

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

Second SOD

PRINTED: 04/29/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185330	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/24/2011
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF CAMPBELLSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718		
(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 March 22-24, 2011. Deficient practice was identified with the highest scope and severity at 'E' level.	F 000	The submission of this plan of correction does not constitute an admission by the provider of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted because it is required by law.		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to implement developed policies and procedures to prohibit mistreatment/abuse of residents. A review of employee files revealed the facility failed to conduct required criminal background screenings for one of five sampled employees (volunteer #1). The findings include: A review of volunteer #1's employee file revealed the volunteer had been at the facility since September 24, 2009. Further review of volunteer #1's employee file revealed no evidence the facility had conducted a criminal background screening on volunteer #1 as required. A review of the facility's Abuse Policy (dated October 2009) revealed the facility would conduct criminal background screenings on all potential new employees. An interview was conducted on March 24, 2011,	F 226	1. The center completed a criminal background screen on 04/07/11 for the volunteer identified as # 1 on 03/24/11. 2. All volunteers who are involved in activities that are in non-public areas will be audited to assure all have a criminal background screen completed. Any identified as not having a criminal background screen will have a criminal background screen completed prior to being allowed to volunteer. This audit was conducted by the Life Enrichment Director and the Business Office Manager on 04/07/11. 3. The Life Enrichment Director has been re-educated by the Administrator on 3/28/11 related to the requirements to have any volunteer who conducts activities in a non-public setting complete a criminal background screen prior to participating in non-public activities. 4. The Administrator will review all new volunteer files monthly to assure compliance with criminal background screens. The results of these audits will be reviewed by the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified a Quality Assurance Committee meeting will be held to	05/08/11	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Melda Reed, Administrator* TITLE _____ (X6) DATE *5-3-11*

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

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F 226	Continued From page 1 at 3:00 p.m., with the Regional Director of Clinical Services (RDCS). The RDCS stated the facility only conducted a criminal background check for volunteer staff that performed one-to-one activities with the residents. An interview conducted with volunteer #1 on March 22, 2011, at 11:45 a.m., revealed the volunteer provided services for the residents usually two days a week. The volunteer stated he/she passed trays to the residents in the dining room, passed ice to the residents in their rooms, and played games/read to the residents.	F 226	review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Clinical Reimbursement Coordinator. The Medical Director will attend at least quarterly.	5/08/11	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain housekeeping and maintenance services necessary to maintain a sanitary, comfortable, and orderly environment. Walls in three resident rooms were observed to have areas of chipped paint. Seven resident rooms were observed to have worn, stained, and cracked tiles. Five resident rooms were observed to have soiled toilets. The threshold in one resident room was missing. The overbed table in one resident room was ragged around the edges. The edges of two resident room doors were observed to be splintered. In addition, three of the four medication carts were observed to be	F 253	1. The paint in Rooms 32, 16, and 31 will be repaired by 5-8-11. The floor tiles in rooms 30, 28, 26, 21, 6 and 9 will be cleaned and repaired by 5-8-2011. The toilets in resident rooms 34, 30, 24 and 31 were cleaned on 03/24/11. The threshold in resident room 21 will be replaced by 5-8-2011. The overbed table in resident room 29 will be repaired by 5-8-2011. The doors to Rooms 7 and 16 will be repaired by 5-8-2011. The medication carts were observed by the Director of Nursing to be cleaned on 4-12-2011. 2. Observations of all toilets will be completed by the Housekeeping Supervisor by 5-8-2011 to identify any soiled toilets; any identified as soiled will be cleaned. An audit of resident walls, floor tiles, thresholds, overbed tables, resident room doors will be completed by the	05/08/11	

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F 253	<p>Continued From page 2 soiled.</p> <p>The findings include:</p> <p>During the environmental tour with the maintenance and housekeeping supervisors on March 24, 2011, at 1:00 p.m., the following areas were observed to be in need of maintenance/housekeeping services.</p> <ol style="list-style-type: none"> 1. Resident rooms 32, 16, and 31 had walls that were marred/chipped with areas of missing paint. 2. Resident rooms 30, 28, 26, 21, 6, and 9 had floor tiles that were worn, cracked, and stained. 3. The toilets in resident rooms 34, 30, 24, and 31 were soiled and in need of cleaning. The toilet in resident room 34 was observed to be soiled on March 23, 2011, at 11:00 a.m., and remained soiled on March 24, 2011, at 11:30 a.m. and 1:00 p.m. 4. The threshold in resident room 21 was observed to be missing. 5. The overbed table in resident room 29 was observed to be ragged around the edges. 6. Resident rooms 7 and 16 had doors with splintered edges. 7. Three of the four medication carts were observed to be soiled with debris and pill residue inside the drawers. <p>An interview with the Maintenance Supervisor (MS) on March 24, 2011, at 1:15 p.m., revealed the MS did not make routine rounds in the facility</p>	F 253	<p>Maintenance Supervisor by 5-8-2011 to identify any concerns; any concerns will be scheduled for correction. An audit by the Director of Nursing will be completed by 5-8-2011 to assure all medication carts are clean; any identified concerns will be cleaned</p> <ol style="list-style-type: none"> 3. All Licensed staff (LPN and RNs) will be re-educated on keeping the medication carts clean by the Education and Training Director, the Director of Nursing or the Assistant Director of Nursing by 5-8-2011. The Housekeeping staff will be re-educated by the Housekeeping Supervisor related to following the cleaning schedule by 5-8-2011. The Administrator will re-educate the Maintenance Supervisor related to conducting environmental rounds weekly to identify any repair concerns by 5-8-2011. 4. The Director of Nursing, the Assistant Director of Nursing or the Education and Training Director will audit medication carts weekly times twelve (12) weeks to assure the medication carts are clean. The Administrator will conduct weekly rounds with the Housekeeping Supervisor and the Maintenance Director to assure the cleaning schedule is followed and the environmental rounds identify and correct concerns. These audits will be conducted weekly for twelve (12) weeks. 	05/08/11	

