

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

PRINTED: 11/18/2011
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185309 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 11/03/2011 |
| NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY, 42754 | | |
| (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 An annual survey and an abbreviated survey (KY #16955) was conducted on 11/01/11 through 11/03/11, and a Life Safety Code survey was conducted on 11/02/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S of an "F." KY #16955 was substantiated with deficiencies. | F 000 | Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law. | | |
| F 315 SS=E | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to ensure residents who are incontinent of bladder receive appropriate treatment and services to restore as much normal bladder function as possible for three residents (#2, #4 and #5), in the selected sample of 15. Observations of incontinent care, on Residents #2, #4 and #5, revealed staff cleaned the residents' private areas without changing areas of the washcloth. | F 315 | <u>F 315</u> <u>483.25(d) No Catheter, Prevent UTI, Restore Bladder</u> It is the normal practice of Springview Health and Rehab to ensure that a resident who enters the facility, who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. <u>Corrective Measures for those Residents Identified in the Deficiency:</u> Residents #2, #4 and #5 will be provided with appropriate and thorough incontinent care by staff. CNA'S were re-educated on proper procedure for providing incontinent care on 11/11/11 by the Staff Development Nurse, DON, and LPN Supervisor. Direct care staff for Residents #2, #4 and #5 were observed by the Staff Development Nurse and LPN Supervisor providing incontinent care to these identified residents on 11/22/11 utilizing the incontinent care skills checklist. The direct care staff were observed to delivery proper incontinent care. | 12/16/11 | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Dmarcello B. Lahr* TITLE: Administrator DATE: 12/09/11

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 those 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 315 | Continued From page 1 Findings include: A review of the facility's policy/procedure "Incontinent Care Education," undated, revealed "staff are to use gloves and perform handwashing in accordance with Standard Precautions and Infection Control practice. Wet washcloths with warm water. Apply perineal wash or soap - female separate labia, cleanse perineal area front to back with one stroke. Repeat until clean, using a clean part of the washcloth for each stroke. Change washcloths as needed. Male - retract the foreskin if uncircumcised. Grasp the penis. Cleans the tip, start at the urethra (opening) and work outward. Use a clean part of the washcloth each time. Rinse if not using a no-rinse product. Return foreskin to the normal position. Cleanse shaft of penis. Cleanse scrotum. Rinse washed areas of both male and female if not using a no-rinse product. Pat areas dry. Turn to side and cleanse rectal area. Female resident, wash from the vagina to the anus area with one stroke. Repeat as needed to clean using a clean pat of the washcloth each time. Rinse if required by product and pat dry. Apply moisture barrier." An interview with the Director of Nursing (DON), on 11/3/11 at 3:25 PM, revealed the facility used a protocol for incontinent care and infection control, but had no policy and procedure. 1. A record review revealed Resident #2 was admitted to the facility on 07/26/11, and re-admitted on 09/16/11, with diagnoses to include Multiple Sclerosis, Depressive Disorder, Peripheral Neuropathy and Chronic Indwelling Catheter. | F 315 | F 315 (continued) <u>How other Residents who may have been affected by the Practice were Identified:</u> A list of residents was developed by the DON of Residents who are dependent for incontinent care utilizing the MDS Assessment 11/22/11. These Residents have the potential to be affected by the practice. <u>Measure Implemented or Systems Altered to Prevent Re-Occurrence:</u> All CNA'S were re-educated on appropriate incontinent care by 11/11/11 by the DON, Staff development Nurse and LPN Supervisor. Any CNA'S that could not attend, will be in-serviced prior to their next shift worked. The DON will be responsible to provide or arrange for the education. All residents who are dependent for incontinent care will be observed receiving peri care from the direct care staff, utilizing the incontinent care check sheet. The Observations will be conducted by the Staff Development Nurse, LPN Supervisor and DON. This will be completed by 12/5/11. <u>Monitoring Measures to Maintain Ongoing Compliance:</u> The Staff Development Nurse/LPN Supervisor or DON will conduct random observations of peri care delivery on 6 residents in the facility who are dependent for incontinent care. (approx 10%) of residents. Three residents from 100 hall and three residents from 200 hall will be randomly selected. Observations will be conducted weekly X 8 weeks, then monthly X 3 months. Results will be reported to the DON, and the Quality Assessment and Assurance Committee. If any areas of concern are identified, the frequency or duration of the audit may be increased. | | |

