

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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185236	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/13/2013
NAME OF PROVIDER OR SUPPLIER OWENSBORO CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD. OWENSBORO, KY 42303		
(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 Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 12/13/13 as alleged.	{F 000}			

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

TITLE

(X6) DATE

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

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F 000	INITIAL COMMENTS	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Owensboro Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the "Monthly Room Inspection" guidelines, it was determined the facility failed to ensure residents received services in the facility with reasonable accommodations of individual needs and preferences for one (1) of twenty-four (24) sampled residents (Resident #8). Resident #8 was observed to have boxes stacked at the head of the bed to prevent his/her pillow from falling behind the bed when it was raised. The findings include: Observation, on 10/29/13 at 11:00 AM and 3:20 PM, and on 10/30/13 at 8:40 AM and 10:30 AM, revealed there were multiple boxes stacked at the head of the bed, between the end of the mattress and the headboard. The resident's head of the	F 246	1. Boxes were removed from the head of resident # 8's bed on 10/30/2013 by the facilities Maintenance Director. A wedge cushion was placed at the head of residents # 8 bed between the end of the mattress and the head board to prevent pillows from falling when the Resident raised the head of the electric bed. Resident voiced acceptance of the wedge cushion and the care plan was up dated to reflect the intervention on 10/30/2013. 2. Facility rounds, to include all newly purchased electric beds, were completed and documented by the facility Maintenance Director to ensure all residents receive services with reasonable accommodations of individual needs and preferences on 10/30/2013, no other resident was identified. 3. The facility staff to include nursing, maintenance and housekeeping received re-education on 11/8/13 regarding the rights of the residents to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered by the Facility Staff Development Coordinator. Re-	

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

Wendell Smith

TITLE

Administrator

(X6) DATE

11/22/13

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F 246	<p>Continued From page 1 bed was raised slightly, in all observations.</p> <p>Interview with Resident #8, on 10/30/13 at 8:40 AM, revealed he/she put the boxes at the head of the bed to keep the pillows from falling off when the bed was raised. The resident stated he/she had been doing this for the last three or four months. He/she revealed staff were made aware; however, "that's as far as it gets."</p> <p>Review of the "Monthly Room Inspection" guidelines, undated, revealed a room inspection included the following: Mattresses: condition, sized to bed</p> <p>Review of the Monthly Room Inspection for the resident's room (room #18), dated 04/23/13, revealed there were no issues identified involving the resident's mattress. There was no documentation of a room inspection for room #18 after 04/23/13.</p> <p>Interview with the Maintenance Supervisor, on 10/30/13 at 2:30 PM and 4:00 PM, revealed the resident's bed frame was eighty (80) inches; however, the mattress was only seventy-eight (78) inches. He indicated a two (2) inch extender had already been placed at the end of the mattress; but, it still did not fit the frame when the head of the bed was raised. He was not aware the resident had an issue keeping his/her pillow on the bed when it was raised. He revealed the expectation was to do room inspections, one wing every week; however, it may not always get done.</p> <p>Interview with the Director of Nursing (DON), on 10/31/13 at 10:00 AM, revealed the issue was not a problem with the mattress, it was the resident's comfort. She revealed staff should have</p>	F 246	<p>education further included staff are to report any incident noted of residents modification of environment to include modifications of electric beds to ensure appropriate interventions are in place.</p> <p>4. Audits will be conducted by the facility Maintenance Director and/or the facility Administrative staff using the facility environmental rounding tool 2x a week x1 month then monthly ongoing to ensure residents accommodations of individual needs and preferences is met. A summary of the findings will be submitted by the facility Maintenance Director to the Performance Improvement Committee monthly for further review and recommendations.</p>	12/13/13	

