

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 226 SS=D	<p>A Standard Recertification Survey was initiated on 03/30/10 and concluded on 04/01/10 and a Life Safety Code Survey was conducted on 04/01/10. Deficiencies were cited with the highest scope and severity being an "E".</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure abuse policies and procedures were followed for one (1) of twenty (20) sampled residents, Resident #13.</p> <p>The findings include:</p> <p>On 03/31/10 the facility Administrator informed the survey team of an allegation of abuse related to a staff member and a resident. Review of the initial abuse report from the facility revealed that on 03/30/10 at approximately 11:00 AM the alleged perpetrator was witnessed to taunt Resident #13 using a closed fist.</p> <p>Review of the facility's policy "Protection of Resident During an Investigation" revealed a staff member implicated in an abuse situation would be immediately removed from any resident contact. However, the investigation determined the the alleged perpetrator was allowed to work from 11:00 AM (estimated time the event</p>	F 226	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F226</p> <p>Resident #13 was assessed on 3/30/10 with no apparent injuries secondary to potential abuse noted; however, resident did receive skin tear while being combative in event leading up to potential abuse episode. Treatment of "Adaptic dressing with Kling wrap twice-a-day for 5 days" was obtained on 3/30/10 and was successful in healing</p> <p>Residents have the potential to be affected. LPN #3 was re-educated on 3/30/10 on Abuse and Neglect policy and procedures by the administrator; including immediate reporting of any instance where abuse/neglect may have occurred. The aide in-question was immediately removed from direct resident care.</p> <p>All facility staff have been re-educated on the Abuse and Neglect policy and procedures by the Staff Development Coordinator (SDC), the Director of Nursing (DNS) and/or the Administrator by 5/14/2010. All applicable agency staff has received education by agency nurse management by 5/14/2010 with verification submitted to the SDC.</p>	5/14/2010

RECEIVED
APR 26 2010
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X8) DATE 4/23/2010
---	-----------------------------	------------------------

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

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330	
(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 226	<p>Continued From page 1 occurred) until after 2:30 PM (the end of the alleged perpetrator's scheduled shift).</p> <p>Interview, on 03/31/10 at 2:10 PM, with Certified Nursing Assistant (CNA) #2 revealed she had been assisting the alleged perpetrator provide care to Resident #13. She stated the resident had been combative and the Alleged Perpetrator had spoken in a tone that expressed she was "aggravated/bothered" by the resident's combative behavior. CNA #2 stated she did not see the alleged perpetrator, taunt the resident because her back was to alleged perpetrator. CNA #2 stated the alleged perpetrator was still in the facility when she left at approximately 2:45 PM.</p> <p>Interview, on 04/01/10 at 10:00 AM, with Licensed Practical Nurse (LPN) #3 revealed she was present when the alleged perpetrator had taunted Resident #13. She stated the alleged perpetrator had jabbed her fist toward the resident and said "who you going to hit". The LPN stated upon exiting the room the alleged perpetrator stated "that's why we don't f***ing deal with him". The LPN stated she did not remove the alleged perpetrator from caring for residents because she did not initially see the taunting as abusive. LPN #3 stated later that day she had talked with her supervisor and realized the taunting was abusive. The LPN stated she should have removed the alleged perpetrator from resident care immediately after observing the incident.</p> <p>Interview, on 04/01/10 at 12:09 PM, with Registered Nurse (RN) #4 revealed LPN #3 had told her about what occurred between Resident #13 and the alleged perpetrator. RN #4 stated it was after the alleged perpetrator had left for the</p>	F 226	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Any new agency staff will receive education by agency nurse management with verification submitted to the SDC. Any staff member not educated by 5/14/2010 will be removed from the schedule until such re-education has been completed. All new hires after 5/14/2010 will receive this education during orientation.</p> <p>Quarterly in-services will be conducted for two quarters by the Administrator, Social Worker and/or the Director of Nursing to include verbal testing of employee's knowledge of Abuse and Neglect policy. Any further abuse/neglect allegations will be reviewed by the Administrator and/or the Director of Nursing to verify protocol followed. All allegations will be presented by the Administrator to PI for three months then as-needed to monitor for adherence to policy and identify any trends.</p>	5/14/2010