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| F 315 | Continued From page 2 Observations, on 11/02/11 at 9:55 AM, revealed Certified Nurse Aide (CNA) #1 was assisted by CNA #2 to complete incontinent care for Resident #2. CNA #1 was observed to wipe the genitalia and shaft several times without changing areas of the washcloth. CNA #1 did not retract the foreskin of the penis and cleanse the glans. The CNA did not use additional washcloths to rinse the soap off and dry the resident before applying a clean incontinent brief. An interview with CNA #1, on 11/02/11 at 10:35 AM, revealed while providing incontinent care, she did not change areas of the washcloth, but knew to cleanse the resident with a different area of the washcloth each time. A review of the comprehensive care plan "Activity of Daily Living (ADL) Functional Rehab Potential," dated 08/09/11, revealed the resident required extensive assistance with dressing, toileting, and hygiene. He/she was frequently incontinent of bowel, with incontinent care being provided as needed. 2. A record review revealed Resident #4 was admitted to the facility on 03/05/07, and readmitted 09/04/09, with diagnoses to include Esophageal Stricture, General Osteoarthritis, Depressive Disorder and Failure to Thrive. Observation of incontinent care, on 11/02/11 at 8:10 AM, revealed CNA #3 transferred the resident to bed utilizing a gait belt. CNA #3 provided incontinent care and wiped back and forth three times in the groin area without changing areas of the soapy washcloth. She | F 315 | | | |

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| F 315 | <p>Continued From page 3</p> <p>wiped down the middle of Resident #4's vaginal area. She had the resident to roll over on his/her side and she wiped Resident #4's buttock back and forth without changing areas of the washcloth. CNA #3 did not use a clean washcloth to rinse the soap off the resident and she did not use a dry washcloth to pat the resident dry before applying a clean incontinent brief.</p> <p>An interview with CNA #3, on 11/02/11 at 8:25 AM, revealed she knew not to use the same area of the washcloth to clean a resident. She stated she usually had two washcloths available to use while providing incontinent care, and stated she did not rinse or pat the area dry before applying a new brief.</p> <p>3. A record review revealed Resident #5 was admitted to the facility on 08/23/11 with diagnoses to include Alzheimer's Disease, Hypertension and Depressive Disorder.</p> <p>Observation of incontinent care, on 11/02/11 at 8:32 AM, revealed CNA #1 and CNA #2 transferred the resident from his/her wheelchair to the bed. CNA #1 grabbed a washcloth and saturated it with soap and water. She wiped the resident's buttocks first with the same area of the washcloth two times. CNA #1 then washed Resident #5's scrotum area two times with the same area of the washcloth. The CNA placed the clean incontinent brief on the resident without rinsing the soap off or patting his/her perineal area dry.</p> <p>An interview with CNA #2, on 11/02/11 at 10:50 AM, revealed during incontinent care staff are</p> | F 315 | | | |

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| F 315 | Continued From page 4 supposed to use a different area of the washcloth to clean the genitalia. She stated "we are not supposed to go back and forth with the same area of the washcloth because that could cause an infection to occur." An interview with the DON, on 11/03/11 at 7:40 AM, revealed the staff are supposed to clean the resident's private area from clean to dirty. They are supposed to use a different area of the washcloth each time. With male residents, the staff should retract the foreskin if they are not circumcised. Cleanse in a circular motion and use a different area of the washcloth. | F 315 | | |
| F 332 SS=E | 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to ensure it was free of medication error rates of five percent or greater. Observations of three medication passes with three Certified Medication Technicians (CMT), on two out of three halls, revealed there were 43 opportunities with three medication errors, which resulted in a six percent (6%) medication error rate. Findings include: A review of the facility's Medication Administration | F 332 | F 332 483.25(m)(1) Free Of Medication Error Rates of 5% Or More It is the normal practice of Spring view Health and Rehab to ensure that it is free of medication error rates of five percent or greater. <u>Corrective Measures for those Residents Identified in the Deficiency:</u> Resident #16 did not voice any complaints of increased anxiety on 11/2/11 and the Licensed staff did not note any issues with increased anxiety on 11/2/11. Resident #9 was reassessed by the licensed nurse and blood pressure was taken on 11/2/11 and was noted to be within acceptable range. The attending physician was notified and no new orders were given. Resident was discharged home as previously planned on 11/2/11. Resident # 11's physician was re-notified by the licensed nurse of the residents refusal to take the Synthroid at the time ordered on 11/2/11. A new order was received from the physician to change the medication time on 11/2/11. The MAR now | 12/16/11 |