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F 246	Continued From page 2 attempted to find out what the resident needed the boxes for, to ensure a more appropriate intervention.	F 246		
F 253 SS=E	Interview with the Administrator, on 10/31/13 at 10:10 AM, revealed he preferred staff to do monthly room checks. He revealed staff should have reported the issue when the boxes were noticed at the head of his/her bed. 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 provide the housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior, related to the storage of bed pans and bath basins. Bed pans, wash basins and urine graduates were left out uncovered on three (3) wings of the facility. The findings include: Observations during the initial tour of the facility on 10/29/13 at 10:40 AM revealed the following: Room #305- several wash basins stacked together and bedpans placed on top of them setting on the back of the commode uncovered. Room #310- Wash basins were stacked together with bedpans placed inside them stored on top of	F 253	F 253 1. Residents room #305, #310, #1, #2, #4, #6, #7, and #11, have had bedpans/specimen pans and bath basins replaced with new bedpans/ specimen pans and/or bath basins. All have been marked by nursing staff with residents name and covered and stored in resident bathrooms. 2. Facility rounds were conducted on 10/31/2013 including all residents' rooms, bathrooms and shower rooms to ensure the facility maintained a sanitary, orderly and comfortable interior. Any issues identified were corrected at this time. 3. The Nursing staff were re-educated on 11/8/13 by the facility Staff Development Coordinator. The re-education included cleaning bed pans/ specimen pans and bath basins after each use and storing in bed pan/bath basin covers. When bed pans/ specimen pans and/or bath basins are replaced, the bed pan and/or bath basin will be marked with resident's name. 4. The Director of Nursing and or Unit Managers will complete an audit 2x a week times 1 month then monthly using the facility audit tool to ensure the facility is maintained in a sanitary, orderly and comfortable manner. A summary of the findings will be submitted to the Performance Committee monthly times 6 months for further review and recommendations.	12/13/13

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F 253	<p>Continued From page 3</p> <p>paper towel holder uncovered. A urine graduate was setting on back of commode without a label and not placed in a bag.</p> <p>Room #1- one (1) bedpan lying in the bathroom floor uncovered, with a dried brown substance.</p> <p>Room #2- one (1) bedpan lying in the bathroom floor uncovered.</p> <p>Room #4 - one (1) bedpan on top of paper towel dispenser in the bathroom uncovered, with a brown, dried substance and two (2) unlabeled wash basins on back of the commode.</p> <p>Room #6 - one (1) bedpan on the back of commode in the bathroom, not labeled or covered with a brown, dried substance and six (6) bath basins stacked on the back of the commode not labeled.</p> <p>Room #7 - food on the night stand with an unlabeled specimen pan sitting on top of the food.</p> <p>Room #11- one (1) bedpan on the bathroom floor not labeled and covered with a brown dried substance.</p> <p>Interview with Licensed Staff #3, on 10/30/13 at 2:40 PM, revealed the facility policy was that the Certified Nurse Aides (CNAs) should clean the bedpans after each use and cover the bedpans in a plastic bag when not in use. The CNAs should label the bedpans with a permanent marker with the resident's name.</p> <p>Interview with Registered Nurse (RN) #1, on 10/31/13 at 9:25 AM, revealed bedpans should be labeled, cleaned by the CNAs after each use, and stored in a bag covering. She stated the bedpans should be stored in the resident's</p>	F 253			

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F 253	Continued From page 4 bathroom.	F 253			
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the interventions of the care plan were carried out for one (1) of twenty four (24) sampled residents (Resident #14) related to the failure to utilize a dignity bag to cover the urinary catheter bag.</p> <p>The findings include:</p> <p>An interview with the Director of Nursing, on 10/31/13 at 11:40 AM, revealed there was no specific policy for the placement of the urinary catheter bag covering or dignity bag.</p> <p>Record review revealed the facility admitted Resident #14 on 03/05/12 with diagnoses to include Dementia; Benign Prostatic Hypertrophy (BPH), Failure to Thrive and Malignant Neoplasm of the Intestines. A review of the Comprehensive Care Plan for the urinary catheter, dated 03/06/12, revealed an intervention that required a privacy cover for the urinary catheter bag.</p> <p>Observations on all three days of the survey (10/29-31/13), revealed the catheter bag was</p>	F 282	F 282	<p>1. The dignity bag for resident #14 was replaced by CNA #2 on 10/31/2013. Resident #14 has expressed no concerns with dignity.</p> <p>2. Rounds were conducted by the facility Unit Managers for all residents with Foley catheters on 10/31/2013 to ensure services were provided or arranged by the facility by qualified persons in accordance with each resident plan of care. No other issues identified.</p> <p>3. Re-education was provided by the facility Staff Development Coordinator beginning on 11/8/13. The re-education included all residents' plan of care are to be followed to include covering Foley catheter bags.</p> <p>4. The Director of Nursing and/or the facility Unit Managers will complete an audit of the facility 2x a week for 1 month then monthly for 6 months to ensure residents plan of care is followed. The Director of Nursing will submit a summary of the findings to the Performance Improvement Committee monthly times 6 months for further review and recommendations.</p>	12/13/13