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F 253	Continued From page 3 but relied on staff to notify him of maintenance needs. An interview with the Housekeeping Supervisor (HS) on March 24, 2011, at 1:20 p.m., revealed the HS had not been monitoring staff to ensure all housekeeping tasks were completed. An interview with Licensed Practical Nurse (LPN) #5 on March 24, 2011, at 1:30 p.m., revealed the LPN was unaware of a cleaning schedule for the medication carts. LPN #5 stated whoever had time was supposed to clean the carts. An interview conducted with the Director of Nursing (DON) on March 24, 2011, at 1:35 p.m., revealed a Certified Medication Aide (CMA) was responsible for checking to ensure medication carts were clean. The DON further stated the nurses were required to clean them and once weekly the CMA was to check and clean if needed. The DON also stated there was no facility policy regarding cleaning of the medication carts or documentation to indicate when the med carts had been cleaned.	F 253	The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Clinical Reimbursement Coordinator. The Medical Director will attend at least quarterly.	05/08/11	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide services to meet professional standards of quality for two of seventeen sampled residents (residents #7 and #17). The facility failed to	F 281			

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F 281	<p>Continued From page 4</p> <p>utilize geri-sleeves for resident #7. Staff failed to maintain aseptic technique during medication administration for resident #17.</p> <p>The findings include:</p> <p>1. Observation of medication administration to resident #17 on March 23, 2011, at 9:00 a.m., revealed Licensed Practical Nurse (LPN) #1 prepared a Fish Oil capsule 1,000 milligrams by using his/her bare hands to cut the end off the capsule. The LPN then squeezed the medication out of the capsules with her bare hands prior to placing the medication in a cup of water and administering this medication to resident #17 via the resident's gastrostomy tube.</p> <p>The LPN was also observed to handle a Docusate Sodium 250-milligram capsule with his/her bare hands while cutting off the end of the capsule. The LPN then squeezed the medication out of the capsules with his/her bare hands prior to placing the medication in a cup of water and administering the medication to resident #17 via the resident's gastrostomy tube.</p> <p>The LPN was observed to remove a Clonidine Patch 0.1 milligrams from the arm of resident #17 and reapply a new Clonidine Patch with his/her bare hands.</p> <p>An interview conducted with LPN #1 on March 23, 2011, at 9:30 a.m., revealed the LPN stated he/she would normally have worn gloves while removing medication from a capsule and while removing and replacing medicated patches. The LPN stated further he/she just forgot, and was just nervous.</p>	F 281	<p>1. Resident #7 was observed by the Director of Nursing on 4-13-11 to be wearing geri-sleeves as ordered. The Director of Nursing observed medication administration to Resident #17 on 4-13-11 and confirmed the nurse utilized aseptic technique.</p> <p>2. All current resident's physician orders will be reviewed by the Director of Nursing, the Assistant Director of Nursing, or the Education and Training Director by 5-8-2011 to determine any order for supportive equipment and to assure that the supportive protective equipment is in place. Any identified supportive protective equipment not in place will be put in place. All supportive protective equipment will be listed on the Nursing Assistant worksheet. An observation of Medication Administration was conducted by the Director of Nursing on 3/28/11 & 3/30/11 to assure aseptic technique was maintained during medication administration. No concerns were identified.</p> <p>3. All Licensed staff (LPN and RNs) will be re-educated by the Education and Training Director, the Director of Nursing or the Assistant Director of Nursing related to following physician orders and Medication Administration including aseptic technique by 5-8-2011.</p>	5/08/11

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F 281	<p>Continued From page 5</p> <p>An interview conducted with the Director of Nursing (DON) for the facility on March 23, 2011, at 3:50 p.m., revealed the nurse was expected to wear gloves when removing medications from a capsule and when removing and replacing a topical medication patch.</p> <p>A review of the facility's policy titled Medication Administration, dated January 2001, revealed the policy did not address removing medication from a capsule. The policy also did not address wearing gloves when removing or replacing a topical medication patch.</p> <p>2. A review of the medical record revealed resident #7 was admitted to the facility on October 16, 2006, with diagnoses to include Atrial Fibrillation with Coumadin therapy, Fracture Femur, Dementia, Congestive Heart Failure, and Blindness.</p> <p>Further record review revealed resident #7 sustained a skin tear to the right lower leg on September 24, 2010. A review of the incident/accident report dated September 24, 2010, revealed the skin tear occurred when the resident crossed his/her legs and hit the right leg against the left foot. The report further noted the intervention to prevent reoccurrence was to apply geri-sleeves to both of the resident's lower extremities.</p> <p>A review of the March 2011 physician's orders revealed an order for geri-sleeves to be applied to both of the resident's lower extremities at all times and to remove the geri-sleeves for personal hygiene.</p> <p>Resident #7 was observed to be sitting in a</p>	F 281	<p>4. The Director of Nursing, Assistant Director of Nursing or the Education and Training Director will audit the Nursing Assistance Worksheets five (5) times per week for two (2) weeks then three (3) times per week for four (4) weeks followed by weekly for six (6) weeks to assure compliance with application of supportive protective equipment. The Director of nursing, the Assistant Director of Nursing or the Education and Training Director will observe Medication Administration 5 x per week x 12 weeks on random shifts to assure licensed staff are wearing gloves when contact with medication is anticipated. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed.</p> <p>The members of the Quality Assurance Committee will consist of a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Clinical Reimbursement Coordinator. The Medical Director will attend at least quarterly.</p>	5/08/11	