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| F 332 | <p>Continued From page 5</p> <p>policy and procedure, dated 09/10, revealed "medications should be administered in accordance with written orders of the prescriber."</p> <p>1. A record review revealed Resident #16 was admitted to the facility with a diagnosis of Anxiety.</p> <p>A review of the November 2011 physician's orders and Medication Administration Record (MAR), revealed an order for Buspar (anti-anxiety) 15 milligrams (mg) three times a day (8:00 AM, 2:00 PM and 9:00 PM).</p> <p>An observation during the medication pass, on 11/01/11 at 3:00 PM, revealed CMT #1, did not administer Buspar 15 mg as ordered.</p> <p>An interview with CMT #1, on 08/03/11 at 8:10 AM, revealed she overlooked the Buspar on the MAR.</p> <p>2. A record review revealed Resident #9 was admitted to the facility on 10/19/11 with a diagnosis of Hypertension.</p> <p>A review of the November 2011 physician's orders and MAR, revealed an order for Cardura (to lower blood pressure) two mg, one by mouth at bedtime (8:00 PM).</p> <p>An observation during the medication pass, on 11/02/11 at 8:15 AM, revealed CMT #2 administered Cardura two milligrams.</p> <p>An interview with CMT #2, on 11/02/11 at 10:00 AM, revealed she must have looked at the MAR and read the time wrong, and stated it was a mistake.</p> | F 332 | <p>F-332 (continued)</p> <p>reflects the new medication administration time for synthroid. The resident is accepting the medication at the new time.</p> <p>CMT #1, #2 and #3 were re-educated on 11/8/11 by the pharmacist on proper medication administration.</p> <p><u>How other Residents who may have been affected by the practice were Identified:</u></p> <p>Residents residing on 100 and 200 Halls who receive oral medications have the potential to be affected by the practice.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-Occurrence:</u></p> <p>All CMT'S were re-educated on 11/8/11 by the pharmacist on proper medication administration procedures. All CMT'S will have medication observations performed by Pharmacy Consultant staff by 12/15/11. The results of the observations will be reported to the Director of Nursing. Additional education will provided if concerns are identified by the Pharmacy Consultant staff or the Director of Nursing.</p> <p><u>Monitoring Measures to Maintain Ongoing Compliance:</u></p> <p>The Staff Development Nurse or designee will conduct unannounced medication observations of 2 CMT's per month. The observations will be conducted monthly x 3 months to verify ongoing compliance. The findings will be reported to the Director of Nursing and the Quality Assessment and Assurance committee. If any areas of concern are identified, the frequency and or duration of the observations may be increased.</p> | |
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| F 332 | Continued From page 6 3. A record review revealed Resident #11 was admitted to the facility on 09/30/11 with a diagnosis of Hyperthyroidism. A review of the physician's orders, dated 10/21/11, and November 2011 MAR revealed an order for Synthroid 150 micrograms (mcg) (thyroid hormone) by mouth at 6:00 AM. An observation during a medication pass, on 11/02/11 at 7:40 AM, revealed CMT #3 administered Synthroid 150 mcg. An interview with CMT #3, on 08/02/11 at 9:00 AM, revealed she gave the Synthroid 150 mcg at that time because the resident will not take any medication before eating. She stated she did not know if the nurses called and made the physicians aware. An interview with the Director of Nursing (DON), on 11/02/11 at 10:00 AM, revealed staff should administer the medications according to the physician's orders. | F 332 | | | |
| F 371 SS-E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions | F 371 | F-371 483.35(i)FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY It is the normal practice of Spring view Health and Rehab to store, prepare, distribute and serve food under sanitary conditions. | 12/16/11 | |

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| F 371 | <p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to serve food under sanitary conditions. Observation of the kitchen revealed approximately 40 plate bonnets and bottoms were stacked with water on the inside of them, and the food processor container was stored with approximately a tablespoon of water on the inside of it.</p> <p>A review of the census and condition, dated 11/01/11, revealed there were 62 residents in the building and two of those were tube feeders.</p> <p>Findings include:</p> <p>An interview with the Dietary Manager, on 11/02/11 at 2:00 PM, revealed there was no policy and procedure to address the drying of the food processor container and plate bonnets and bottoms, but staff should have ensured the plate bonnets and bottoms were thoroughly air dried before they were stacked and the food processor container was put away.</p> <p>An observation of the kitchen, on 11/02/11 at 9:45 AM, revealed approximately 40 plate bonnets and bottoms were stacked with water on the inside of them and the food processor container had approximately one tablespoon of water in it.</p> <p>An interview with the Dietary Manager, dated 11/02/11 at 9:45 AM, revealed the dietary staff should have tilted the plate bonnets and bottoms and allowed them to totally air dry before they were stacked and put away. She stated staff</p> | F 371 | <p>F-371 (continued)</p> <p><u>Corrective Measures for those Residents Identified in the deficiency:</u></p> <p>No residents were identified in the deficiency.</p> <p><u>How other Residents who may have the potential to be affected were identified:</u></p> <p>Residents who receive meal trays have the potential to be affected by the practice.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-Occurrence:</u></p> <p>The kitchen staff were re-educated on 11/2/11 by the Registered Dietician and Dietary Manager on kitchen sanitation with emphasis placed on the bonnets, bottoms and food processor being dry prior to being stacked and stored. Any staff member that was unable to attend, will be re-educated prior to their next shift worked by the Dietary Manager.</p> <p>As of 11/2/11, the bonnets and the bottoms are now being stacked vertically, standing on end in the rack to allow for proper drying.</p> <p>As of 11/2/11, the food processor is being placed aside to allow drying prior to storage, and a different bowl will be utilized each time.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>The daily kitchen audit tool has been revised and monitoring of the bonnets, bottoms and the food processor for dryness has been added to the audit tool. The audit tool will be completed by the Dietary Manager or designee on a daily basis. The Registered Dietician will review the audit tool on weekly basis x 8 weeks, then every 2 weeks x 8 weeks, then monthly ongoing to verify ongoing compliance.</p> | |
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| F 371 | Continued From page 8 should have dumped the water out of the food processor container and allowed it to thoroughly dry before it was placed back on the food processor. | F 371 | F-371 (continued) Results of the audits will be reported to the Administrator and the Quality Assessment and Assurance Committee. If concerns are identified, the frequency or duration of audits may be increased. | | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must 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. (c) Linens | F 441 | F-441 <u>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</u> The facility has an established infection control program that is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. <u>Corrective Measures for those Residents identified in the deficiency:</u> Resident # 2 was assessed on 11/23/11 by the licensed nurse and no signs or symptoms of infection were identified. On 11/24/11 direct care staff were observed by the Staff Development Nurse and the LPN Supervisor, for proper hand washing, utilizing the hand washing protocol while preparing for and completing peri care on resident #2, and proper hand washing procedure was followed. Resident # 4 was assessed on 11/23/11 by the licensed nurse and no signs or symptoms of infection were identified. On 11/23/11 direct care staff were observed by the Staff Development Nurse and the LPN Supervisor, for proper hand washing utilizing the hand washing protocol, while preparing for and completing peri care on resident #4, and proper hand washing procedures were followed. | 12/16/11 | |