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F 282	Continued From page 5 visible from the doorway of the room and there was no dignity bag covering the catheter bag. An interview with Certified Nurse Aide (CNA) #1 and CNA #2, on 10/31/13 at 9:50 AM, revealed they were aware the resident required a dignity bag but were not sure why there was not one on the catheter bag. An interview with Licensed Practical Nurse (LPN) #1, on 10/31/13 at 9:55 AM, revealed all residents with a urinary catheter were to have a dignity bag covering. She stated she usually makes a hall check on all the residents to check for these things and ensure everything was in place. An interview with the DON, on 10/31/13 at 11:45 AM, revealed she would have expected the care plan to have been followed and the dignity bag to have been in place.	F 282		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS 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. This REQUIREMENT is not met as evidenced by:	F 328	F 328 1. Resident #5 was assessed by the licensed nurse on 10/29/2013. Resident's O2 saturation remained 97% on room air. Resident #5's physician was notified of resident's status of O2 saturation 97% on room air and resident was in no distress. Orders received at that time to decrease O2 to 2 liters for 1 week then 1 liter for 1 week. O2 saturation remained 97%. O2 was discontinued at that time. Resident remains in facility and has had no signs or symptoms of infection. The O2 concentrator was plugged in by the licensed nurse on 10/29/2013 at 3:40 PM. 2. On 10/29/2013 the facility Unit Managers monitored other residents with special needs to ensure that the residents in the facility received proper treatment and care for special needs. No other residents identified. 3. Nurse #2 received re-education on 10/29/13. And a facility skills check off was	

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F 328	<p>Continued From page 6</p> <p>Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure appropriate care and treatment for one (1) of twenty-four (24) sampled residents (Resident #5), requiring tracheostomy (trach) care with oxygen (O2) therapy. Resident #5 was observed with his/her O2 concentrator unplugged. Additional observation revealed staff failed to maintain sterile technique during suctioning the trach of Resident #5.</p> <p>The findings include:</p> <p>A review of the facility policy, titled "Tracheostomy Care Skills Test" dated 09/2010, revealed during tracheostomy care with inner cannula, to replace tracheostomy collar oxygen source over the outer cannula while cleaning the inner cannula to prevent oxygen desaturation. A review of the policy titled "Tracheostomy Management Skills Testing General Overview", dated 09/2010, revealed trach care should be performed by putting on sterile gloves and designate one has as contaminated for disconnecting and working with the suction control while the dominant hand is kept sterile and will be used to thread the suction catheter.</p> <p>Record review revealed the facility admitted Resident #5 on 07/01/12 with diagnoses to include Oropharyngeal Dysphagia, Chronic Pain Syndrome, Hypoxemia, Sleep Apnea, Seizure Disorder and Congestive Obstructive Pulmonary Disease.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/28/13, revealed the facility had assessed Resident #5 with no cognitive impairment and requiring extensive assistance</p>	F 328	<p>completed by the facility Assistant Director of Nursing at this time.</p> <p>4. The Director of Nursing and/or Unit Managers will complete audits of 5 residents' with special needs 1x a week for 1 month then monthly x 5 months using the facility audit tool. A summary of findings will be submitted by the Director of Nursing to the Performance Improvement Committee monthly times 6 months for further review and recommendations.</p>	12/13/13	

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F 328	<p>Continued From page 7 with activities of daily living.</p> <p>Review of Resident #5's Physician's Orders, dated 04/2013, revealed he/she was to receive O2 at 3 liters per minute (LPM) humidified trach collar.</p> <p>Observation, on 10/29/13 at 3:20 PM, revealed Nurse #2 failed to maintain sterile technique during trach care and trach suctioning. The nurse placed a sterile glove on her right hand and a non-sterile glove on the left hand. She then proceeded to use the left hand with the non-sterile glove to direct the suction catheter into the trach breaking sterile technique. The sterile gloved hand was used to occlude the vacuum port of the catheter. Further observation was made revealing Resident #5 was not receiving O2 trach collar at 3 LPM as ordered due to the concentrator at the bedside being unplugged from the wall.</p> <p>Observation, on 10/29/13 at 3:39 PM, revealed the O2 tubing not connected and pulled away from the humidifier and concentrator and the resident was not receiving any O2.</p> <p>Interview with Registered Nurse (RN) #2, on 10/29/13 at 3:48 PM, revealed he/she should have verified the oxygen concentrator was working prior to performing trach care and trach suctioning.</p> <p>Interview with the Unit Manager, on 10/29/13 at 3:50 PM, revealed, the oxygen concentrator should be checked before and after trach care and suctioning. The Unit Manager stated the staff was trained on oxygen and suctioning during competency check-off's annually.</p>	F 328			

