

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

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185217	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	<div style="border: 2px solid black; padding: 5px; font-size: 2em; font-weight: bold; letter-spacing: 0.5em;">RECEIVED</div>	(X3) DATE SURVEY COMPLETED AUG - 1 2011 07/14/2011
--	--	--	--	---

NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE, PO BOX 115 EDMONTON, SK T4E 1A9 Division of Health Care Enforcement Branch
---	--

(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 F 253 SS=E	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted on 07/12-14/11. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Wheelchairs/geri-chairs for twelve residents were observed to have torn, ragged areas. All resident room, storage room, and central bathroom doors were observed to be soiled on the lower portions of the doors. Doors in resident rooms 109, 112, and 113 were observed to be very difficult to open/close.</p> <p>The findings include:</p> <p>The following areas were observed to be in need of housekeeping/maintenance services:</p> <p>1. Observations in the dining room at 12:00 PM on 07/14/11, revealed torn and ragged chairs for Residents #5, #10, #16, #17, #18, #19, #20, #21, #22, #23, #24, and #25.</p>	F 000 F 253	<p>The preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.</p> <p>1. The wheelchair arms for residents #5, 10, 16, 17, 18, 19, 20, 21, 22, 23, 24, and 25 have been repaired. The doors to residents rooms #109, 112, and 113 have been repaired. The door kick plates throughout the facility have been deep cleaned.</p> <p>2. The housekeeping and maintenance staff have inspected the facility wheelchairs, doors, and door kick plates. All issues requiring repair and/or cleaning have been addressed.</p> <p>3. The housekeeping and maintenance staff have received in-service education on the need to inspect facility wheelchairs, doors, and door, kick plates to identify issues requiring repair and/or cleaning as provided by the Staff Development Coordinator on 7/28/11.</p> <p>4. The CQI Indicator for the monitoring of the facility interior and equipment will be utilized monthly X 2 months then in accordance with the established CQI calendar under the supervision of the Housekeeping Supervisor.</p>	8/26/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ally Neighbors</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/4/11</i>
--	-----------------------------------	--------------------------------

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185217	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/14/2011
NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE, PO BOX 115 EDMONTON, KY 42129	
(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 253	<p>Continued From page 1</p> <p>An interview with the Director of Nursing (DON) on 07/14/11, at 3:00 PM, revealed the facility had an employee who cleaned residents' chairs and she usually informed Management when chairs needed repair. The DON had not been made aware of the ragged areas on the wheelchairs.</p> <p>An interview with Resident #25 on 07/14/11, at 3:40 PM, revealed he/she said her/his chair looked bad.</p> <p>2. On 07/14/11, at 2:15 PM, resident rooms 109, 112, and 113 were observed to be very difficult to open when they were closed.</p> <p>An interview with the Maintenance Supervisor (MS) on 07/14/11, at 2:15 PM, revealed the MS was unaware of the sticking doors. The MS stated staff was to complete a maintenance request when repairs were needed but no one had completed one regarding the doors.</p> <p>3. All resident room doors, central shower room doors, and storage room doors were observed to be soiled on the lower portions of the doors.</p> <p>An interview with the Housekeeping Supervisor (HS) on 07/14/11, at 2:35 PM, revealed she had attempted to clean the doors but had been unable to find any product that would remove the soil from the doors. The HS stated she would continue to try to find something that would work.</p>	F 253		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185217	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	RECEIVED AUG - 1 2011 07/13/2011 Division of Health Care Compliance Compliance and Correction Branch		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE, PO BOX 115 EDMONTON, KY 42125			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER/CLIA IDENTIFICATION NUMBER	COMPLETION DATE		
K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on 07/13/11. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.	K 000		8/26/11		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by:	K 018				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Stacy McNeighon* TITLE: Administrator DATE: 8/1/11

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185217	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/13/2011
NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE, PO BOX 115 EDMONTON, KY 42129		
(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 018	Continued From page 1 Based on observation and interview, the facility failed to ensure corridor doors were able to resist the passage of smoke. This deficient practice affected one of six smoke compartments, staff, and approximately 30 residents. The facility has the capacity for 101 beds with a census of 90 on the day of the survey. The findings include: During the Life Safety Code tour on 07/13/11, at 10:05 AM, with the Director of Maintenance (DOM), observation revealed resident room E112 was observed to have an approximate one-inch gap at the top of the door. Corridor doors must be able to resist the passage of smoke in a fire situation. An interview with the DOM on 07/13/11, at 10:05 AM, revealed corridor doors in this section of the building were difficult to maintain.	K 018			
K 025 SS=D	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	K 025	1. The unsealed penetrations of electrical conduit and duct work in the attic area above the fire/smoke barrier doors next to room 102 have been sealed. 2. The remaining electrical conduit and duct work in the attic area was inspected for any unsealed penetration, with no further issues identified. 3. The maintenance staff have received in-service education on the need to inspect the electrical conduit and duct work in the attic area for any unsealed areas on a yearly basis, and to seal any areas identified as provided by the Administrator on 8/8/11. 4. The CQI Indicator for the monitoring of unsealed penetrations in the attic area will be	8/26/11	

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

PRINTED: 07/28/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185217	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/13/2011
NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE, PO BOX 115 EDMONTON, KY 42129	
(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 025	<p>Continued From page 2</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain smoke barriers with at least a one-half hour fire resistance rating as required. This deficient practice affected two of six smoke compartments, staff, and approximately thirty residents. The facility has the capacity for 101 beds with a census of 90 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 07/13/11, at 10:00 AM, with the Director of Maintenance (DOM), unsealed penetrations of electrical conduit and ductwork were observed in the attic area above the fire/smoke barrier doors next to room 102. In a fire situation, unsealed penetrations of smoke barriers aid in the spread of smoke and fire to other parts of the building. An interview with the DOM on 07/13/11, at 10:00 AM, revealed the DOM was not aware the fire/smoke barrier wall needed repair.</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</p>	K 025	utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Director of Maintenance.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185217	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/13/2011
NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE, PO BOX 115 EDMONTON, KY 42129	
(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 052	Continued From page 4 facility has the capacity for 101 beds with a census of 90 on the day of the survey. The findings include: During the Life Safety Code tour on 07/13/11, at 10:20 AM, with the Director of Maintenance (DOM), a test of the facility fire alarm system revealed the fire doors would close when the alarm was activated but could be reset while in the silent mode to the open position while the system was still showing fire conditions. An interview with the DOM on 07/13/11, at 10:20 AM, revealed the DOM was not aware fire doors should not be able to be reset while the fire alarm system was still showing fire conditions. Reference: NFPA 72 (1999 Edition). 3-9.6.3 All door hold-open release and integral door release and closure devices used for release service shall be monitored for integrity in accordance with 3-9.2.	K 052		