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| F 441 | <p>Continued From page 9</p> <p>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 policy/procedure review, it was determined the facility failed to ensure the infection control program was implemented related to handwashing between residents to help prevent the development and transmission of diseases and infections for three residents (#2, #4, and #5), in the selected sample of 15. On 11/02/11, staff were observed not washing or sanitizing their hands after providing care for the residents.</p> <p>Findings include:</p> <p>A review of the handwashing protocol, dated 01/27/11, revealed handwashing should be done, but is not limited to the following times: when coming on duty, before and after care for each resident, after handling equipment that is contaminated, after using the toilet or wiping nose, before and after eating, and whenever hands are obviously soiled.</p> <p>1. Observation, on 11/02/11 at 8:32 AM, revealed Certified Nurse Aide (CNA) #2 assisted CNA #3 with incontinent care for Resident #4. After the incontinent care was completed, CNA #2 removed her gloves and exited the room without washing her hands or utilizing sanitizer.</p> | F 441 | <p>F-441 (continued)</p> <p>Resident # 5 was assessed on 11/23/11 by the licensed nurse and no signs or symptoms of infection were identified. On 11/23/11 direct care staff were observed by the Staff Development Nurse and the LPN Supervisor for proper hand washing procedures utilizing the hand washing protocol while preparing for, and completing per care on resident #5 and proper hand washing procedures were followed.</p> <p><u>How other Residents who may have been affected by the practice were identified:</u></p> <p>A list of residents was developed by DON of residents who are dependent for incontinent care utilizing the MDS assessment 11/22/11. These Residents have the potential to be affected by the practice.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>All CNA'S, CMT'S, and Licensed Nurses were re-educated on proper hand washing procedures by 11/22/11 by the Staff Development Nurse and LPN Supervisor. In addition, all licensed nurses will be re-educated on the proper handling of soiled linen by the Staff Development Nurse and the LPN Supervisor. Re-education was initiated on 11/23/11 and will be completed by 12/5/11 for handling of soiled linen. Any staff member that is unable to attend during this time will be re-educated prior to their next shift worked. The DON will be responsible to see that the education is provided. Repeat training will be conducted semi-annually on Hand washing to include Handling of soiled linen, by the Administrative Nurses or LPN Supervisor.</p> | |