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F 281	Continued From page 6 wheelchair, dressed in a long-sleeve top and long pants, on March 22, 2011, at 10:20 a.m., 11:30 a.m., and 12:30 p.m.; at 2:30 p.m. on March 22, 2011, the resident was observed to be lying on the bed. No geri-sleeves were observed to be in place to the resident's lower extremities. On March 23, 2011, resident #7 was observed up in a wheelchair at 9:45 a.m. and 2:10 p.m., with no geri-sleeves in use. A skin assessment conducted with facility staff on March 23, 2011, at 2:15 p.m., revealed no red or broken areas were noted. An interview conducted with CNA #5 on March 22, 2011, at 2:40 p.m., revealed the CNAs were responsible to review the CNA assignment sheet for specific resident care needs. CNA #5 stated he/she believed resident #7 was to have geri-sleeves applied to both arms when the resident was dressed in short-sleeve clothing. However, a review of the CNA assignment sheet revealed the geri-sleeves were not identified as a care need for resident #7. An interview conducted with RN #4 revealed the CNA assignment sheet was reviewed/updated during the morning meetings with the Interdisciplinary Team (IDT). RN #4 stated the IDT had failed to update resident #7's CNA assignment sheet to reflect the physician's order for the use of geri-sleeves to the resident's lower extremities.	F 281			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323			

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F 323	<p>Continued From page 7 prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide supervision to prevent accidents for two of seventeen residents (residents #10 and #3). Resident #10 was assessed to require extensive assistance of two staff persons for toileting needs and transfers. However, the resident was left unsupervised in the bathroom and fell from the commode on March 20, 2011. Resident #10 sustained swelling to the back of the resident's head. Resident #3 was to be in a supervised area while in the Broda chair. The resident was observed on March 22, 2011 and March 23, 2011, to be up in the Broda chair in the resident's room unsupervised.</p> <p>The findings include:</p> <p>Resident #10 was observed on March 24, 2011, at 9:30 a.m., to be sitting in a wheelchair dressed in personal clothing. An alarm was observed to be in place on the back of the resident's wheelchair. Resident #10 was unable to recall what the resident ate for breakfast. The resident was again observed at 11:10 a.m. on March 24, 2011, to be propelling the wheelchair in the hallway.</p> <p>A review of the medical record revealed resident #10 was admitted to the facility on November 4, 2009, with diagnoses to include Diabetes Mellitus II, Fracture Femur, Coronary Artery Disease, Dementia, and Thalamic Stroke. A review of the</p>	F 323	<ol style="list-style-type: none"> 1. Resident # 10 was observed by the Director of Nursing to be supervised while on the toilet on 03/30/11. Resident # 3 careplan has been reviewed by the Inter Disciplinary Team and adjustments made to meet the resident's needs. Observation by the Director of Nursing on 4/01/11 noted the careplan interventions and interventions on the Nursing assistant worksheets to be in place. 2. An audit of all Nursing Assistant worksheets and careplan will be completed by the Interdisciplinary Team by 5-8-11 to assure all careplan interventions for falls are accurate on the Nursing assistant worksheets. Any identified concerns will be corrected on the careplan and worksheet. A review of all current residents will be conducted by the Interdisciplinary Team to assure current supervision is appropriate to meet the needs of the residents by 5-8-2011. Any identified concerns will be reviewed with the Interdisciplinary team to determine if adjustments are needed. 	5/08/11

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F 323	<p>Continued From page 8</p> <p>annual comprehensive assessment dated November 22, 2010, revealed resident #10 was assessed to require extensive assistance of two staff persons for bed mobility, transfers, and toileting. Resident #10 was also assessed to be frequently incontinent of bowel and occasionally incontinent of bladder with falls occurring during the past 30 days and in the past 60 days to six months.</p> <p>A review of the comprehensive care plan for resident #10 dated October 22, 2011, revealed the facility identified the resident's fall risks were related to poor weight bearing, bowel and bladder incontinence, dementia, and stroke. Interventions to prevent a fall with injury included to provide "general" supervision and to transfer the resident with two staff person assist.</p> <p>A review of the CNA assignment sheet revealed resident #10 required the assistance of two staff persons for toileting and transfer needs. The assignment sheet also noted the resident required supervision when the resident was up in a wheelchair and outside of the resident's room.</p> <p>A review of the accident/incident report dated March 20, 2011, at 10:50 a.m., revealed resident #10 was left unattended in the bathroom; the resident attempted to stand/transfer without assistance and fell onto the floor. The report noted the resident hit his/her head on the wall which resulted in a swollen area to the back of the resident's head.</p> <p>Further review of the medical record revealed the attending physician and responsible party (R/P) were notified of the incident. Physician's orders were obtained for a CT scan to be conducted of</p>	F 323	<p>3. All nursing staff will be re-educated to ensure supervision while toileting for residents requiring alarm devices for reminder to call for assistance. This education will be conducted by the education Training Director, Director of Nursing or Assistant Director of Nursing by 05/08/11. All nursing staff will be re-educated on following the nursing assiatant assignment sheets. Education will be provided by the education training Director, Director of Nursing or Assistant Director of Nursing by 05/08/11.</p>	5/08/11