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330
--	--

(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 226	Continued From page 2 day. She explained as soon as she was made aware of the situation she reported the event of possible abuse to the Administrator. Interview, on 04/01/10 at 2:00 PM, with the Alleged Perpetrator revealed she denied saying or doing anything that was alleged by LPN #3. She stated she did not become aware of the allegations until later in the evening when the Administrator called and informed her not to come to work until the investigation was completed. Interview, on 04/01/10 at 2:14 PM, with the Administrator revealed the facility policy was to immediately suspend anyone accused of abuse. He stated upon receipt of the allegation LPN #3 was in-serviced on the abuse policy and an investigation was initiated. The Administrator stated the facility planned to substantiate the allegation due to testimony of the witnesses.	F 226	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	5/14/2010
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure comprehensive assessments were completed in	F 273	F273 Resident #8's MDS in question was reviewed by the Inter-Disciplinary Team "IDT" (Consisting of Administrator, DNS, SDC, UM (Unit Manger), MDS Coordinator, Case Manager, Social Worker, Activity Director, Therapy Manager, Dietary Manager and/or Assistant Social Worker) to ensure no vital information was missed during the initial 14 day assessment window and that the 3/2/10 Significant Change of Condition was accurate. All admitted/readmitted residents have the potential to be affected. A review of all (re)admissions within the past 30 days was	

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330
--	--

(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 273	<p>Continued From page 3</p> <p>a timely manner for one (1) of twenty (20) sampled residents (Resident #8). Resident #8 was readmitted to the facility on 02/09/10 however, the comprehensive assessment was noted to have been completed on 03/02/10.</p> <p>The findings include:</p> <p>Review of Resident #8's medical record revealed the resident was readmitted to the facility on 2/9/2010, with diagnoses which included right hip fracture. A Significant Change Comprehensive Assessment was completed by the facility, which was signed, by the RN (Registered Nurse) Assessment Coordinator as being completed on 03/02/10. Therefore, the assessment failed to be completed within fourteen (14) days after the resident was readmitted to the facility.</p> <p>Interview with RN #1/MDS Coordinator, on 4/1/2010 at 2:40 PM, revealed Resident #8's Minimum Data Set (MDS) had not been completed in fourteen (14) days. RN #1 stated "I'm just one person doing the best I can with the total number of new or significant change assessments, to monitor time frames on, one may have slipped through".</p>	F 273	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>conducted by the Case Manager between 4/1 to 4/10/2010.</p> <p>A calendar with all applicable assessment timeframes has been implemented to ensure timely completion of assessments. The Inter-Disciplinary Team "IDT" (Consisting of Administrator, DNS, SDC, UM, MDS Coordinator, Case Manager, Social Worker, Activity Director, Therapy Manager, Dietary Manager and/or Assistant Social Worker) was educated by Administrator on the calendar.</p> <p>An audit will be completed for 4 weeks then monthly for 2 months by the DNS or Case Manager to ensure timely MDS submittals. The Case Manager will submit audit results to PI for three months then as-needed to ensure compliance and address any noted trends.</p>	5/14/2010
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive</p>	F 279	<p>F279</p> <p>Resident #9 will be re-assessed by the Inter-Disciplinary Team "IDT" (Consisting of Administrator, DNS, SDC, UM, MDS Coordinator, Case Manager, Social Worker, Activity Director, Therapy Manager, Dietary Manager and/or Assistant Social Worker)</p>	

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330
--	--

(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 279	<p>Continued From page 4 assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure a Comprehensive Plan of Care was developed based on the needs for one (1) of twenty (20) sampled residents (Resident #9). The facility identified through the MDS Assessment Resident #9 received Antipsychotic medications, however, a Comprehensive Plan of Care was not developed related to the use of these medications.</p> <p>The findings include:</p> <p>Record review revealed Resident #9 was admitted with diagnoses which included Alzheimers, Psychosis and Dementia. Review of the Physician orders revealed Resident #9 received included the following medications related to Psychosis; Depakote, Namenda, Razadyne and Zyprexa.</p> <p>Review of the Annual MDS Assessment, with an Assessment Reference Date of 10/30/09 revealed, the facility assessed Resident #9 as</p>	F 279	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>with updated MDS and applicable RAPS by 5/14/10 to ensure all appropriate medications have been addressed and care planned.</p> <p>All residents have the potential to be affected. All RAPS have been reviewed to ensure that triggered areas included documentation to describe the nature of condition; complications and risk factors; factors that must be considered in development of care plan; and the need for referrals. In addition, all residents have been reviewed to ensure that appropriate care plans were developed based on RAP documentation.</p> <p>IDT members were re-educated by the DNS or the Administrator on process of ensuring any items triggered have a corresponding and detailed care plan and RAP that addresses the issue. Any new IDT members after 5/14/2010 will receive this education during orientation. Agency is not used in lieu of IDT members.</p> <p>Audits will be conducted by the DNS for all full assessments for 3 months. Then, audits will be submitted to PI for three months and as-needed thereafter to identify any trends.</p>	5/14/2010