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| F 441 | Continued From page 10 2. Observation, on 11/02/11 at 10:00 AM, revealed CNA #2 assisted CNA #1 with incontinent care for Resident #2. CNA #1 was completing the incontinent care and a resident's alarm was sounding. CNA #2 was observed to remove her gloves, turn the handle of the bedroom door and enter the resident's room directly across from Resident #2 without washing her hands. An interview with CNA #2, on 11/02/11 at 10:50 AM, revealed gloves should be changed when going in and out of a room while providing care. She stated as a CNA, she was taught to wash her hands before bathing a resident. If something happened during the bathing, then wash hands and put a new pair of gloves on. Upon completion of a task, wash hands and arms again. She stated she was expected to wash or sanitize her hands before providing care for the next resident. 3. Observation, on 11/02/11 at 4:20 PM, revealed Licensed Practical Nurse (LPN) #2 completed a head to toe skin assessment on Resident #5. Resident #5 had a small bowel movement and fecal matter was noted on his/her dressings. LPN #2 removed her gloves and exited the room without washing her hands. LPN #2 was observed to lay a soiled incontinent brief with soiled washcloths on the floor. She re-entered the room at 4:25 PM, opened the dressings and dated them with a marker she removed from her pocket, then donned a pair of gloves without washing her hands. Additionally, at 4:35 PM, CNA #4 stopped and changed her soiled gloves while she assisted LPN #2 with the care of Resident #5, but did not wash her hands prior to | F 441 | F-441 (continued) <u>Monitoring Measures to Maintain ongoing Compliance:</u> The LPN supervisor will randomly select 3 staff members from each unit daily x 7 days and without prior notification, observe for proper hand washing procedure. The observations will be conducted by the Staff Development Nurse and LPN Supervisor. Observations will continue to be conducted weekly x 8 weeks, then monthly x 3 months. Repeat training will be conducted semi annually for all CNA's, CMT's and Nurses. Results of the observations will be reported to the DON and to the Quality Assessment and Assurance Committee. If any areas of concern are identified, the frequency or duration of the observations may be increased. | | |

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| F 441 | <p>Continued From page 11 donning new gloves.</p> <p>An interview with CNA #4, on 11/02/11 at 4:55 PM, revealed she assisted LPN #2 with provision of incontinent care for the resident. She stated she should have washed her hands between glove changes while providing care.</p> <p>An interview with LPN #2, on 11/02/11 at 5:00 PM, revealed she was expected to wash her hands or use sanitizer between each resident. Additionally, she stated she did not wash her hands before she left the room and did not wash her hands when she re-entered the room. LPN #2 stated she should have washed her hands between each glove change to prevent the spread of infection; however, she did not do so.</p> <p>An interview with the Director of Nursing (DON), on 11/03/11 at 7:40 AM, revealed anytime staff come out of a resident's room and go into another room, they should sanitize their hands. The staff can use the sanitizer three times, then they have to wash their hands. When staff leave the room, they should wash or sanitize their hands. If staff leave the room and return, they should sanitize or wash their hands before returning to care.</p> | F 441 | | |

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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 1992, 2008

SURVEY UNDER: 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: One (1) story, Type V Unprotected

SMOKE COMPARTMENTS: Four (4) smoke compartments

FIRE ALARM: Complete fire alarm system with smoke detectors

SPRINKLER SYSTEM: Complete automatic dry sprinkler system

GENERATOR: Type II generator, fuel source is propane.

A standard Life Safety Code survey was conducted on 11/02/11. Spring View Health and Rehab was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for seventy one (71) beds and the census was sixty (60) on the day of the survey.

The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)

K 000 Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.

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

Amayla B. Lobb

TITLE

Administrator

(X6) DATE

11/28/11

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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| K 000 | Continued From page 1 | K 000 | | |
| K 027 SS=F | <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure access doors in smoke barriers were installed in accordance with NFPA Standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for seventy one (71) beds with a census of sixty (60) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 11/02/11 at 3:31 PM, with the Maintenance Assistant revealed three (3) unrated homemade smoke barrier access doors located in the attic.</p> | K 027 | <p>K027</p> <p>It is the normal practice of Spring View Health and Rehab to install access doors in smoke barriers in accordance with the NFPA code standards.</p> <p><u>Corrective Measures for Residents Identified in the Deficiency:</u></p> <p>No residents were identified in this deficiency.</p> <p><u>How Other Residents were Identified who may have been affected by this practice were identified:</u></p> <p>Residents in 4 of the 4 smoke compartments have the potential to be affected by the practice.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>The 3 homemade smoke barrier access doors will be removed by 11/25/11. The fire barrier will be restored in those areas. Two new access points will be created to allow access into each smoke compartment from the floor by 11/30/11 This will be completed by the Maintenance Assistant. On 11/21/11 the maintenance assistant was educated on smoke barrier door regulation by the administrator.</p> | 12/16/11 |

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| K 027 | Continued From page 2 Interview, on 11/02/11 at 3:31 PM, with the Maintenance Assistant revealed he was not aware the doors in the attic must be rated for use. Reference: NFPA 101 (2000 Edition) 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 1/2 hour. Reference: NFPA 101 (2000 Edition) Continuity 8.3.2 Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. | K 027 | K 027 (continued) Inspection of the smoke barrier doors will be conducted by the administrator upon completion. <u>Monitoring Measures to Maintain Ongoing Compliance:</u> The Maintenance Director will audit the smoke barriers on a monthly basis and report findings to the Administrator and Quality Assessment and Assurance Committee to validate ongoing compliance. | |
| K 029 SS=0 | NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from | K 029 | K029 It is the normal practice of Spring View Health and Rehab to meet Protection of Hazards in accordance with NFPA Standards | 12/16/11 |

