (100) beds and the census was of eighty (80) on the day of the survey. The findings include: Observation, on 09/18/12 at 11:10 AM, with the Maintenance Director revealed the grease fryer was located directly next to the open flame burner of the stove. The stove did not have an 8 inch splash guard in place. Interview, on 09/18/12 at 11:10 AM, with the Maintenance Director revealed he was unaware the grease fryer had to have a minimum of sixteen (16) inches clearance between the fryer and the stove unless an eight (8) inch splash guard is installed. NFPA 96 (1998 Edition) 9-1.2.3 All deep fat fryers shall be installed with at least 16-in. (406.4-mm) space between the fryer and surface flames from adjacent cooking equipment. Exception: Where a steel or tempered glass baffle plate is installed	K 069	K 069 The Maintenance Director moved the deep fryer 18" away from the stove on 9/18/12. The Maintenance Director and Assistant Maintenance Director were re-educated on 10/9/12 by the Executive Director regarding K 069 NFPA 101 Life Safety Code Standard and a review of the 9/18/2012 Life Safety Code Deficiencies which details the requirement for the minimum of 16" clearance between the deep fryer and the stove unless an 8" splash guard is installed. The Maintenance Director or Assistant Maintenance Director audited the space between the deep fryer and the stove daily (Monday-Friday) 9/20/12 thru 10/23/12 to ensure that there was a minimum of 16" between the stove and the deep fryer until the steel baffle plate was installed on 10/24/12 at a minimum of 8" in height between the deep fryer and the stove. Anyone in the kitchen had the potential to be affected by the practice but there were no negative outcomes. The Dietary Manager was educated by the Executive Director on 10/10/12 and all Dietary staff were educated by the Dietary Manager not to move the deep fryer from its current location (18" away from the stove) by 10-13-12 and that the space between the deep fryer and surface flames	10/25/12	



from adjacent cooking equipment must be a minimum of 16" space until the Maintenance Director had a steel baffle plate installed on 10/24/12 at a minimum 8" in height between the fryer and the stove. The Maintenance Director or Assistant Maintenance Director completed an audit tool daily (Monday – Friday) from 9/20/12 thru 10/23/12 to verify that the space between the deep fryer and the stove was a minimum of 16" between the stove and the deep fryer until the steel baffle plate was installed on 10/24/12 at a minimum of 8" in height between the deep fryer and the stove. The Maintenance Director or Assistant Maintenance Director will complete an audit tool to determine that proper placement of the steel baffle plate is maintained weekly for 2 months, semi-monthly for 2 months and monthly for 2 quarters to ensure that the steel baffle plate continues to separate the deep fryer and stove. The Executive Director will review audit findings from the Maintenance Director/Assistant Maintenance Director weekly for 1 month, and monthly for 8 months.

The Maintenance Director or Assistant Maintenance Director will complete an audit tool to determine that proper placement of the steel baffle plate is maintained weekly for 2 months, semi-monthly for 2 months and monthly for 2

Page 5A



quarters to ensure that the steel baffle plate continues to separate the deep fryer and stove. The Executive Director will review audit findings from the Maintenance Director/Assistant Maintenance Director weekly for 1 month, and monthly for 8 months. The Performance Improvement Committee will review the monthly findings and make recommendations if deemed necessary.