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330	
(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 279	Continued From page 5. receiving Antipsychotic medications seven (7) out of seven (7) days. However, review of the Resident Assessment Protocol Summary (RAPS), dated 11/10/09, reveled no documented evidence the facility address the use of these medications or any complications and/or risk factors related to these medications. Review of Resident #9's Comprehensive Plan of Care, dated on 02/16/10, revealed no documented evidence a Plan of Care had been developed related to this resident's use of Antipsychotic medications. Interview on 04/01/10, with RN #1/MDS Coordinator revealed a Plan of Care should have been developed related to the use of Psychotropic medications since it had been a triggered area on the RAPS.	F 279	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	5/14/2010
F 286 SS=E	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined the facility failed to ensure residents' assessment data completed within the previous fifteen (15) months were maintained in the residents' active record and or in a centralized location, accessible to all professional staff who need to review the information in order to provide care to the resident, for seven (7) of twenty (20) sampled	F 286	F286 Resident records #3, #4, #9, #11, #14, #15 and #16 were all reviewed by 4/30/10 with any applicable MDS assessments made available for the last 15 months. All residents have the potential to be affected. An audit was completed by the Health Information Coordinator from 4/26/10 to 4/30/10 to ensure all residents have the required 15 months of assessments readily available to all applicable healthcare professionals. Any noted to have missing assessments have been updated. Re-education occurred on 3/31/10 with the Date Entry Coordinator regarding responsibilities of timely filing of assessments to include current 15 months available at all times. Any new employee updating MDS assessments after 5/14/2010 will obtain this education during orientation. No agency personnel are used in this capacity. The Case Manager will conduct audits of MDS assessments to ensure timely completion for four weeks, then monthly for two months for verification. Case Manager	

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330
--	--

(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 286	<p>Continued From page 6</p> <p>residents (Resident's #3, #4, #9, #11, #14, #15 and #16).</p> <p>The findings include:</p> <p>Review of Resident #4's medical record revealed the RAPS for a Significant Change Assessment with an assessment reference date of 12/13/09, was not in the active record.</p> <p>Review of Resident #14's medical record revealed only 8 months (04/24/09 through 12/28/09) of the resident's assessment information was in the active record.</p> <p>Review of Resident #3's medical record on 03/31/10 at 11:00 AM, revealed that the Resident was admitted to the facility on 03/15/06. Further review revealed that only 9 (nine) months (05/09/09 through 01/06/10) of the Minimum Data Set (MDS) was in the active record.</p> <p>Review of Resident #16's medical record revealed the resident was admitted to the facility on 03/08/09. Further review revealed only 9 (nine) months (05/08/09 through 01/07/10) of the Minimum Data Set (MDS) was in the active record.</p> <p>Review of the medical record revealed, Resident #9, #11 and #15 failed to fifteen (15) months of Minimum Data Sets (MDS) readily available. Resident #9's Quarterly assessment, with Assessment Reference Date (ARD) of 01/20/10, was not readily available. Resident #11's Annual assessment, with an ARD of 02/08/10, was not readily available. Resident #15's Admission assessment, with an ARD of 03/22/10, was not readily available.</p>	F 286	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>will present results to PI for three months then as-needed to determine any noted trends or concerns.</p>	5/14/2010

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 863 LEXINGTON ROAD HARRODSBURG, KY 40330
--	--