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F 323	<p>Continued From page 9</p> <p>the resident's head; however, the R/P did not want the resident transported for the scan of the head. The facility continued to monitor the resident for signs/symptoms of head injury for 72 hours and no further problems were identified.</p> <p>An interview conducted with CNA #7 on March 24, 2011, at 11:35 a.m., revealed he/she was the only CNA on the floor when resident #10 requested to go to the bathroom on March 20, 2011. CNA #7 stated he/she asked the Medical Records person (who was also a CNA) to assist CNA #7 to transfer resident #10 to the commode. CNA #7 stated after resident #10 was assisted to the commode another resident call light sounded. CNA #7 stated he/she gave the call light to resident #10 and told the resident he/she would "be right back." CNA #7 went to transfer another resident from the commode to the wheelchair and heard the call light from resident #10's bathroom sounding. CNA #7 stated when he/she started toward resident #10's room, the CNA heard the resident fall. The CNA stated resident #10 had been left unattended for approximately ten minutes. CNA #7 stated he/she had not been directed to stay with resident #10 during toileting. The CNA stated a nurse was also on the floor and he/she could have asked the nurse to assist the CNA.</p> <p>An interview with the DON on March 24, 2011, at 12:55 p.m., revealed the CNA lunch breaks were supposed to be altered so that adequate staff would be available during meal times. The DON stated he/she was not aware that only one CNA was covering the floor during the noon meal on March 20, 2011. The DON stated residents' supervision needs were determined through the IDT team and were based on the resident's</p>	F 323	<p>4. The Director of Nursing , the Assistant Director of Nursing , or the Education and Training Director will audit 5 records per week x 12 weeks assure fall interventions are in place as well as 5 observations per week x 12 weeks to assure supervision for toileting is appropriate to meet the needs of the residents.. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Clinical Reimbursement Coordinator. The Medical Director will attend at least quarterly.</p>	5/08/11

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F 323	<p>Continued From page 10</p> <p>individual needs. The DON stated the IDT had not considered all of resident #10's fall risks to determine the appropriate level of supervision the resident required for safe toileting. The DON further stated resident #10 had not made previous attempts to self-transfer from the commode.</p> <p>An interview conducted with RN #5 on March 24, 2011, at 1:10 p.m., revealed the RN was responsible for staff education. RN #5 stated he/she had not provided training for staff regarding fall risks associated with toileting and supervision needs. RN #5 also stated resident #10 had not been considered a risk to fall from the commode until the incident on March 20, 2011.</p> <p>A review of the policy/procedure related to Supervision (dated January 2009) revealed "general" supervision was to be utilized for all residents that did not have another supervision level ordered. The policy/procedure further noted that residents on general supervision were able to move around the facility at will.</p> <p>A review of the facility's Fall policy/procedure (dated November 1998) revealed the facility was "obligated" to provide adequate supervision to prevent accidents. The policy/procedure noted adequate supervision was defined by the type and frequency of supervision, and was based on the individual resident's assessed needs and identified hazards in the resident's environment.</p> <p>2. A review of the medical record for resident #3 revealed the resident was admitted to the facility on July 30, 2008, with diagnoses that included Chronic Obstructive Pulmonary Disease,</p>	F 323			

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F 323	<p>Continued From page 11</p> <p>Syncope, Alzheimer's Dementia, Hypertension, Dementia with Psychosis, and Weakness.</p> <p>A review of an Accident/Incident Report dated January 22, 2011, at 1:15 p.m., revealed resident #3 had fallen from the resident's Broda chair. The Accident/Incident Report further revealed the immediate action taken was for the resident to be in a supervised area when in the Broda chair.</p> <p>A review of the Interdisciplinary Team (IDT) notes dated January 24, 2011, revealed the resident was not to be in the Broda chair without supervision. The IDT notes further revealed an entry dated February 7, 2011, stating current interventions had been reviewed and were effective.</p> <p>Although the comprehensive plan of care did not include the above intervention, a review of the Nursing Assistant Assignment Worksheet (NAAW) dated March 23, 2011, revealed resident #3 was to be in a supervised area when out of bed.</p> <p>Resident #3 was observed in the resident's room on March 22, 2011, at 12:15 p.m., up in the Broda chair unsupervised. On March 23, 2011, at 10:00 a.m., 11:00 a.m., 11:40 a.m., 12:45 p.m., and 1:45 p.m., resident #3 was observed up in the Broda chair unsupervised in the resident's room.</p> <p>An interview conducted on March 23, 2011, at 2:30 p.m., with CNA #1, who was assigned to provide care for resident #3 on March 22, 2011, revealed resident #3 was supposed to have been taken to the nurses' station while in the Broda chair. The CNA stated resident #3 should not have been left alone in the resident's room in the</p>	F 323			

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F 323	Continued From page 12 Broda chair. The CNA stated he/she had been so busy he/she had forgotten to take the resident up front. An interview conducted on March 23, 2011, at 2:40 p.m., with CNA #2, who was assigned to provide care for resident #3 on March 22, 2011, revealed the CNA was supposed to have placed the resident in front of the nurses' station when in the Broda chair. The CNA did not know why he/she had left the resident in the Broda chair in the room alone. An interview conducted with the Unit Manager (UM) for the East Wing of the facility on March 23, 2011, at 2:50 p.m., revealed resident #3 was supposed to be in a supervised area when in the Broda chair. The UM further stated a supervised area would be in front of the nurses' station. The UM stated resident #3 had a tendency to slide down in the Broda chair.	F 323		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide foods that were palatable and at the proper temperature during the breakfast meal for residents on the East and West halls of the facility on March 22, 2011.	F 364		