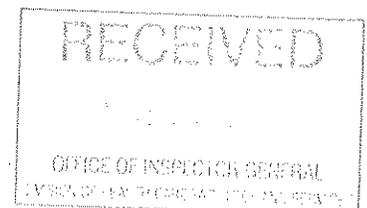
Completion Date: 10/25/12



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

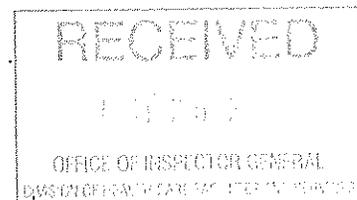
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
(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 069	Continued From page 5 at a minimum 8 in. (203 mm) in height between the fryer and surface flames of the adjacent appliance.	K 069	K 144	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the emergency generator was installed and maintained in accordance with NFPA standards. The deficiency had the potential to affect each of the eight (8) smoke compartments, all residents, staff, and visitors. The facility has one-hundred (100) certified beds and the census was eighty (80) on the day of the survey. The findings include: Observation, on 09/18/12 at 2:00 PM, with the Maintenance Director revealed the annunciator panel for the emergency generator, located in the Mechanical and Electrical Room accessed only from the exterior of the building, was not located in an area that was continuously monitored by Staff, to ensure the generator was functioning	K 144	The facility is requesting a time limited waiver in reference to K 144 being cited on 9/18/12 related to not having an annunciator panel continuously monitored. We will be installing a 350 KW Generator with a completion date of 4/9/13 that will include an annunciator panel that will be located where it will be continuously monitored. We have initiated the following safeguards for resident safety in the interim effective 10/24/12: <ul style="list-style-type: none">Maintenance Director or Assistant Maintenance Director is testing the generator for 30 minutes non-load 2 times a week and 2 times monthly with full load.Anytime the power is off and the generator comes on the Maintenance Director is to be called by staff. All staff were re-educated on or by 10/24/12 or prior to their next shift that whoever is in charge at the time the generator comes on notifies the Maintenance Director or designates another staff member (depending on what the person in charge may be needing to devote their personal attention to at	4/9/13



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
(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 144	Continued From page 6 properly. Interview, on 09/18/12 at 2:00 PM, with the Maintenance Director, revealed he was not aware of a remote annunciator panel for the emergency generator being required to be located outside of the generating room in a location that is continuously monitored by Staff. Reference: NFPA 99 (1999 Edition). 3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended	K 144	the time) to notify the Maintenance Director that the facility is on the emergency generator and the Maintenance Director or the Assistant Maintenance Director comes onsite to check the problem and remains on site until the problem is resolved and the facility is back on regular power. The Executive Director is immediately called by the Maintenance Director or Assistant Maintenance Director after receiving the call from the facility. The Executive Director notifies the Regional Vice President and anyone else requiring notification based on the length of time anticipated that the facility will be on the generator due to the interruption of regular service and as the situation dictates. • Daily audit tool checks to be completed Monday thru Friday effective 10/24/12 by the Maintenance Director and/or the Assistant Maintenance Director on the following items until the new generator and annunciator panel is installed:	



K 144

Wiring
Battery
Anti-freeze
Oil

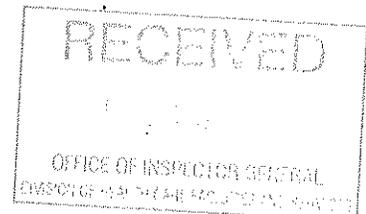
- The Managers on Duty for weekends and holidays received education to look for any visual problems with leaks and wiring on or by 10/24/12 and they will also be completing audit tools. If the Manager on Duty identifies and issue they will immediately notify the Maintenance Director or Assistant Maintenance Director who will come on site and address the issue at that time.

All residents have the potential to be affected but there have been no negative outcomes and no residents were affected.

The new generator annunciator panel will be located in an area that is continuously monitored by staff to ensure that the generator is functioning properly.

We have initiated the following safeguards for resident safety in the interim effective 10/24/12:

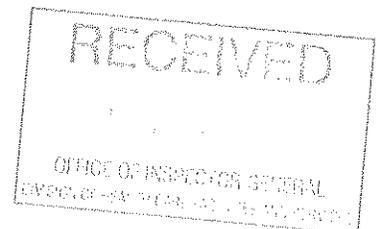
Page 7A



K 144

- Maintenance Director or Assistant Maintenance Director is testing the generator for 30 minutes non-load 2 times a week and 2 times monthly with full load.
- Anytime the power is off and the generator comes on the Maintenance Director is to be called by staff. All staff were re-educated on or by 10/24/12 or prior to their next shift that whoever is in charge at the time the generator comes on notifies the Maintenance Director or designates another staff member (depending on what the person in charge may be needing to devote their personal attention to at the time) to notify the Maintenance Director that the facility is on the emergency generator and the Maintenance Director or the Assistant Maintenance Director comes onsite to check the problem and remains on site until the problem is resolved and the facility is back on regular power. The