(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 286	Continued From page 7 Interview with RN #1 on 03/31/10, at 10:30 A.M., revealed that all MDS data is kept in notebooks at the nursing station and she was unable to locate the MDS for Resident #4, but printed from the computer. Further interview with RN #1, on 04/01/10, at 2:40 P.M., revealed that the Resident Care System Coordinator (RCS), enters all MDS data into the computer, and after the RN Coordinator signed the MDS she was responsible for filing the MDS in the books on the units. She further stated that they (the facility) had a lot of people in the facility assisting with thinning the records and the RCS was very knowledgeable but did not have any guidelines to go by. She also stated if a MDS was not in the book on the unit then it would be in the MDS office and would be available to nurses or other professionals at all times as they have a key to the MDS office. Interview with LPN #3, on 04/01/10, at 3:30 P.M. revealed she was only aware that the MDS were kept in the binders at the nurses station. She further stated "We do not have a key to the MDS office that I'm aware of".	F 286	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	5/14/2010
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced	F 322	F322 Resident #2 was assessed on 4/2/2010 for adverse effects of medications pushed via G-tube with no adverse effects noted. All residents receiving medication and/or flushes via G-tube have the potential to be affected. LPN #2 was re-educated by the Staff Development Coordinator on 4/1/10 regarding the company's policy on G-tube administration of medication and flushes. All nurses have been re-educated on the policy for G-tube administration of medication and/or flushes by the DNS, UM or SDC by 5/14/2010. All agency personnel have been educated by agency nurse management with verification provided to the SDC. Any current nurse that has not received this re-education by 5/14/2010 will be removed from the schedule. Any new agency personnel used will receive this education by agency nurse management and verification provided to the SDC. Any new nurse hired after 5/14/2010 will receive this information during orientation.	

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330	
(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 322	Continued From page 8 by: Based on observation, interview, and record review it was determined the facility failed to ensure one (1) of twenty (20) sampled residents, Resident #2 received appropriate treatment and services related to a gastrostomy tube (g-tube). The findings include: Observation, on 03/31/10 at 11:00 AM, revealed Licensed Practical Nurse (LPN) #2 administered medication via a g-tube for Resident #2. After checking placement of the g-tube the LPN aspirated approximately 60 cubic centimeters (cc) of water into the syringe. The LPN then attached the syringe to the g-tube and pushed the water through the g-tube. Interview, on 04/01/10 at 10:49 AM, with LPN #2 revealed she always pushed the first flush through the g-tube. She stated she did not know the facility's policy related to flushing g-tubes. Interviews, on 04/10/10 at 10:41 AM, with LPN #4 revealed all medications and flushes given via a g-tube were to be allowed to flow by gravity and not pushed. Interview, on 04/10/10 at 11:28 AM, with the Director of Nursing revealed all flushes given via g-tube were to be allowed to flow by gravity and not pushed. Review of the facility's policy "Medication via Feeding Tube" all medications were to be allowed to flow via gravity.	F 322	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> Each nurse will be evaluated via demonstration by the DNS, UM or SDC quarterly for two quarters to verify proper procedure. SDC will report nursing evaluations to PI for three months then as-needed to ensure all applicable staff adheres to procedures and to determine any trends and/or additional educational needs. F328 Resident's #4, #7, #14 and #16 oxygen equipment was assessed on 4/2/10 with all filters cleaned and tube appropriately dated. All residents receiving continuous oxygen have the potential to be affected. On 4/2/10 contracted vendor cleaned all concentrators currently in use and all tubing dated.	5/14/2010
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328		

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330	
(X4) ID-PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID-PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	<p>Continued From page 9</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure proper treatment and care for special services for four (4) of twenty (20) sampled residents, Residents #4, #7, #14, and #16, related to Respiratory Care.</p> <p>The findings include:</p> <p>Observation of Resident #4 on 03/30/10, at 10:30 A.M. through 4:00 P.M., revealed the resident was receiving oxygen (O2) at 2 liters per minute via nasal canula (NC), no date was observed on the O2 tubing and the concentrator's filter was covered with dust particles. Review of the Physician orders revealed the resident was to receive O2 at 2 liters per minute via NC.</p> <p>Observation of Resident #7 on 03/30/10, at 10:35 A.M., revealed the resident had O2, the tubing was laying on the bed and resident appeared to be sleeping. The O2 tubing was noted to be undated and the concentrator filter was covered</p>	F 328	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>No concerns were identified with care pertaining to: Parenteral/Enteral Fluids; Colostomy, Ureterostomy or Ileostomy; Tracheostomy Care; Tracheal Suctioning; Respiratory Care; Foot Care or Prostheses.</p> <p>Contracted vendor was instructed by the Administrator on 4/2/10 to review all concentrators weekly to ensure clean filters at all times. Contracted vendor also instructed to date all tubing weekly as tubing for each applicable resident is changed. Contracted vendor to provide weekly verification of work completed to the Administrator.</p> <p>All nurses re-educated by 5/14/2010 by the DNS, UM or SDC on the requirement to date tubing if changed and the procedure of cleaning filters if needed between weekly maintenance by the contracted vendor. All applicable agency nurses have received education by agency nurse management by 5/14/2010 with verification submitted to the SDC. Any new agency nurse will receive education by agency nurse management with verification submitted to the SDC. Any nurse hired after 5/14/2010 will receive this education during orientation.</p>	5/14/2010

