

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185174	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Florence Park Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6975 Burlington Pike Florence, KY 41042	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50192</p> <p>Based on observation, interview, review of the website https://www.accessdata.fda.gov, and review of the facility's policy, the facility failed to ensure all drugs used in the facility were labeled in accordance with professional standards and used prior to the expiration date for 2 of 7 medication carts, C1 Hall and C2 Hall Medication Carts.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Storage of Medications, revised date 11/2023, revealed the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. In addition, the policy stated some drugs had a shelf life that was different from the expiration date after opening (i.e. insulin). Per the policy, those drugs shall be labeled with the date opened to ensure that no outdated or deteriorated drugs were stored.</p> <p>Review of the website https://www.accessdata.fda.gov under Instructions for Use, for a Novolog insulin vial, revised 12/2012, revealed opened Novolog vials should be thrown away after 28 days, even if they still have insulin left in them.</p> <p>1. Observation on 10/16/2024 at 2:50 PM revealed the medication cart, located on C1 Hall, contained a multi-dose vial of Novolog insulin, which was opened on 09/10/2024 and had exceeded the 28 day use date by eight days. This insulin was still in the medication cart and available for use.</p> <p>Further observation revealed the cart contained the following medications that were opened and not dated: Pro-Air multi-use inhaler (rapid relief inhaler); guaifenesin syrup (expectorant); and milk of magnesia (laxative).</p> <p>2. Observation on 10/17/2024 at 8:22 AM revealed the medication cart, located on C2 Hall, contained an unopened epinephrine pen (medication and hormone used to treat an allergic reaction) which expired in 07/2024.</p> <p>During an interview on 10/17/2024 at 8:22 AM with an agency nurse, Licensed Practical Nurse (LPN) 12, she stated she would question how effective the epinephrine pen would be since it had expired. She stated it was the responsibility of the nurse to verify that the medications should be checked and used before the expiration date and to replace them as needed.</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 185174
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/16/2024 at 3:10 PM with LPN6, she stated the risk of giving expired medications could be that they would not be as effective. She stated it was the nurse's responsibility to ensure medications given were not past the expiration date, to obtain refills as needed, and to place the opened date on the label of the medication. She also stated without identifying the date opened, it would be difficult to determine if the medication was still appropriate to use.</p> <p>During an interview on 10/16/2024 at 3:35 PM, a pharmacist with the facility's contracted pharmacy stated it was possible that any medication given past its expiration date could decrease the effectiveness and adversely affect the resident.</p> <p>During an interview on 10/17/2024 at 3:29 PM with the Assistant Director of Nursing (ADON), she stated it was the responsibility of the nurse and Unit Coordinator to monitor the carts for expired medications. She stated she expected all nursing staff to add an opened date to any medication that had the potential to be used more than once.</p> <p>During an interview on 10/18/2024 at 9:27 AM with the Administrator, she stated she expected the nursing staff to always follow the facility's policies.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>32635</p> <p>Based on observation, interview, and review of the facility's policy, the facility failed to serve hot food at a proper and palatable temperature. Observation of the test tray on 10/16/2024 revealed the scrambled eggs were 114 degrees Fahrenheit (F) and tasted warm for 3 of 25 sampled residents (Resident (R) 43, R59, and R66).</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Food Temperatures at Point of Service, not dated, revealed the food temperatures at the point of service included the dining room and room tray, which shall meet the palatability requirement of the resident community. Per the policy, hot foods would be served as hot as safely possible to meet the palatability requirement of the resident community.