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| K 029 | <p>Continued From page 3</p> <p>other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to meet the requirements of Protection of Hazards, in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of the four (4) smoke compartments, residents, staff and visitors. The facility is licensed for seventy one (71) beds with a census of sixty (60) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 11/02/11 at 2:05 PM, with the Maintenance Assistant revealed the oxygen storage room door, located in the 100 nurse's station, was not equipped with a self closing device.</p> <p>Interview, on 11/02/11 at 2:05 PM, with the Maintenance Assistant revealed he was not aware the door to the oxygen room was required to be self closing.</p> <p>Reference: NFPA 101 (2000 Edition).</p> | K 029 | <p>K 029 (continued)</p> <p><u>Corrective Measures For Residents Identified in the Deficiency</u></p> <p>No residents were identified in this deficiency.</p> <p><u>How Other Residents were Identified that may have been affected by the practice:</u></p> <p>Residents in one of four smoke compartments have the potential to be affected by the practice.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-Occurrence:</u></p> <p>A self closing device was installed on the oxygen storage door on 100 hall on 11/7/11 by the Maintenance Assistant. The Maintenance Assistant was re-educated by the administrator on 11/21/11 on proper self closure devices on doors of oxygen storage rooms.</p> <p><u>Monitoring Measures To Maintain Ongoing Compliance:</u></p> <p>Monitoring of all oxygen storage room doors was added to the audit tool for the Maintenance Department on 11/22/11. The audit will be conducted monthly by the maintenance assistant. The results of the audit will be reported to the Administrator and the Quality Assessment and Assurance committee to validate ongoing compliance.</p> | |

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| K 029 | Continued From page 4 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. | K 029 | | |
| K 038 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section | K 038 | K 038 It is the normal practice of Spring View Health and Rehab to ensure means of egress according to NFPA code. | 12/16/11 |

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K 038 Continued From page 5
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 means of egress in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for seventy one (71) beds with a census of sixty (60) on the day of the survey.

The findings include:

Observation, on 11/02/11 at 2:41 PM, with the Maintenance Assistant revealed the exit at the end of the 200 Hall next to room # 207, did not have a durable surface to a public way. The exit is identified on the evacuation plan as an exit in the event of an emergency.

Interview, on 11/02/11 at 2:41 PM, with the Maintenance Assistant revealed he was not aware the exit needed a durable surface to a public way. The Maintenance Director also confirmed the exit was identified on the evacuation plan.

Exits must have a durable surface to the public

K 038 K 038 (continued)

Corrective Measure for those Residents identified in the deficiency:

No residents were identified in the deficiency.

How other Residents were Identified that May have been affected by the practice:

Residents in smoke compartment one of four have the potential to be affected by the practice.

Measures Implemented or Systems Altered to Prevent Re-occurrence:

The Contracting Company was contacted by administrator on 11/28/11 and has agreed to install a durable surface to the public way at the exit on the end of 200 Hall. This will be completed by 12/15/11. The maintenance assistant was re-educated on the requirement for exits to have a durable surface to a public way by the administrator on 11/3/11.

Monitoring Measures to Maintain Ongoing Compliance:

The durable surface will be inspected by the administrator upon completion to verify compliance.

Auditing of exit accesses will be conducted by the maintenance assistant on a quarterly basis to verify continuing compliance. The findings will be reported to the administrator and the Quality Assessment and Assurance committee to verify ongoing compliance.

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K 038 Continued From page 6
way to support wheelchairs, beds, equipment, etc., in case of an emergency situation.

K 050 SS=F NFPA 101 LIFE SAFETY CODE STANDARD
Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2

This STANDARD is not met as evidenced by:
Based on interview and fire drill review it was determined the facility failed to ensure fire drills were conducted quarterly in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for seventy one (71) beds with a census of sixty (60) on the day of the survey.

The findings include:

Fire Drill review, on 11/02/11 at 10:00 AM, with the Maintenance Assistant revealed the facility failed to conduct a fire drill in the 2nd quarter of 2011 for 3rd shift. The facility also failed to conduct a fire drill in the 3rd quarter of 2011, for 2nd shift.

Interview, on 11/02/11 at 10:00 AM, with the

K 038

K 050 K 050 12/16/11

K 050
It is the normal practice of Spring View Health and Rehab to conduct Fire drills on a quarterly basis On accordance with NFPA standards.

Corrective Action for Residents Identified in the Deficiency:
No residents were identified in the deficiency.

How other Residents were Identified that May have been affected by the Practice:
Residents in 4 of 4 smoke compartments have the potential to be affected by the practice.

Measures Implemented or Systems Altered to Prevent Re-occurrence:
The schedule for quarterly fire drills was reviewed by the administrator on 11/22/11 to validate that fire drills are scheduled on a quarterly basis for all shifts. The Maintenance Assistant was re-educated on 11/21/11 by the Administrator on conducting timely fire drills for all shifts.