Page 7B



K 144

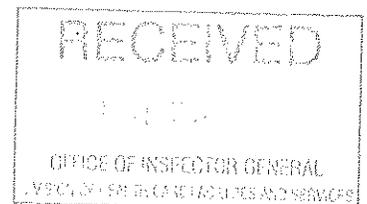
Executive Director is immediately called by the Maintenance Director or Assistant Maintenance Director after receiving the call from the facility. The Executive Director notifies the Regional Vice President and anyone else requiring notification based on the length of time anticipated that the facility will be on the generator due to the interruption of regular service and as the situation dictates.

- Daily audit tool checks to be completed Monday thru Friday effective 10/24/12 by the Maintenance Director and/or the Assistant Maintenance Director on the following items until the new generator and annunciator panel is installed:

Wiring
Battery
Anti-freeze
Oil

- The Managers on Duty for weekends and holidays received in-servicing to look for any visual problems with leaks and wiring on

Page 7C



K 144

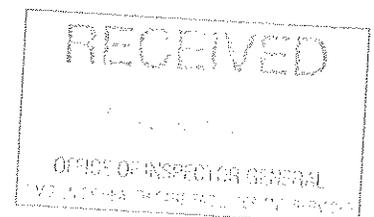
or by 10/24/12 and they will also be completing audit tools. If the Manager on Duty identifies and issue they will immediately notify the Maintenance Director or Assistant Maintenance Director who will come on site and address the issue at that time.

DMK Development Group is the contractor being utilized for the project. The work plan/time line is as follows:

- 350 KW Generator Pre-Work to be completed by 2/11/13
- Generator Delivery completed by 1/24/13
- Generator Pad completed by 2/22/13
- Annunciator Panel completed by 2/22/13
- Inspection by State completed by 3/15/13

Doug Crisp of DMK Development Group is the on-site Project Leader and he and the Executive Director are responsible for project oversight. The Project Leader and the Executive Director communicate daily

Page 7D

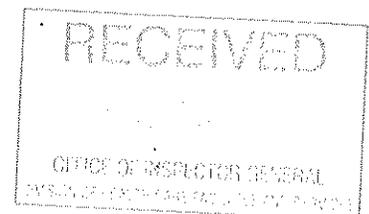


K 144

(Monday-Friday) regarding any/all construction phasing, progress and potential obstacles. The on-site Project Leader will keep the Executive Director informed of any potential concerns that might result in the installation of the new generator and annunciator panel falling behind schedule. It will then be the Executive Director's responsibility to notify the State Agency if the project falls behind and will not meet the completion date and the Executive Director needs to request an extension. Please note that we have built some additional time in the timeline for completion to assist with any unforeseen obstacles at this point and are requesting a completion/compliance date of 4/9/13.

The Executive Director will review the Maintenance Director/Assistant Maintenance Director audit tools and the Weekend Manager audit tools weekly until the project is completed--not to exceed 4/8/13 to meet our requested time based waiver completion date of 4/9/13. The Executive Director will bring the results of the audits to the monthly Performance Improvement Committee meeting monthly until the project is completed and we are in compliance as of 4/9/13 for review and further recommendations if needed.