</p> <p>Observation revealed the breakfast test tray for the 200 Unit arrived on 10/16/2024 at 8:27 AM. Test tray results on 10/16/2024 at 8:39 AM, revealed oatmeal was at 153 degrees (F), scrambled eggs were at 114 degrees (F), milk was at 47 degrees (F), and Orange Juice (OJ) was at 40 degrees (F). The milk and OJ were cold and tasted cold; the oatmeal was hot and tasted hot; the scrambled eggs tasted room temperature and did not taste warm; and the hot plate was room temperature to the touch.</p> <p>In an interview with the Dietary Manager on 10/16/2024 at 8:30 AM, he stated the plates were placed in the warmer.</p> <p>Review of the facility's form Dietary Meal Temperature Log revealed the beginning food temperature for scrambled eggs was 172 degrees (F) at 7:30 AM and at 8:15 AM was 170 degrees (F).</p> <p>In an interview with R59 on 10/14/2024 at 3:00 PM, he stated the food tasted bad and cold. He stated he asked for food to be warmed, staff became frustrated, and he ate cold food.</p> <p>In an interview with the Dietary Supervisor on 10/17/2024 at 2:27 PM, he stated the plates were turned on for warming after the cook entered the kitchen. He stated, if the plates were not all heated in the warmer, they would not stay hot, and the scrambled eggs would not be acceptable to the residents.</p> <p>In an interview with the Dietary Manager on 10/17/2024 at 2:43 PM, he stated the plates were stacked high in the warmer and not hot. He stated the scrambled eggs were not hot and would not taste good to the residents.</p> <p>In an interview with the Assistant Director of Nursing (ADON) on 10/17/2024 at 3:30 PM, she stated she expected food to be served at the proper standard temperature.</p> <p>In an interview with the Administrator on 10/17/2024 at 3:50 PM, she stated if the resident's hot food was cold, the staff would provide a new tray.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>32635</p> <p>Based on the observation, interview, and record review, the facility failed to store food safely. Observation on 10/14/2024, during the initial kitchen tour, revealed the refrigeration storage log was incomplete for eight out of 14 days.</p> <p>The findings include:</p> <p>Review of the facility's document Monthly Temperature Logs, revealed it was used to record daily temperatures for the refrigerator, freezer, and dry storage. Further review revealed a notation on the bottom of the document which stated, Please notify Food Service Director if proper temperature is not held in any unit; Fridge 32-41 F [Fahrenheit]; Freezer-Below 0 F; and Dry Storage 50-70 F.</p> <p>Observation on 10/14/2024 at 4:30 PM, during the initial kitchen tour, revealed the posted Monthly Temperature Log, dated 10/2024, for refrigeration equipment revealed the dates for 10/01/2024, 10/02/2024, 10/03/2024, 10/04/2024 and 10/07/2024 were documented. However, no refrigeration equipment temperatures were documented for 10/05/2024, 10/06/2024, 10/08/2024, 10/09/2024, 10/10/2024, 10/11/2024, 10/12/2024, and 10/13/2024.</p> <p>In an interview with the Dietary Supervisor on 10/17/2024 at 2:27 PM, he stated it was important to ensure food was at the proper temperature to prevent the growth of bacteria. He stated equipment temperatures were recorded to ensure they were working properly.</p> <p>In an interview with the Dietary Director on 10/17/2024 at 2:43 PM, he stated the Dietary Supervisor covered many shifts and forgot to record the equipment temperature on the temperature log. He stated it was important to check the temperatures to ensure equipment was working properly because if they were not, the food could thaw and refreeze, and the food quality could change, allowing bacteria to grow.</p> <p>In an interview with the Assistant Director of Nursing (ADON) on 10/17/2024 at 3:30 PM, she stated there was a potential for spoilage of food if the refrigeration equipment was not working properly.</p> <p>In an interview with the Administrator on 10/17/2024 at 3:50 PM, she stated she expected refrigeration/freezer equipment temperatures to be taken and documented to ensure the equipment worked properly.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50192</p> <p>Based on observation, interview, record review, and review of the facility's policies, the facility failed to identify and correct problems related to infection prevention practices for 2 out of 25 sampled residents (Resident (R) 73 and R35). This failure placed the residents at increased risk for healthcare-associated infections (HAI). In addition, observation revealed two used breakfast trays and one used lunch tray left on the sink against the pump of thickened liquids container in the C Unit/COVID Unit kitchenette.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Medication Administration, revised 11/2023, revealed the individual administering medications would follow the infection control procedures including hand hygiene, aseptic technique, and isolation precautions during the administration of medications.