Monitoring Measures to Maintain Ongoing Compliance:
The Administrator will review the fire drill schedule on a monthly basis to validate ongoing compliance with scheduling.

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| K 050 | Continued From page 7 Maintenance Assistant revealed they realized they missed the 3rd quarter drill on 2nd shift, and conducted a fire drill on October 03, 2011. The facility was not aware they had missed the 2nd quarter for 3rd shift. Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts. | K 050 | K 050 (continued) The results of the audit will be reported to Quality Assessment and Assurance Committee on a quarterly basis. | | |
| K 070 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for seventy one (71) beds with a census of sixty (60) on the day of the survey. The findings include: Observation, on 11/02/11 at 11:44 AM, with the Maintenance Assistant revealed a portable space | K 070 | K 070 It is the normal practice of Spring View Health and Rehab to ensure that portable space heaters are used in accordance with NFPA standards. <u>Corrective Actions for those residents Identified in the deficiency:</u> No residents were identified in the deficiency. <u>How other Residents were Identified that have the Potential to be affected by the Practice:</u> Residents in one of four smoke compartments have the potential to be affected by the practice. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence.:</u> The portable space heater was removed from room #103 on 11/2/11 by the maintenance assistant. Remaining resident rooms were audited on 11/02/11 by the maintenance | 12/16/11 | |

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K 070 Continued From page 8
heater located in resident room #103.

Interview, on 11/02/11 at 11:44 AM, with the Maintenance Assistant revealed, they were not aware the heater did not meet the requirements of the code.

Reference: NFPA 101 (2000 edition)
19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies.
Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).

K 070 K 070 (continued)

assistant for portable heaters, none were identified.

The maintenance assistant was re-educated by the administrator on 11/02/11 on usage of portable heaters in health care occupancies.

Monitoring Measure for Ongoing Compliance:

The Maintenance Assistant will audit all residents rooms weekly x 4 weeks, then every 2 weeks x 4 weeks, then monthly x3months for the presence of portable heaters. The results will be reported to the administrator and the Quality Assessment and Assurance Committee. If concerns are identified, the frequency and or duration of the audit will be increased.

K 072 SS=E NFPA 101 LIFE SAFETY CODE STANDARD

Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for seventy

K 072 K 072

It is the normal practice of Spring View Health and Rehab to maintain means of egress free of all obstructions or impediments to full instant use in case of fire or other emergency.

Corrective Actions for those Residents Identified in the Deficiency:

No residents were identified in the deficiency.

12/16/11

K 072 (continued)

How other residents were identified that have the potential to be affected by the practice:

Residents in 3 of the 4 smoke compartments have the potential to be affected by the practice.

Measures Implemented or Systems Altered to Prevent Re-occurrence:

A storage room was designated for storage of lifts, and linen carts on 100 and 200 Halls on 11/18/11. Facility lifts and linen carts were removed the hall ways on 100 and 200 units by the maintenance assistant and placed in the new storage room. All nursing staff were inserviced by the staff development nurse on 11/23/11 on the new storage area for lifts and linen carts.

Monitoring Measure for Ongoing Compliance:

The Maintenance Assistant or designee will audit for ongoing compliance with proper storage of lifts and linen carts during daily supervisory rounds 5 times a week.

The results of the audit will be reviewed by the Administrator or designee in the Daily Abbreviated QA Meeting 5 times per week.

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| K 072 | Continued From page 9 one (71) beds with a census of sixty (60) on the day of the survey. The findings include: Observation, on 11/02/11 at 11:59 AM, with the Maintenance Assistant revealed linen carts, trash carts, and lifts, were being stored in the 100, and 200 corridors. Interview, on 11/02/11 at 11:59 AM, with the Maintenance Assistant revealed the facility routinely stored linen carts, trash carts, and lifts in the corridors. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. | K 072 | | | |
| K 147 SS=F | 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, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for seventy one (71) beds with a census | K 147 | K 147 It is the normal practice of Spring View Health and Rehab to ensure that electrical wiring and equipment is in accordance with NFPA standards. <u>Corrective Actions for those Residents identified in the Deficiency:</u> No residents were identified in the deficiency. <u>How other residents were Identified that have the Potential to be affected by the Practice:</u> Residents in 4 of 4 smoke compartments have the potential to be affected by the practice. | 12/16/11 | |