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	<p>Continued From page 10</p> <p>with dust particles. Review of the Physician orders revealed the resident was to receive O2 at 2 L per minute via NC. Observation on 03/31/10, at 9:30 A.M., revealed the O2 tubing was laying on the bed, the resident was observed to put the O2 on, at that time.</p> <p>Observation of Resident #16 on 03/31/10 at 6:30 PM and 04/01/10 at 11:50 AM, revealed the resident was receiving oxygen (O2) at 2 liters per minute via NC, no date was observed on the O2 tubing and the concentrator filters were covered with white dust particles. Review of the Physician orders revealed an order for O2 at 2 liters per minute via NC.</p> <p>Observation of Resident #14 on 03/31/10, at 5:30 P.M., and 04/01/10 at 9:05 A.M., revealed the resident was receiving O2 at 2 liters per minute via NC, no date was observed on the O2 tubing and the concentrator filter was covered with dust particles. Review of the Physician orders revealed the resident was ordered to receive O2 at 2 liters per minute via NC.</p> <p>Interview with RN #3, on 04/01/10, at 11:45 A.M., revealed O2 tubing should be changed and dated every week and "as needed". RN #3 indicated she was unsure as to the facility's related to cleaning the filters but, any time they were dirty they should be washed. She further stated "I checked some of the O2 tubings yesterday and there was no date. We need to come up with a schedule to change the tubing and clean the filters".</p> <p>Interview with the Respiratory Technician on 04/01/10 at 2:15 PM, revealed she was hired as a part-time employee on March 1, 2010 to maintain</p>	F 328	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>DNS will conduct weekly random audits of tubing and filters for four weeks then monthly for two months to ensure compliance. Audits will be reported by the DNS during P1 for three months then as-needed to verify appropriate procedures and to identify any trends.</p>	5/14/2010

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 863 LEXINGTON ROAD HARRODSBURG, KY 40330
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 11 the oxygen concentrators at the facility until the contract ends in May 2010. Oxygen concentrator filters were to be cleaned every Thursday of each week. She stated that she was not trained by the facility on O2 policies and was not aware of a policy for cleaning the filters on a as needed basis. Further, she stated she doesn't check or date tubing when changed; therefore, staff wouldn't know when tubing was changed.	F 328	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</i>	
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 be free of medication error rate of less than five percent (5%). It was determined the facility had four (4) medication errors out of forty-five (45) opportunities, for an error rate of eight percent (8%). The findings include: Review of the facility's policy "Medication Administration" revealed medications were to be administered within sixty (60) minutes earlier or later than the scheduled time of administration. Additionally, the policy stated the MAR should be review to verify the necessary doses of medication were administered. Observation of the medication pass, on 03/31/10 at 9:34 AM, revealed Licensed Practical Nurse	F 332	F 332 Resident #24 was assessed on 4/1/10 and showed no adverse signs/symptoms to medication errors. MD notified on 4/1/10 with no additional orders received. All residents have the potential to be affected. LPN #3 was re-educated by SDC on 4/1/10 regarding medication administration protocol. All nurses received re-education by 5/14/2010 by the DNS, UM or SDC on medication administration policy. All applicable agency nurses have received education by agency nurse management by 5/14/2010 with verification submitted to the SDC. Any new agency nurse will receive education by agency nurse management with verification submitted to the SDC. Any nurse not receiving this re-education by 5/14/2010 will be removed from the schedule. All newly hired nurses after 5/14/2010 will receive this education during orientation. All nurses will be observed during med pass once per quarter for two quarters by the DNS, UM or SDC to ensure medication	5/14/2010