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F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>F 441</p> <p>1. Resident #3 had no signs or symptoms of urinary tract infection documented in the nurses notes. The facility Nurse Practitioner assessed resident # 3 on 11/14/2103 with no signs or symptoms of urinary tract infection noted in progress notes. 2. The facility Unit Managers conducted observations during incontinent care to ensure care was provided in a safe, sanitary and comfortable environment and to help prevent the spread of infection on 10/31/2013. Concerns identified were corrected when noted. 3. Re-education was provided to the nursing staff regarding Infection control, to include hand washing and incontinent care by the facility Staff Development Coordinator on 11/8/2013. 4. The facility Unit Managers will conduct observations of 5 residents during incontinent care weekly x 1 month then bi-weekly x 5 months and these observations will be documented on the facility audit tool. The Director of Nursing will present summary of finds to the Performance Improvement Committee monthly times 6 months for further review and recommendations.</p>	12/13/13	

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F 441	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure appropriate handwashing and glove changes during the provision of incontinent care for one (1) of twenty-four (24) sampled residents (Resident #3).</p> <p>The findings include:</p> <p>Review of the "Hand Hygiene" policy, revised 10/01/13, revealed to wash hands with soap and water before and after direct patient care and when hands were visibly soiled or contaminated.</p> <p>1. Observation of incontinent care for Resident #3, on 10/30/13 at 9:45 AM, revealed State Registered Nurse Aide (SRNA) #3 applied barrier cream to the resident's buttocks while wearing gloves, then used the same gloves to apply barrier cream to the perineal area. After completing care, SRNA #3 gathered the resident's supplies, touched the closet handle, and placed the supplies in a bath basin wearing the same soiled gloves.</p> <p>Interview with SRNA #3, on 10/30/13 at 10:00 AM, revealed she probably should have changed her gloves when applying barrier cream from the buttocks to the perineal area. She stated she also should have removed her soiled gloves before putting the resident's supplies in the closet.</p> <p>Interview with the Director of Nursing (DON), on 10/31/13 at 10:00 AM, revealed she expected staff to apply barrier cream from the perineal area to the buttocks, "clean to dirty," just as they would during the provision of incontinent care. Staff was</p>	F 441			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185236	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2013
NAME OF PROVIDER OR SUPPLIER OWENSBORO CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD. OWENSBORO, KY 42303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 10 expected to wash their hands immediately after incontinent care, before doing anything else in the room. 2. Observation on 10/30/13 at 12:25 PM revealed SRNA #4 failed to wash her hands after obtaining ice from stored receptacle, preparing a drink for resident consumption and feeding a resident. Interview conducted 10/31/13 at 9:30 AM with SRNA #4 revealed she should have washed her hands before getting ice from the ice bucket and prior to feeding any of the residents. The SRNA stated it could have caused the spread of germs. Interview with the DON, on 10/31/13 at 11:45 AM, revealed staff should wash their hands in between services to each resident.	F 441			

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NAME OF PROVIDER OR SUPPLIER OWENSBORO CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD. OWENSBORO, KY 42303	
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{K 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 12/13/13 as alleged.	{K 000}		

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

TITLE

(X6) DATE

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

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K 000	<p>INITIAL COMMENTS</p> <p>Building: 01</p> <p>Plan Approval: 1966, 1999</p> <p>Survey under: NFPA 101 (2000 edition) Chapter 19</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type III (211)</p> <p>Smoke Compartment: 9</p> <p>Fire Alarm: Complete fire alarm installed in 1966. Panel upgraded in 2001</p> <p>Sprinkler System: Complete automatic dry sprinkler system installed in 1966 and upgraded in 2012.</p> <p>Generator: Type II, Natural Gas, installed in 1983.</p> <p>A standard Life Safety Code survey was conducted on 10/30/13. Owensboro Place Care and Rehabilitation Center was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for One-Hundred Forty-Five (145) beds with a census of One-Hundred Forty-One (141) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (life Safety from Fire)</p> <p>Deficiencies were cited with the highest</p>	K 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Owensboro Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> 	