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F 364	<p>Continued From page 13</p> <p>The findings include:</p> <p>1. Observation on March 22, 2011; of the breakfast meal on the East Wing of the facility revealed the first meal cart was delivered to the unit at 7:55 a.m. The last tray to be delivered from the cart was delivered at 9:00 a.m. The surveyor requested a test tray to obtain food temperatures and conduct palatability testing. The temperature of the pureed sausage, gravy, and scrambled egg mixture was 83.9 degrees Fahrenheit and was cold to taste. The temperature of the oatmeal was 108.8 degrees Fahrenheit and was also cold to taste.</p> <p>The temperatures were verified with the facility's Dietary Manager (DM) and cook. The foods were also tasted by the cook, who agreed the foods tasted cold.</p> <p>An interview conducted with Certified Nursing Assistant (CNA) #2, who was assigned to the residents on the East Wing of the facility on March 22, 2011, at 3:25 p.m., revealed the CNA felt it took longer on that day to pass the breakfast trays. The CNA further stated a tray should sit for no longer than 25 to 30 minutes before being provided to a resident. The CNA went on to say if the tray sat too long the CNA was expected to notify the dietary staff to replace the tray. The CNA stated he/she had just gotten out of routine that morning.</p> <p>An interview conducted with the DM of the facility on March 22, 2011, at 3:40 p.m., revealed the trays were expected to be passed within 20 to 30 minutes after arriving on the resident unit. The DM further stated the staff was expected to notify</p>	F 364	<ol style="list-style-type: none"> Appropriate food temperatures at point of service are now served. Nutrition Service manger completed test tray on 3/30/11. Quality Validation Test Tray's have been requested/food temperatures recorded to identify any other food temp concerns. Meal Service Tray Cart delivery schedule was revised on 03/28/11 to facilitate appropriate food temperatures. Dietary and Nursing staff have been re-educated on food temperatures at point of service and revised cart schedule. This education will be provided by the Dietary Service Manager, the Director of Nursing, the Assistant Director of Nursing, or the Education and Training Director and will be completed by 5-8-11. Food temperatures at point of service will obtained 5x per week x 3 weeks, 3 times per week x 2 weeks, 2 x per week; alternating between breakfast, lunch and dinner. NHA will obtain food temps at point of service randomly. If other concerns are identified at any time, the Quality Assurance Committee will review and make further revisions as indicated. The Quality Assurance Committee will be comprised of facility Nutrition Services Manager, Director of Nursing, Regional Dietician and Administrator. 	05/08/11	

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F 364	<p>Continued From page 14</p> <p>dietary staff to replace the tray if the trays were on the unit too long before being served.</p> <p>2. Observation of the breakfast meal service on March 22, 2011, at 8:00 a.m., revealed the first cart was delivered to the West Hall from the kitchen at 8:20 a.m. A second cart was observed to be delivered to the West Hall at 8:26 a.m. The last tray was observed to be removed from the second cart at 8:47 a.m., and a test tray was removed from the food cart at that time in order to check the food temperatures, and to conduct a palatability test of the food. The food temperatures revealed the sausage/gravy and biscuits were at 91 degrees Fahrenheit, milk was at 40.3 degrees Fahrenheit, and the yogurt was at 55.5 degrees Fahrenheit. The palatability test revealed the biscuits/gravy, yogurt, and milk were cool to taste.</p> <p>A review of the temperatures from the kitchen's steam table revealed the food temperatures ranged from 167 degrees Fahrenheit to 180 degrees Fahrenheit (within normal holding temperatures) when the food was served from the kitchen.</p> <p>An interview conducted with the Certified Nurse Aide (CNA #1) on March 22, 2011, at 12:25 p.m.; revealed food trays were required to be delivered to the residents within 15 to 20 minutes after being delivered from the kitchen.</p> <p>An interview conducted with the DM on March 22, 2011, at 5:00 p.m.; revealed the facility did not have a specific policy/procedure related to required timeframes for tray delivery, but the DM believed the trays should be delivered within 15 to 30 minutes after arriving on the resident unit. The</p>	F 364		

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F 364	Continued From page 15 DM stated the Registered Dietitian (RD) conducted test trays for temperature and palatability once a month. The DM stated cold food temperatures had been identified during the breakfast meal. The resident group interview was conducted at 3:00 p.m. on March 22, 2011, with nine alert and oriented facility residents. All nine of the residents stated they were served food that was cold to taste. The residents further stated breakfast was served cold more than other meals.	F 364			
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the therapeutic diet prescribed by the attending physician was provided for one of seventeen sampled residents (resident #7). The findings include: A review of the physician's telephone order dated March 18, 2011, revealed the physician had ordered a Dysphagia Three diet with no green leafy vegetables and enhanced foods to be served on colored plates for resident #7. In addition, a review of the current March 2011 physician's orders revealed resident #7 had a physician's order for a House Supplement 120 cc to be administered three times a day with meals.	F 367			