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 332	<p>Continued From page 12</p> <p>(LPN) #3 passed medications to an un-sampled resident, Resident #24. These medications were administered one and one-half hour, after the scheduled time. Allopurinol (Gout Medication) 100 milligrams (mg) was given, however per review of the Medication Administration Record (MAR) the medication was scheduled for 8:00 AM. Coreg (blood pressure medication) 6.25 mg was not administered, but was available in a location unknown to the nurse. Metformin (diabetic medication) 500 mg was given, however per the MAR the medication was scheduled for 8:00 AM. Additionally, Resident #24 received one (1) spray of Flonase to each nares, however per the MAR the resident was to receive two (2) sprays per nares.</p> <p>Review of the Physician's Orders revealed Resident #24 was to received Metformin 500 mg, Coreg 6.25 mg, and Allopurinol 100 mg twice daily. Additionally, Resident #24 was to received Flonase nasal spray two (2) sprays per each nares daily.</p> <p>Interview, on 04/01/10 at 10:00 AM, with LPN #3 revealed she was new to the facility was just learning the residents' routine. She explained as a result she was spending time trying to locate residents in order to provide medications. She stated this resulted in the medications being given late. LPN #3 stated she had learned Resident #24's Coreg had been stored in another medication cart at the end of her shift on 03/31/10. The LPN stated the facility policy was that medication can be given one (1) prior to one (1) hour after the scheduled time. Additionally, LPN #3 stated she did not give Resident #24 the second spray of Flonase as ordered. The LPN explained she usually waited five (5) minutes</p>	F 332	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <hr/> <p>administration is timely, accurate and in accordance with policy and procedure.</p> <p>Observations will be reported by the SDC to PI for three months then as-needed to identify any trends and/or further educational needs.</p>	5/14/2010

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 863 LEXINGTON ROAD HARRODSBURG, KY 40330
--	--

(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 13 between each spray per the resident's preference. LPN #3 stated she "did not go back and do it yesterday".	F 332	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> F431 Nystop was disposed of on 4/2/10. All residents have the potential to be affected. On 4/2/10 all resident care areas were assessed to ensure no medications were accessible to unauthorized staff and/or residents. All licensed staff were re-educated on the policy for proper storage of medication and proper disposal/return of medication/treatments of discharged residents by the DNS, UM or SDC by the 5/14/2010. All applicable agency staff has received education by 5/14/2010 by agency nurse management with verification submitted to the SDC. Any new agency personnel will receive education by agency nurse management with verification submitted to the SDC. All licensed staff not receiving this re-education by 5/14/2010 will be removed from the schedule until this re-education has been received. All newly hired licensed staff after 5/14/2010 will receive this education during orientation. The UM or SDC will do weekly rounds of resident-care areas for four weeks,	5/14/2010

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330	
(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 431	<p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to store medications in a locked compartment which permitted access to authorized personnel. Observation of the north shower room revealed a bottle of Nystop (an anti-fungal medication) was stored in a wash basin accessible by unauthorized staff and residents who utilized the shower room.</p> <p>The finding include:</p> <p>Review of the facility's policy "Storage of Medications" access to medications was restricted to those personnel lawfully authorized to administer medications.</p> <p>Observation of the north shower room on 03/30/10 at 9:15 AM and 03/31/10 at 10:12 AM revealed a wash basin containing a bottle of Nystop which was labeled with a resident's name. Review of the facility discharge records revealed the resident was discharged on 01/13/10. Observation of the north shower room on 04/01/10 at 9:35 AM, revealed the wash basin containing Nystop remained in the shower room.</p> <p>Interview, on 04/01/10 at 9:35 AM, with Certified Nursing Assistant (CNA) #4 revealed medications were not to be stored in the shower room. She stated all items were to be returned to the resident's room after use.</p> <p>Interview, on 04/01/10 at 9:40 AM, with CNA #3 revealed all personal care items are to be returned to resident rooms after use. She stated</p>	F 431	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</i></p> <p>then monthly for two months to ensure compliance by all licensed staff. The SDC will provide rounds to PI for three months then as-needed to identify areas of concern or any trends.</p>	5/14/2010