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| K 147 | Continued From page 10 of sixty (60) on the day of the survey. The findings include: Observation, on 11/02/11 between 10:00 AM and 4:00 PM, with the Maintenance Assistant revealed: 1) An extension cord to a television located in room #115. 2) A resident bed plugged into a power strip located in room #114, 111, 106, 105. 3) An oxygen concentrator and a B-PAP machine plugged into a power strip located in room #112. 4) An extension cord being used in the Conference Room, Reception Area, and the MDS Office. 5) An electrical panel in the 100 Hall was not locked. 6) An oxygen concentrator and a resident bed were plugged into a power strip, located in room # 104. 7) Two resident beds, an oxygen concentrator, and a B-PAP machine were plugged into a power strip, located in room # 109. 8) An extension cord to a television located in room #108. 9) An oxygen concentrator and a resident bed were plugged into a power strip located in room #108. 10) An ice machine permanently installed in front of an electrical panel, located in Dining Room C. 11) A resident bed plugged into an extension cord that was plugged into a power strip located in room #118. 12) An IV machine, mattress pump, and a resident bed were plugged into a power strip | K 147 | K 147 (continued) <u>Measures Implemented or Systems Altered To Prevent Re-Occurrence:</u> 1)The extension cord in room #115 was removed on 11/3/11 by the maintenance assistant. 2)The resident beds in rooms #114,111,106,105 were unplugged from the power strips. The beds were plugged directly into the wall receptacles on 11/3/11 by the maintenance assistant. 3)The oxygen concentrator and bi-pap machine were removed from the power strip and plugged into wall receptacle, on 11/9/11 by the maintenance assistant in room # 112. 4)The extension cords were removed from the Conference Room, Reception Area and the MDS Office on 11/15/11 by the maintenance assistant. 5) A lock was placed on the electrical panel in 100 Hall on 11/8/11 by the maintenance assistant. 6) The oxygen concentrator and the resident bed cords were removed from the power strip and plugged directly into the wall receptacle on 11/15/11 by the maintenance assistant in room #104. 7) The two resident beds, oxygen concentrator and bi-pap machine were unplugged from the power strip and plugged into the wall receptacle in room # 109 by the maintenance assistant on 11/4/11. | | |

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| K 147 | <p>Continued From page 11 located in room #204.</p> <p>13) An extension cord to a television located in room # 204.</p> <p>14) A Dina Map machine plugged into an extension cord to charge located in the 200 nurses station.</p> <p>15) Two extension cords plugged into a power strip located in room #219.</p> <p>16) Open electrical junction boxes, located in the attic above the 100, and 200 Halls.</p> <p>Interview, on 11/02/11 between 10:00 AM and 4:00 PM, with the Maintenance Assistant revealed they were not aware of the extension cords and power strips being misused. He was also not aware of the open junction boxes, storage in front of electrical panels, and that the electrical panels had to be locked in resident areas.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> | K 147 | <p>K 147 (continued)</p> <p>8)The extension cord was removed from room #108 on 11/15/11 by the maintenance assistant.</p> <p>9) The oxygen concentrator and resident bed were unplugged from the power strip and plugged into the wall receptacle in room #108 on 11/16/11 by the maintenance assistant.</p> <p>10)The ice machine was removed from in front of the electrical panel in Dining Room C on 11/3/11 by the maintenance director.</p> <p>11)The resident bed in room #118 was removed from the power strip and plugged directly into the wall receptacle on 11/15/11 by the maintenance assistant.</p> <p>12) The IV pump, mattress pump, and resident bed cords were removed from the power strip and plugged directly into the wall receptacle on 11/15/11 in room # 204 by the maintenance assistant.</p> <p>13) The extension cord was removed from room # 204 on 11/15/11 by the maintenance assistant.</p> <p>14) The extension cord was removed from the DinaMap Machine on 200 hall nurses station on 11/3/11 by the maintenance assistant.</p> <p>15) The two extension cords were removed from the power strip in room #219 on 11/3/11 by the maintenance assistant.</p> <p>16) The open electrical junction boxes located in the attic above the 100 and 200</p> |

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| K 147 | <p>Continued From page 12</p> <p>370.28(c) Covers.</p> <p>All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.</p> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> | K 147 | <p>K 147 (continued)</p> <p>Halls will have an adapter box and a cover plate installed by 11/30/11. This will be completed by the maintenance assistant .</p> <p>All resident rooms were audited by the maintenance assistance on 11/15/11 and validated that no extension cords were present in the facility and all medical equipment was plugged directly into the wall receptacles.</p> <p>The maintenance assistant was re-educated on electrical wiring and equipment in accordance with the NFPA codes by the administrator on 11/21/11. All employees will be inserviced by the administrator or Maintenance Assistant on properly plugging medical equipment into wall receptacles, and non use of extension cords, by 12/05/11.</p> <p><u>Monitoring Measures for Ongoing Compliance:</u></p> <p>Maintenance Assistant or designee will audit four rooms weekly X 8 weeks then weekly X 4 weeks, then monthly X 6 months to verify ongoing compliance with properly plugging medical equipment into wall receptacles and non use of extension cords. The four rooms will include resident rooms and offices. This is approximately 10% of facility rooms.</p> <p>Results of the findings will be reported to the Administrator and the Quality Assessment Assurance Committee. If any areas of concern are identified, the frequency and or duration of the audit may be increased.</p> | |