</p> <p>Review of the facility's policy titled, General Infection Control, revised 03/2024, revealed all staff was expected to perform hand hygiene before and after resident contact, after removing gloves or other personal protective equipment (PPE), before eating, drinking, or handling food, and whenever hands became visibly soiled.</p> <p>1. a. Observation of medication administration by Licensed Practical Nurse (LPN) 12 on 10/15/2024 at 8:09 AM revealed she did not wash or otherwise disinfect her hands and did not apply gloves before administering medications, including eye drops, to R73. LPN12 also had an opened bottle of iced coffee on the top of her medication cart.</p> <p>During an interview on 10/15/2024 at 8:12 AM with LPN12, she stated the hand sanitizer on her cart would be an appropriate method of cleaning her hands between residents and gloves would have been appropriate for the administration of eye drops.</p> <p>b. Observation on 10/15/2024 at 8:13 AM revealed Activity Assistant (AA) 2 assisted R73 with her breakfast tray. AA2 had not washed or otherwise sanitized her hands, nor did she wear gloves. AA2 then picked up bacon and toast with her bare hands and made a sandwich for R73 to eat.</p> <p>During an interview with AA2 at the time of observation, she stated she should have washed her hands and used gloves before handling the resident's food, and she was in a hurry and was not paying attention.</p> <p>c. Observation of medication administration on 10/15/2024 at 8:15 AM by LPN12 revealed she failed to wash or otherwise disinfect her hands before administering medications to R35.</p> <p>During an interview on 10/17/2024 at 3:29 PM with the Assistant Director of Nursing (ADON), she stated she expected nursing staff to use alcohol based hand sanitizer between residents' medication administration, unless hands were visibly soiled, and then to use soap and water.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/18/2024 at 9:27 AM with the Administrator, she stated she was not clinical, but she expected the nursing staff to follow the facility's policies and the directions of the Director of Nursing (DON).</p> <p>32635</p> <p>2. Observation on 10/16/2024 at 2:29 PM revealed two used breakfast trays and one used lunch tray left in the C Unit/COVID kitchenette on the sink against the pump of the thickened liquids container.</p> <p>Review of the facility's form Tray Cart Times, not dated, revealed Breakfast was at 8:30 AM and Lunch was at 12:30 PM.</p> <p>In an interview with State Trained Nurse Aide (STNA) 18 from the C Unit on 10/18/2024 at 8:34 AM, she stated she called dietary for a cart to load the trays into. She stated the soiled trays were not placed in the kitchenette to prevent cross-contamination.</p> <p>In an interview with the C Unit Supervisor, who was also LPN1, on 10/18/2024 at 9:44 AM, she stated the tray cart was not available for late trays. She stated staff called the kitchen and asked for a tray cart for the C Unit. She stated staff placed used trays into the kitchenette until the tray cart returned. She stated soiled trays were picked up after meals. She stated there was possibly an infection control concern about storing soiled trays and dishes in the kitchenette.</p> <p>In an interview with the ADON on 10/18/2024 at 9:52 AM, she stated the tray cart was not available for trays of residents who got up late. She stated some residents took longer to eat than others. She stated staff placed these used trays in the kitchenette. She stated dietary staff cleared out the soiled trays, and patient care took priority over the trays with floor staff. She stated there was no problem with cross-contamination because the food was contained in packages in the kitchenette. She stated floor staff would call dietary staff for the trays to be picked up.</p> <p>In an interview with the Dietary Manager on 10/18/2024 at 9:58 AM, he stated floor staff called dietary for a tray cart. He stated the Dietary Aide, after the last cart went back to the main dining room, was responsible for bringing the used/soiled trays back. He stated there was no concern because the kitchenette was not a food prep area, and the food was prepackaged.</p> <p>In an interview with the Administrator on 10/18/2024 at 10:12 AM, she stated used/soiled trays were put in the kitchenette, and staff called the kitchen to pick up the extra trays. She stated there was no cross-contamination issue or concern. She stated some residents took longer to eat or wake up and had trays from a meal after the tray cart was returned to the kitchen. She stated there usually were not more than three trays left after meals, and dietary checked often to see if there were any to pick up.</p>		