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330	
(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 431	Continued From page 15 any medications should be taken to the nurse, who will put back in the medication cart. CNA #3 stated the un-sampled resident had expired at the facility, but could not remember the date. CNA #3 discarded all items which did not have a resident name on them and took the medication to the nurse. Interview, on 04/01/10 at 9:50 AM, with the Unit Manager/ RN #4 revealed she was not aware the medication was in the shower room until the CNA "brought it to her attention, just now". The Unit Manger stated the Nystop powder should have been returned to the treatment cart for storage after it was used. She explained only licensed nurses should have access and use the Nystop.	F 431	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (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	F 441	F441 Resident #23, #2 and #3 were assessed on 4/3/2010 and determined to have no negative outcomes secondary to potential infection control non-adherence. All residents have the potential to be affected. LPN #2, 3 and 4 were re-educated on 4/2/10 regarding policies on "Regulated Waste Management" and "Medication via Feeding Tube". All nurses received re-education by 5/14/2010 by the DNS, UM or SDC on policies for "Medication via Feeding Tube" and "Regulated Waste Management". Education included, but not limited to, appropriate handling and disposal of contaminated items, sharps, and the appropriate handling, cleaning and storage of syringes for enteral feeding. All applicable agency nurses have received education by agency nurse management by 5/14/2010 with verification submitted to the SDC. Any new agency nurse will receive education by agency nurse management with verification submitted to the SDC.	5/14/2010

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330	
(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 16</p> <p>isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to maintain an infection control program to help prevent the development and transmission of disease and infection within the facility. Facility staff were observed to discard blood soaked glucose strips and lancets into the trash cans in two (2) resident rooms, placed the plunger for a syringe used for a tube feeding resident onto a beside table, and one (1) Licensed Practical Nurse (LPN) removed blood soak glucose strips without wearing gloves.</p> <p>The findings include:</p> <p>Review of the facility's policy "Regulated Waste Management" revealed any item which had blood present was contaminated. Additionally, the policy defined items contaminated by blood as Regulated Waste which is to be separated from</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>All nurses not receiving this re-education by 5/14/2010 will be removed from the schedule. All newly hired nurses after 5/14/2010 will receive this education during orientation.</p> <p>Observations will be conducted by the DNS, UM or SDC to verify no improper disposal of regulated waste and for appropriate handling of enteral feeding syringes. Observation will be conducted for 4 weeks, then monthly for two months to ensure adherence to proper waste disposal. Additionally, all nurses will receive a review of proper medication administration via feeding tube monthly over the next 3 months by the DNS, UM or SDC.</p> <p>The SDC will present audits to PI for three months then as-needed, to identify any trends. The SDC will also present medication audits to PI for three months then as-needed to determine medication compliance is maintained.</p>	5/14/2010

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330
--	--

(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 17</p> <p>the general waste stream in the resident care areas. Per the policy the separation of regulated waste would be implemented by utilizing the appropriate containers until the waste could be transported.</p> <p>1. Observation, on 03/30/10 at 11:40 AM, revealed LPN #4 removed a glucose strip from the glucometer with her un-gloved hand and discard the glucose strip into the resident's trash can. LPN #4 repeated this process with two (2) additional strips, for the un-sampled resident, Resident #23. Additional observation at 11:45 AM revealed LPN #3 entered Resident #3's room and again removed the glucose strip soiled with blood using an un-gloved hand and discarded the strip into the resident's trash can.</p> <p>Observation, on 03/31/10 at 11:00 AM, revealed LPN #2 attempted to perform an accu-check for Resident #3. The first finger stick did not provide sufficient blood for the test. The LPN gathered the blood soaked strip and lancet and threw them into the resident's trash can. LPN #2 then obtained a second lancet and glucose strip and obtained the blood sugar reading. The LPN removed the blood soaked strip from the glucometer and picked up the lancet from the bed side table. LPN #2 removed her gloves in a manner to wrap the lancet and the glucose strip inside the glove. The LPN left Resident #3's room and discarded the gloves into the trash container located on the side of the medication cart.</p> <p>Interview, on 04/01/10 at 10:41 AM, with LPN #4 revealed she was not aware she removed her gloves prior to removing the glucose strips from the glucometer and threw the strips into the</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	5/14/2010