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F 367	Continued From page 16 Observations on March 22, 2011, at 12:20 p.m., revealed resident #7 was in the dining room for the noon meal. At 12:30 p.m., a staff person was observed to serve/set up resident #7's tray. The meal tray consisted of cream-style corn, barbecue on a bun, and French fries served on a colored plate. In addition, a bowl of fruit, ice cream, and a glass of iced tea were also noted to be served to the resident. However, there was no evidence a house supplement was provided for resident #7. The resident was observed to consume 50 to 75 percent of the barbecue/bun, French fries, fruit, and ice cream. In addition, resident #7 drank two glasses of iced tea. A review of resident #7's tray card on March 22, 2011, at 12:35 p.m., revealed the tray card noted a Dysphagia Three diet, Enhanced foods, colored plate, no cabbage, no yogurt, no bananas, and no green leafy vegetables. The tray card further noted that resident #7 was to be provided milk three times a day and to give ice cream to the resident. The tray card did not include the physician's order for the house supplement three times a day with meals. An interview conducted with the Dietary Aide (DA) on March 23, 2011, at 9:30 a.m., revealed the DA was responsible to check the tray for accuracy after the tray was prepared on the tray line. The DA stated trays were filled on the tray line as directed by each resident's tray card. The DA stated he/she was not aware the resident was supposed to receive a house supplement three times a day. The DA stated the CNAs were responsible to provide the resident's milk from a cooler sent from the kitchen.	F 367	<ol style="list-style-type: none"> Resident # 7 tray card has been corrected. 100% resident tray card audit has been completed to validate accuracy of tray cards. 100% audit of resident clinical charts to verify ordered supplements to ensure accuracy. The center will re-educate all licensed staff related to completing dietary communication forms with physician orders for diet changes. This education will be completed by the Education and Training Director, the Director of Nursing or the Assistant Director of Nursing, by 5-8-11. Nutrition Service Manager and Administrator will monitor tray accuracy at point of service 5 times per week x 3 weeks, 3 times per week x 2 weeks then weekly. Any identified concerns will be reviewed by the Quality Assurance Committee and revised as indicated. Quality Assurance Committee will be comprised of Nutrition Service Manager, Director of Nursing, Regional Dietician and Administrator. 	5/08/11	

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F 367	Continued From page 17 CNA #6 stated in an interview conducted on March 23, 2011, at 10:00 a.m., resident tray cards were required to be checked when the resident's tray was served to ensure accuracy of the meal. CNA #6 stated resident #7 had asked for iced tea and the milk had not been served. An interview conducted with the Dietary Manager (DM) on March 22, 2011, at 5:00 p.m., revealed a new diet order form was received from the nurses when a new diet order was received. The DM stated he/she was responsible to enter the information into the computer system to generate a new tray card. The DM stated he/she was aware resident #7 was to receive ice cream and milk at each meal; however, the DM could not explain why the house supplement was not on the resident's tray card.	F 367			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441			

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F 441	<p>Continued From page 18</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens 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, the facility failed to provide appropriate technique to prevent the development and transmission of infection during wound care for one of seventeen residents (resident #1).</p> <p>The findings include:</p> <p>A review of the medical record revealed resident #1 was admitted to the facility on March 30, 2008, with diagnoses to include Quadriplegia, Decubitus Ulcers, Methicillin Resistant Staph Aureus (MRSA) Sepsis, Chronic Osteomyelitis, and Septicemia. No recent wound cultures had been obtained.</p> <p>A review of the most recent skin assessment</p>	F 441	<ol style="list-style-type: none"> The Director of Nursing observed wound care to Resident # 1 on 3/31/11 . The observation revealed that correct infection control procedures were applied by staff. A 100% audit and observation of current residents with open wounds by the Director of Nursing, the Assistant Director of Nursing and the Education and Training Director by 05/08/11 will occur to assure appropriate infection control procedures were followed. Any identified concerns with appropriate infection control technique will be immediately corrected to include education of involved staff. All Licensed Nursing staff will be re-educated by 5-8-2011 by the Education and Training Director, the Director of Nursing or the Assistant Director of Nursing related to appropriate infection control procedures with wound care. 	5/08/11

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F 441	<p>Continued From page 19</p> <p>conducted on March 22, 2011, revealed resident #1 was assessed to have the following wounds: an open 2.6-cm by 1-cm area to the bend of the right foot, a 15-cm by 24-cm open area with some necrosis to the buttocks area, a 1.8-cm by 1.2-cm eschar area to the right outer ankle, a 2-cm by 2-cm eschar area to the left inner ankle, a 7.5-cm by 12.5-cm eschar area with sloughing and red tissue to the right thoracic area, a 2-cm by 2-cm with 6-cm depth Stage 4 area to the right groin area, a 4-cm by 2-cm eschar area to the left heel, a 7-cm by 4.2-cm eschar area of the right heel, and a 2-cm by 3-cm with 3.6-cm depth Stage 4 area to the right-side abdominal folds.</p> <p>Observation of wound care for resident #1 was conducted with two facility LPNs (LPNs #1 and #6) and CNA #5 on March 23, 2011, at 10:15 a.m. LPN #6 was observed to remove the soiled dressings with moderate to large amounts of purulent yellow/bloody drainage noted from resident #1's right and left lower extremities, left hip, buttocks, right thoracic area, right-side abdominal folds, inner left hip, and foot while using the same gloves. LPN #6 removed the soiled gloves, washed his /her hands at the sink, and donned clean gloves. LPN #6 provided wound care and applied a new dressing to the wound on the resident's right thoracic area. While still wearing the same gloves, LPN #6 was observed to place a previously handled 4 x 4 gauze back on top of the clean 4 x 4s on the table. LPN #6 then picked up the dirty, wet 4 x 4 and cleaned the upper right hip wounds (three separate wounds) with the 4 x 4, and then covered the wounds with dry 4 x 4s and an Island Telpa dressing. LPN #6 continued to clean and apply new dressings to the buttocks wound while wearing the same gloves. LPN #6 was then</p>	F 441	<p>4. The Director of Nursing, the Assistant Director of Nursing or the Education Training Director will observe staff performing wound dressing changes to ensure appropriate infection control technique. Observations will be completed five (5) times per week for three (3) weeks, then three (3) times per week for two (2) weeks, then weekly for seven (7) weeks. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Clinical Reimbursement Coordinator. The Medical Director will attend at least quarterly.</p>	5/08/11	