Page 7E

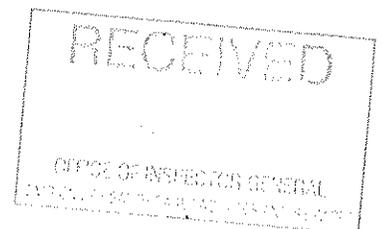


K 144

We have initiated the following safeguards for resident safety in the interim effective 10/24/12:

- Maintenance Director or Assistant Maintenance Director is testing the generator for 30 minutes non-load 2 times a week and 2 times monthly with full load.
- Anytime the power is off and the generator comes on the Maintenance Director is to be called by staff. All staff were re-educated on or by 10/24/12 or prior to their next shift that whoever is in charge at the time the generator comes on notifies the Maintenance Director or designates another staff member (depending on what the person in charge may be needing to devote their personal attention to at the time) to notify the Maintenance Director that the facility is on the emergency generator and the Maintenance Director or the Assistant Maintenance Director comes onsite to check the problem and remains on site until the problem is resolved and the facility

Page 7F



K 144

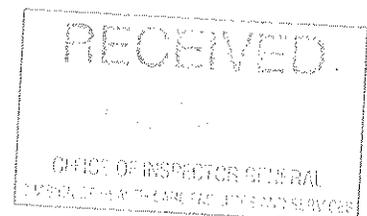
is back on regular power. The Executive Director is immediately called by the Maintenance Director or Assistant Maintenance Director after receiving the call from the facility. The Executive Director notifies the Regional Vice President and anyone else requiring notification based on the length of time anticipated that the facility will be on the generator due to the interruption of regular service and as the situation dictates.

- Daily audit tool checks to be completed Monday thru Friday effective 10/24/12 by the Maintenance Director and/or the Assistant Maintenance Director on the following items until the new generator and annunciator panel is installed:

Wiring
Battery
Anti-freeze
Oil

- The Managers on Duty for weekends and holidays received in-servicing to look for any visual

Page 7G



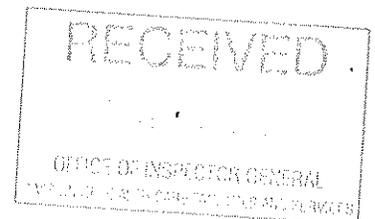
K 144

- problems with leaks and wiring on or by 10/24/12 and they will also be completing audit tools, If the Manager on Duty identifies and issue they will immediately notify the Maintenance Director or Assistant Maintenance Director who will come on site and address the issue at that time.

DMK Development Group is the contractor being utilized for the project. The work plan/time line is as follows:

- 350 KW Generator Pre-Work to be completed by 2/11/13
- Generator Delivery completed by 1/24/13
- Generator Pad completed by 2/22/13
- Annunciator Panel completed by 2/22/13
- Inspection by State completed by 3/15/13

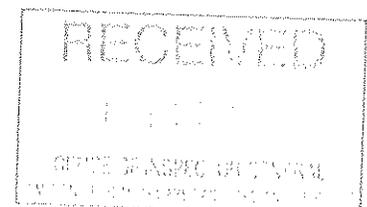
Doug Crisp of DMK Development Group is the on-site Project Leader and he and the Executive Director are responsible for



K 144

project oversight. The Project Leader and the Executive Director communicate daily (Monday-Friday) regarding any/all construction phasing, progress and potential obstacles. The on-site Project Leader will keep the Executive Director informed of any potential concerns that might result in the installation of the new generator and annunciator panel falling behind schedule. It will then be the Executive Director's responsibility to notify the State Agency if the project falls behind and will not meet the completion date and the Executive Director needs to request an extension. Please note that we have built some additional time in the timeline for completion to assist with any unforeseen obstacles at this point and are requesting a completion/compliance date of 4/9/13. The Executive Director will bring the status of time lines of the project thru the Performance Improvement Committee Meeting monthly until the project is completed and we are in compliance as of 4/9/13 for review and further recommendations if needed. The Executive Director will review the Maintenance Director/Assistant Maintenance Director audit tools and the Weekend Manager audit tools weekly until the project is completed--not to exceed 4/8/13 to meet our requested time based waiver completion date of 4/9/13. The Executive Director will bring the results of the audits to the monthly Performance

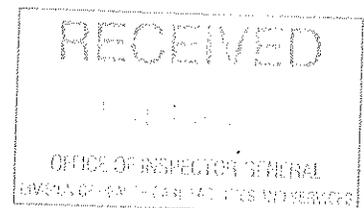
Page 71



K 144

Improvement Committee meeting monthly until the project is completed and we are in compliance as of 4/9/13 for review and further recommendations if needed.