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 883 LEXINGTON ROAD HARRODSBURG, KY 40330	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 441	<p>Continued From page 18</p> <p>residents' trash cans. LPN #4 stated the strips and lancets should be discard in a sharps container.</p> <p>Interview, on 04/01/10 at 10:49 AM, with LPN #2 revealed she was not aware she had discarded the lancet and strip into Resident #3's trash can. Additionally, the LPN stated she did not realize she had discarded the second lancet and strip in the trash on the medication cart. LPN #2 stated they should have been placed into the sharps constrainer.</p> <p>Interview, on 04/01/10 at 11:00 AM, with the Infection Control Nurse revealed lancets and glucose strips should have been discarded in the sharps container and not the residents' trash cans.</p> <p>2. Observation, on 03/31/10 at 11:24 AM, revealed LPN #2 administered medications via gastronomy tube (g-tube) to Resident #2. During the administration of the medication the LPN placed the plunger from the syringe onto the resident's bed side table. Upon completion of the medication administration LPN #2 placed the plunger back into the syringe, placed the syringe into plastic bag, hung the bag on the pole for the tube feeding pump, and exited the room. The LPN did not rinse the syringe after the medication was administered.</p> <p>Interview, on 04/01/10 at 10:49 AM, LPN #2 revealed she had placed the plunger on the bed side table while administering the medications. The LPN did not identify the placement of the plunger on the bed side table as a concern. In additional interview, LPN #2 stated she should</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	5/14/2010

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 441	Continued From page 19 have rinsed the syringe prior to placing it back in the plastic bag. Interview, on 04/10/10 at 11:00 AM, with the Infection Control Nurse revealed the plunger should not have placed on the bed side table. She stated it should have been placed on a paper tower or held to prevent contamination. Review of the facility's policy "Medication via Feeding Tube", dated 04828/09 revealed there was guidance as to where to place the plunger once it was removed from the syringe.	F 441	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The findings include: Observation of the north shower room on 03/30/10 at 9:15 AM and 03/31/10 at 10:12 AM revealed a wash basin containing several residents' personal care items. Observation of the north shower room on 04/10/10 at 9:35 AM, revealed the wash basin containing the personal care items and Nystop remained in the shower	F 465	F465 Nystop was disposed of on 4/2/2010. All residents have the potential to be affected. On 4/2/10 all resident care areas were assessed to ensure no medications were present and all applicable wash basins and resident's personal belongings were in the appropriate locations. All licensed staff received re-education by 5/14/2010 on proper storage of personal affects and appropriate storage of medication. This re-education conducted by the DNS, UM or SDC. All applicable agency staff received education by agency nurse management by 5/14/2010 with verification submitted to the SDC. Any new agency staff will receive education by agency nurse management with verification submitted to the SDC. Any licensed staff that has not received the re-education by 5/14/2010 will be removed from the schedule until re-education occurs. All newly hired licensed staff after 5/14/2010 will receive this education during orientation.	5/14/2010

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 863 LEXINGTON ROAD HARRODSBURG, KY 40330
--	--

(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 465	<p>Continued From page 20 room. (Cross Reference F-431).</p> <p>Interview, on 04/01/10 at 9:35 AM, with Certified Nursing Assistant (CNA) #4 revealed personal care products and medications were not stored in the shower room. She stated all items were to be returned to the resident's room after use. CNA #4 exited the shower room leaving the wash basin and personal care items.</p> <p>Interview, on 04/01/10 at 9:40 AM, with CNA #3 revealed all personal care items were to be returned to resident rooms after use. She stated any medications should be taken to the nurse, who will put back in the medication cart. CNA #3 stated the un-sampled resident had expired at the facility, but could not remember the date. CNA #3 discarded all items which did not have a resident name on them and took the medication to the nurse.</p> <p>Interview, on 04/01/10 at 9:50 AM, with the Unit Manager (Registered Nurse #4) revealed she was not aware the medication was found in the shower room until the CNA "brought it to her attention, just now". The Unit Manger stated the personal care items should have been returned to the residents' rooms after their showers.</p>	F 465	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Weekly monitoring will be conducted by the DNS, UM, SDC or Administrator for 4 weeks, then monthly for two months to ensure compliance. The SDC will present audits to PI for three months then as-needed to evaluate compliance by licensed staff and identify any trends.</p>	5/14/2010

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

PRINTED: 04/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2010
NAME OF PROVIDER OR SUPPLIER HARRODSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 669 LEXINGTON ROAD HARRODSBURG, KY 40330	
(X4) ID PREFIX TAG K 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on April 1, 2010 for compliance with Title 42, Code of Federal Regulations, 483.70 and found the facility in compliance with NFPA 101 Life Safety Code, 2000 Edition. No deficiencies were identified during this survey.	ID PREFIX TAG K 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

RECEIVED
MAY 21 2010
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Nancy Russell* TITLE *Executive Director* (X6) DATE *5-21-10*

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.