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NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF CAMPBELLSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718	
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F 441	<p>Continued From page 20</p> <p>observed to remove the soiled gloves, perform handwashing at the sink, and put on clean gloves. LPN #6 placed gauze over the resident's right heel wound. LPN #6 then unfolded/handled wet 4 x 4s and cleaned the right foot (bend of foot) wound. The LPN was observed to wrap the two wounds with Kling and secure with tape. LPN #6 proceeded to pick up wet 4 x 4s with the same soiled gloves, cleaned the left heel wound, and placed a dry 4 x 4 over the wound. Resident #10 was then repositioned and the buttock wound dressing was reinforced with another Island Telpha dressing by LPN #6 using the same gloves.</p> <p>An interview conducted with LPN #6 on March 23, 2011; at 10:45 a.m., revealed the LPN stated he/she had been trained to remove all the soiled dressings using the same gloves. LPN #6 also stated he/she had not been trained to change gloves or perform handwashing after cleaning a resident's wounds and before applying clean dressings.</p> <p>An interview conducted with RN #4 on March 24, 2011, at 9:35 a.m., revealed the RN was responsible for the Infection Control Program. RN #4 stated the nurses were required to change gloves and perform hand washing procedures after cleaning a wound and before applying a clean dressing. RN #4 further stated he/she had not conducted observations of staff nurses who performed wound care to ensure aseptic technique had been followed. RN #4 stated the Education Coordinator was responsible for education regarding infection control techniques.</p> <p>RN #5 was interviewed on March 24, 2011, at 1:10 p.m., and stated he/she was responsible for</p>	F 441		

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F 441	Continued From page 21 staff education. RN #5 stated he/she had never observed staff performing wound care.	F 441			
F 502 SS=D	An interview conducted with the DON on March 24, 2011, at 11:30 a.m., revealed staff nurses were required to change gloves and perform hand washing procedures between cleaning and dressing a resident's wounds. A review of the Wound Treatment policy (dated November 1998) revealed residents would receive the necessary treatment and services to promote healing and prevent infections. 483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to obtain laboratory services as ordered by the physician for one of seventeen sampled residents (resident #7). The findings include: A review of the facility Lab Services policy/procedure (dated February 25, 2006) revealed the DON was responsible to schedule lab tests to be obtained. The policy/procedure noted the charge nurse was responsible to check off the log when the lab test results were reported to the facility. The policy/procedure further revealed the DON was responsible to conduct a monthly and/or quarterly audit to ensure lab tests	F 502	1. Resident # 7 identified in sample, MD notified of lab omission, received to obtain lab. Lab drawn on 3/22/11, results received and MD/responsible party notified. No MD orders given r/t results of lab. 2. 100% audit of resident clinical charts/labs completed. No other omitted labs identified. 3. Staff re-trained on lab process, by 05/08/11; training provided by the Director of Nursing, Education and training director or the Assistant Director of Nursing. Binders established with individual resident lab orders per calendar year. Last week of each month, labs will be scheduled for the upcoming month onto the lab requisition & the lab monitoring tool form by the DON, ADON or charge nurse. Any new lab orders will be transcribed onto the current month lab requisition form & the lab monitoring tool by the nurse receiving the physician lab order. New lab orders will be reviewed the Following morning or (Monday Following the weekend) during Morning Triage meeting to ensure accuracy of lab requisition forms.	05/08/11	

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F 502	<p>Continued From page 22 were obtained as ordered by the physician.</p> <p>A review of the physician's orders dated March 2011 for resident #7 revealed orders for Digoxin 125 mcg to be administered daily to the resident and for facility staff to obtain a Digoxin level every six months for this resident. However, there was no evidence the Digoxin level had been obtained for resident #7 since May 17, 2010.</p> <p>An interview conducted with the Director of Nurses (DON) on March 23, 2011, at 8:30 a.m., revealed the DON or designee was responsible to review the lab test log monthly and complete a lab requisition request for the lab test to be obtained. The DON stated when the lab test results were received by the facility, the lab test log was required to be initialed, and the physician and responsible party were to be notified of the test results. The DON stated random audits were conducted to ensure the lab tests had been obtained as ordered by the physician and the Digoxin level had not been identified. The DON further stated the Digoxin level for resident #7 had not been obtained.</p>	F 502	<p>4. Charge nurse will verify daily lab results compared to the lab requisition sheets for same date to verify completion beginning 04/25/11. DON, ADON will audit weekly lab requisition forms, verify labs completed and results received x 4 weeks, x 2 per month x 2 months then monthly. Any identified concerns will be Reviewed during monthly Quality Assurance Committee, revisions made as indicated.</p>	05/08/11
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APR 18 2011

Division of Health Care
Surveillance Enforcement Branch

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K 000	<p>INITIAL COMMENTS</p> <p>TYPE OF STRUCTURE: 1982 One-story unprotected frame Type 111(200) with a complete automatic sprinkler system throughout.</p> <p>A life safety code survey was initiated and concluded on March 23, 2011. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). Medco Center of Campbellsville was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at 'F' level.</p>	K 000	<p>The submission of this plan of correction does not constitute an admission by the provider of any fact or conclusion set forth in this statement of deficiency. This plan of correction is being submitted because it is required by law.</p> <p>K- 052</p>	
K 052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the building fire alarm system</p>	K 052	<ol style="list-style-type: none"> 1. 991 Monitoring Station is calling facility within prescribe time on all received signals, tested on 4/17/11 by facility Maintenance Director. The facility is receiving calls within the prescribed time (4 minutes). 2. 991 Monitoring Station is calling facility within prescribe time on all received signals, tested on 4/17/11 by facility Maintenance Director. The facility is receiving calls within the prescribed time (4 minutes). 3. Facility Nursing Home Administrator and Director of Maintenance will provide the 911 Monitoring Station their personal cell phone numbers to ensure contact with the facility. 4. Facility Maintenance Director will complete monthly test of the fire alarm automatic dialer panel and verify appropriate "trouble" signals are received. Any identified concerns will issues will be repaired immediately and presented to Quality Assurance for review and revisions as indicated. Quality Assurance Committee will be made up of facility Maintenance Director, Housekeeping Director, Director of Nursing and Administrator. 	5-8-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ (X6) DATE _____