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

Wendell Smith

TITLE

Administrator

(X6) DATE

11/22/13

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

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K 000 K 025 SS=E	Continued From page 1 deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers in accordance with NFPA standards. The deficiency had the potential to affect four (4) of nine (9) smoke compartments, forty-eight (48) residents, staff and visitors. The facility is certified for One-Hundred Forty-Five (145) beds with a census of One-Hundred Forty-One (141) on the day of the survey. The facility failed to ensure two (2) smoke barriers have a ½ hour rating. The findings include: Observation, on 10/30/13 between 8:30 AM and 9:00 AM with the Maintenance Supervisor, revealed the smoke partitions, extending above the ceiling located next to room #E14, and D1, were not properly rated at 30 minutes. The barriers were constructed with drywall on one	K 000 K 025	K 025 1. The smoke partitions extending above the ceiling located next to room E14 and D1 will have drywall added to the side that is open in order to bring the rating up to at least 30 minutes. 2. These are the only smoke partitions in the attic that do not have drywall on both sides. This was validated on 10/30/13 by the Maintenance Director and the Life Safety surveyor. 3. The Maintenance Staff was re-educated regarding the requirements of smoke barriers by the Administrator on 10/31/13. The Maintenance Department will inspect the attic smoke barriers after any work in the attic is completed. If the smoke barrier(s) has been damaged or penetrations have been left, corrective action will be taken immediately. 4. The smoke barriers will be inspected and findings will be presented to the facility Performance Improvement (Quality Assurance) monthly times 3 months for review and further recommendations.	12/13/13	

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K 025	<p>Continued From page 2</p> <p>side of the barriers and the framing studs exposed on the interior side of the barriers.</p> <p>Interview, on 10/30/13 between 8:30 AM and 9:00 AM with the Maintenance Supervisor, revealed he was not aware the barriers were not properly constructed to meet the ½ hour rating for a smoke barrier.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. <p>19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than</p>	K 025			

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K 025	Continued From page 3 1/2 hour.	K 025		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, all residents, staff and visitors. The facility is certified for One-Hundred Forty-Five (145) beds with a census of One-Hundred Forty-One (141) on the day of the survey. The facility failed to ensure twelve (12) egress doors had the proper signage for delayed egress doors. The findings include: Observation, on 10/30/13 between 10:30 AM and 3:00 PM with the Maintenance Supervisor, revealed the egress doors throughout the facility were equipped with delayed egress signs that had a clear background which was not contrasting to the lettering. Interview, on 10/30/13 between 10:30 AM and	K 038	K 038 1. The delayed egress signage on all exit doors will be replaced with signage having a contrasting background. The new signage has been received. 2. The delayed egress signage will be replaced on all exit doors. 3. The new signage will be permanent. Maintenance will inspect the condition of the signage monthly to assure that it is easily read. Corrections will be made immediately. 4. The results of the inspections and testing will be presented to the facility Performance Improvement (Quality Assurance) monthly times 3 months for review and further recommendations.	12/13/13

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K 038	Continued From page 4 3:00 PM with the Maintenance Supervisor, revealed he was unaware the doors were required to have signage with a contrasting background. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in	K 038		

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K 038	<p>Continued From page 5 accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p>	K 038			

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K 038	Continued From page 6 (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS NFPA 101 LIFE SAFETY CODE STANDARD	K 038		
K 047 SS=E	Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of nine (9) smoke compartments, One-Hundred Thirteen (113) residents, staff and visitors. The facility is certified for One-Hundred Forty-Five (145) beds with a census of One-Hundred Forty-One (141) on the day of the survey. The facility failed to ensure the exit paths were clearly marked on both sides of smoke doors. The findings include: Observation, on 10/30/13 between 10:30 AM and 3:00 PM with the Maintenance Supervisor, revealed egress paths were not properly marked above the cross-corridor doors in E-hall, D-hall,	K 047	K 047 1. Illuminated exit signs will be added above the cross-corridor doors in E-hall, D-hall and at the C wing nurses' station. The exit sign at the old facility entrance on D wing will be changed and an exit sign will be added above the door by 12/13/13. 2. An inspection of the entire facility exit signage was done by the Administrator on 11/20/13 and other signage changes will be made as needed. 3. Proper operation of all exit signs will be inspected weekly by Maintenance staff. Steps will be taken immediately to make repairs or initiate replacement. 4. The results of the inspections and testing will be presented to the facility Performance Improvement (Quality Assurance) monthly times 3 months for review and further recommendations.	12/13/13