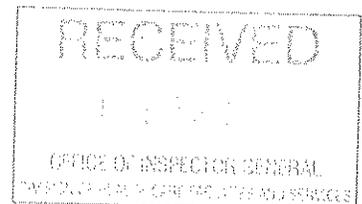
Page 7J



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
(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 144	Continued From page 7 periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]	K 144	K 147 The power strip being used to power an I.V. pole in resident room 334 was removed on 9/18/12 by the Maintenance Director. The power strip being used to power the resident's motorized bed in room 206 was removed on 9/18/12 by the Maintenance Director.	10/25/12
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 electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, approximately thirty-five (35) residents, staff, and visitors. The facility has one-hundred (100) certified beds and the census was eighty (80) on the day of the survey. The findings include: Observation, on 09/18/12 at 10:30 AM, with the Maintenance Director revealed a power strip was being used to power medical equipment (an I.V. pole) in resident room 334. Interview, on 09/18/12 at 10:30 AM, with the Maintenance Director revealed he was not aware of the misuse of a power strip in resident room	K 147	On 9/18/12 upon rounds conducted by the Life Safety Code Surveyor and the Maintenance Director no other areas were identified to have a power strip being utilized improperly. The Maintenance Director and Assistant Maintenance Director were re-educated on 10/9/12 by the Executive Director regarding K 147 NFPA 101 Life Safety Code Standard and a review of the 9/18/2012 Life Safety Code Deficiencies. All staff will be re-educated by the Maintenance Director or Assistant Maintenance Director regarding not plugging any medical equipment, refrigerators, microwaves etc... into power strips on or by 10-24-12 or prior to their next scheduled shift. The Maintenance Director and or Assistant Maintenance Director will audit 100% of the facility by physically inspecting to ensure appliances such as medical equipment, refrigerators and microwaves are not plugged into power strips in any location in the facility. Audit tools are to be	



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

PRINTED: 09/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185149	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BARDSTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 120 LIFE CARE WAY BARDSTOWN, KY 40004	
(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 147	Continued From page 8 334. Further interview, on 09/18/12 at 10:35 AM, with the Nurse in charge of the Wing revealed she was unaware of medical equipment being plugged into a power strip and acknowledged the requirement for medical equipment to be plugged directly into a wall mounted electrical outlet. Observation, on 09/18/12 at 2:30 PM, with the Maintenance Director revealed a power strip was being used to power medical equipment (the resident's motorized bed) in room 206. Interview, on 09/18/12 at 2:30 PM, with the Maintenance Director revealed he was not aware of the resident's motorized bed being plugged into a power strip. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D 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.	K 147	completed weekly for 2 months, semi-monthly for 2 months and monthly for 5 months. The Executive Director will review audit findings from the audits weekly for two months, semi-monthly for 2 months and monthly for 5 months. The Performance Improvement Committee will review the monthly findings and make any recommendations they deem appropriate. The Maintenance Director and or Assistant Maintenance Director will audit 100% of the facility by physically inspecting to ensure appliances such as medical equipment, refrigerators and microwaves are not plugged into power strips in any location in the facility. Audit tools are to be completed weekly for 2 months, semi-monthly for 2 months and monthly for 5 months. The Executive Director will review audit findings from the audits weekly for two months, semi-monthly for 2 months and monthly for 5 months. The Performance Improvement Committee will review the monthly findings and make any recommendations they deem appropriate. Completion Date: 10/25/12	