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

Received Time Apr. 18. 2011 10:26AM No. 8057

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K-052	<p>Continued From page 1</p> <p>functioned as required by NFPA standards. This deficient practice affected four of four smoke compartments, staff, and all of the residents. The facility has the capacity for 67 beds with a census of 62 on the day of the survey.</p> <p>The findings include:</p> <p>Observation during the Life Safety Code survey on March 23, 2011, at 11:05 a.m., with the Director of Maintenance (DOM) revealed a test of the fire alarm automatic dialer panel sent a trouble signal to a continuously occupied location within the facility, however, the monitoring station did not contact the facility of this phone line failure as required. A call to the monitoring station at 11:20 a.m. on March 23, 2011, by the DOM revealed the monitoring station did not have instructions to notify the facility of this phone line failure.</p> <p>An interview with the DOM on March 23, 2011, at 11:05 a.m., revealed the facility had received calls in the past by the monitoring company for other trouble signals but was not aware the monitoring station did not contact the facility for a phone line failure signal.</p> <p>Reference: NFPA 72 (1999 Edition).</p> <p>5-2.6.1.4 Upon receipt of trouble signals or other signals pertaining solely to matters of equipment maintenance of the fire alarm systems, the central station shall perform the following actions: (1) *Communicate immediately with persons designated by the subscriber A-5-2.6.1.4(1) The term immediately in this context is intended</p>	K 052		5-8-11	

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K 052	Continued From page 2 to mean "without unreasonable delay." Routine handling should take a maximum of 4 minutes from receipt of a trouble signal by the central station until initiation of the investigation by telephone. 5-5.3.2.1.6.2 The following requirements shall apply to all combinations in 5-5.3.2.1.6.1: (1) Both channels shall be supervised in a manner approved for the means of transmission employed. (3) The failure of either channel shall send a trouble signal on the other channel within 4 minutes. (8) Failure of telephone lines (numbers) or cellular service shall be annunciated locally.	K 052		5-8-11	
K 147 SS=E	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, the facility failed to ensure that electrical wiring was maintained as required by NFPA standards. This deficient practice affected one of four smoke compartments, staff, and approximately thirty residents. The facility has the capacity for 67 beds with a census of 62 on the day of the survey. The findings include: During the Life Safety Code tour on March 23,	K 147			

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K 147	<p>Continued From page 3</p> <p>2011, from 11:45 a.m. to 12:30 p.m., with the Director of Maintenance (DOM) an electrical outlet located near the sink in resident room 18 was observed not to be Ground Fault rated (GFCI). GFCI receptacles help prevent personnel from accidental shock by receptacles located near wet areas. An interview with the DOM on March 23, 2011, at 11:45 a.m., revealed the facility had these receptacles replaced about three or four years ago and thought the receptacles were GFCI rated. The DOM stated that electrical testing was not part of the maintenance schedule.</p> <p>Reference: NFPA 70 (1999 Edition).</p> <p>517-20. Wet Locations</p> <p>a. All receptacles and fixed equipment within the area of the wet location shall have ground-fault circuit-interrupter protection for personnel if interruption of power under fault conditions can be tolerated, or be served by an isolated power system if such interruption cannot be tolerated. Exception: Branch circuits supplying only listed, fixed, therapeutic and diagnostic equipment shall be permitted to be supplied from a normal grounded service, single- or 3-phase system, provided that</p> <p>a. Wiring for grounded and isolated circuits does not occupy the same raceway, and</p> <p>b. All conductive surfaces of the equipment are grounded.</p> <p>b. Where an isolated power system is utilized, the equipment shall be listed for the purpose and installed so that it meets the provisions of and is in accordance with Section 517-160.</p> <p>FPN: For requirements for installation of therapeutic pools and tubs, see Part F of Article 680.</p>	K 147	<ol style="list-style-type: none"> Rm # 18 repairs were completed to correct ground fault receptacle on 3/28/11 by Maintenance Director. 100% audit of resident room ground fault receptacles has been completed to identify any others which needed repairs. Any identified repairs were made. The Administrator will re-educate the Maintenance Director by 5-8-2011 related to requirement for testing of ground fault receptacles to include testing of ground fault receptacle to be performed upon any replacement or servicing of the device. Maintenance Director will test ground fault receptacles every 6 month and document finding. Results will be reviewed with the Quality Assurance committee at the time of 6 month testing, changes made as indicated. Quality Assurance Committee will consist of facility Maintenance Director, Administrator, Housekeeping Supervisor and Director of Nursing. 	5-8-11	

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K 147	Continued From page 4 3-3.3.3 Receptacle Testing in Patient Care Areas. a. The physical integrity of each receptacle shall be confirmed by visual inspection. b. The continuity of the grounding circuit in each electrical receptacle shall be verified. c. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. d. The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz) 3-3.4.2.3 Maintenance and Testing of Electrical System. a. Testing Interval for Receptacles in Patient Care Areas. 1. Testing shall be performed after initial installation, replacement, or servicing of the device. 2. Additional testing shall be performed at intervals defined by documented performance data. Exception: Receptacles not listed as hospital-grade shall be tested at intervals not exceeding 12 months.	K 147		5-8-11	