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K 047	Continued From page 7 and at the nurses' station on c-hall. Further observation revealed the exit sign was turned wrong at the old entrance to the facility and there was no exit sign above the door. Interview, on 10/30/13 between 10:30 AM and 3:00 PM with the Maintenance Supervisor, revealed he was unaware the signage was missing for the exits. Reference: NFPA 101 (2000 edition) 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.	K 047			
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	K 056 1. The sprinkler heads under the canopy at the old facility entrance will be relocated to afford sprinkler protection above the overhang of the roof. 2. An inspection by the Administrator of the other covered patios on 11/20/13 revealed that the same issue exists under the canopy at the front of A wing. This sprinkler head will also be relocated to afford protection above the overhang of the roof. This will address the issue for all residents. 3. These modifications to the sprinkler system will be permanent changes. All sprinkler inspections in the future will include these modifications.	12/13/13	

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K 056	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, eight (8) residents, staff and visitors. The facility is certified for One-Hundred Forty-Five (145) beds with a census of One-Hundred Forty-One (141) on the day of the survey. The facility failed to ensure the canopy at the old entrance to the facility was properly sprinkler protected. The findings include: Observation, on 10/30/13 at 2:00 PM with the Maintenance Supervisor, revealed the canopy at the old entrance to the facility did not have proper sprinkler protection above the overhang of the roof. Interview, on 10/30/13 at 2:00 PM with the Maintenance Supervisor, revealed we was under the impression that the canopy was properly sprinkler protected because there were sprinkler mounted to the side of the facility. Reference: S&C 09-04 Adoption of New Fire Safety Requirements for Long Term Care Facilities, Mandatory Sprinkler Installation Requirement http://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter09-04.pdf NFPA 101 LIFE SAFETY CODE STANDARD	K 056	4. The Maintenance Department will report any sprinkler system issues and any corrective actions taken to the Performance Improvement (Quality Assurance) Committee for review and further recommendations. The Maintenance Director will assure that testing is done as scheduled. Compliance will be monitored by the administrator.	
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:	K 066	1. New, red containers with self-closing mechanisms will be purchased for both smoking areas. These will be labeled "For Butts and Ashes Only". Additionally, new trash cans will be purchased for each smoking area, and labeled "For Trash Only". These were ordered on 10/21/13. Cigarette butts will be picked up at each of the smoking areas.	12/13/13

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185236	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0101 B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2013
NAME OF PROVIDER OR SUPPLIER OWENSBORO CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD. OWENSBORO, KY 42303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 066	<p>Continued From page 9</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved designated smoking areas, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of nine (9) smoke compartments, residents that smoke, staff and visitors. The facility is certified for One-Hundred Forty-Five (145) beds with a census of One-Hundred Forty-One (141) on the day of the survey. The facility failed to ensure there was not trash being placed in the butte buckets, there were no cigarette butts on the ground, and the use of only approved ashtrays.</p>	K 066	<p>2. There are only two smoking areas for the facility.</p> <p>3. Each smoking area will be inspected weekly and any cigarette butts found on the ground will be picked up. There are only two smoking areas for the facility.</p> <p>4. The Maintenance Department will report any issues regarding the proper disposal of butts, ashes, and trash in the smoking areas to the Performance Improvement (Quality Assurance) monthly times 3 months for review and further recommendations.</p>		

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K 066	<p>Continued From page 10</p> <p>The findings include:</p> <p>Observation, on 10/30/13 between 10:30 AM and 3:00 PM with the Maintenance Supervisor, revealed the smoking areas at the front of the facility and the resident smoking area had paper trash placed in the metal butte buckets. Further observallon revealed over 20 cigarette butts on the ground and the use of an unapproved can for an ashtray at the resident smoking area.</p> <p>Interview, on 10/30/13 between 10:30 AM and 3:00 PM with the Maintenance Supervisor, revealed he was unaware of the trash being placed into the buckets and the unapproved ashtray that showed up. He was aware cigarette butts could not be placed on the ground at the facility and they routinely clean up the smoking areas.</p> <p>Reference: NFPA Standard 101 (2000 Edition).</p> <p>19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where</p>	K 066		

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NAME OF PROVIDER OR SUPPLIER OWENSBORO CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD. OWENSBORO, KY 42303	
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K 066	Continued From page 11 smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066		