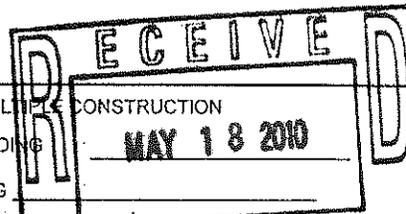


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2010  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/14/2010
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NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE SOUTHERN ENFORCEMENT GROUP 1 SPARKS AVENUE, P O BOX 740 JAMESTOWN, KY 42629
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(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	F 000		
F 225 SS=E	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and</p>	F 225	<p>WRITTEN CREDIBLE ALLEGATION OF COMPLIANCE</p> <p>Fair Oaks Health Systems will ensure that the facility will not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the state nurse aide registry or licensing authorities.</p> <p>Fair Oaks Health Systems will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>Fair Oaks Health Systems will ensure that all alleged violations are thoroughly investigated, and will prevent further potential abuse while the investigation is in progress.</p> <p>CRITERIA I A complete thorough investigation was conducted and documented for the missing items of residents' #24, 25, 26, 27, 28, and 29 confirming the missing items were found, replaced, or monetary value reimbursed per patient choice. (Completion date 5/13/10)</p> <p>Fair Oaks Health Systems revised the Lost and Found Policy and the Lost and Found Log to ensure for residents #24, 25, 26, 27, 28, 29, and for all residents; the Lost and Found log addresses the individual(s) who initially reported an item missing and to ensure a thorough investigation of misappropriation of residents' property. (Completion date 4/29/10)</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Care Admin	(X6) DATE 5/14/2010
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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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NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE, P O BOX 740 JAMESTOWN, KY 42629		
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F 225	<p>Continued From page 1</p> <p>certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that all alleged violations involving mistreatment, neglect, abuse, or misappropriation of residents' property were thoroughly investigated and reported immediately to the appropriate state agencies in accordance with state law for six (6) of thirty-one (31) sampled residents (residents #24, #25, #26, #27, #28, and #29). The facility was notified that residents #24, #25, #26, #27, #28, and #29 had items missing; however, the facility failed to conduct a thorough investigation to determine if the residents' property had been misappropriated and failed to report the possible misappropriation to the appropriate state agencies.</p> <p>The findings include:</p> <p>An interview on April 14, 2010, at 1:25 p.m., with the Activity/Social Director (A/SD) revealed the A/SD was responsible for handling residents' allegations regarding lost items. The A/SD stated the facility staff, family members, and residents verbally informed the A/SD of any lost items. The A/SD stated a Lost or Found log was kept by the A/SD that included the resident's name, date the A/SD was notified of the missing item(s), and what items were missing. The A/SD stated a thorough search was then conducted by the A/SD and staff to try to locate the missing item(s). The A/SD stated most items were found in the</p>	F 225	<p>Fair Oaks Health Systems revised the documentation tool for investigation of items missing ensuring a thorough investigation and reporting to the administrator or his designated representative and to other officials in accordance with state law (including state survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action will be taken. (Completion date 4/29/10)</p> <p>CRITERIA II The Administrator, Activity Director, and Director of Nursing interviewed, and discuss with the Resident Council, all residents, and the resident's family and reviewed the Lost and Found log ensuring no items are currently missing or misappropriated. (Completion date 5/7/10)</p> <p>Fair Oaks Health Systems will ensure that all alleged violations involving mistreatment, neglect, abuse, or misappropriation of residents' property will be thoroughly investigated and reported immediately to the administrator (or his designee) of the facility and to other officials in accordance with state law through established procedures for resident #24, 25, 26, 27, 28, 29, and for all residents. Fair Oaks Health Systems will ensure thorough results of all investigations for resident #24, 25, 26, 27, 28, 29, and for all residents must be reported to the administrator or his designee and to other officials in accordance with state law (including state survey and certification agency) within 5 working days of the incident. (Completion date 5/13/10).</p> <p>CRITERIA III In-service training was conducted on 5/6/10 by Administrator, and Director of Clinical Services for Activity /Social Director, Activity Staff, Director of Nursing, and ADON. Fair Oaks Health Systems' Abuse Policy, the revised Fair Oaks Health Systems' Lost and Found Policy and Log, and how to conduct a thorough investigation was reviewed and discussed ensuring for resident #24, 25, 26, 27, 28, 29, and for all residents that all alleged violations involving mistreatment, neglect, abuse, or misappropriation of residents' property will be thoroughly investigated and reported immediately to the administrator (or his designee) of the facility and to other officials in accordance with state law through established procedures; and the thorough results of all investigations for resident #24, 25, 26, 27, 28, 29, and for all residents</p>		

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F 225	<p>Continued From page 2</p> <p>laundry; however, if an item was not located then the facility replaced the item(s). The A/SD stated the log was updated to reflect if the item was found or if the facility replaced the item. The A/SD stated the Lost or Found log did not contain the individual(s) who initially reported an item missing and the facility did not complete a written investigation on lost items. The A/SD stated the A/SD would ask staff if the staff had seen the item(s) and frequently ask staff to assist with searching for the item(s). The A/SD stated the A/SD never considered the item(s) not found as an allegation of misappropriation of residents' property.</p> <p>Review of the Lost or Found log revealed the A/SD was notified on April 15, 2009, that resident #29 had four gowns missing. The log revealed two gowns were found in the laundry room and that the facility replaced two gowns.</p> <p>Further review of the Lost or Found log revealed on May 1, 2009, resident #26 had a black leather band watch missing. The Lost or Found log indicated the facility replaced resident #26's watch on May 6, 2009.</p> <p>On October 29, 2009, resident #27 reported money was missing. The Lost or Found log revealed resident #27 had two one-dollar bills and two dollars and fifty cents in quarters missing. The Lost or Found log revealed the facility reimbursed resident #27's money on November 2, 2009.</p> <p>The Lost or Found log revealed on December 5, 2009, resident #28 had a robe missing. On December 9, 2009, the facility replaced resident #28's robe.</p>	F 225	<p>must be reported to the administrator or his designee and to other officials in accordance with state law (including state survey and certification agency) within 5 working days of the incident. (See Attachments A-Lost and Found Policy, B-Lost and Found Log, C-Abuse/Misappropriation Investigation )</p> <p>Inservice training was conducted on 4/15/10, 5/6/10, and 5/13/10 by Administrator, Activity /Social Director, and Director of Clinical Services for all staff. Fair Oaks Health Systems' Abuse Policy, and the revised Fair Oaks Health Systems' Lost and Found Policy was reviewed and discussed ensuring for resident #24, 25, 26, 27, 28, 29, and for all residents that: all alleged violations involving mistreatment, neglect, abuse, or misappropriation of residents' property will be thoroughly investigated and reported immediately to the administrator (or his designee) of the facility and to other officials in accordance with state law through established procedures; and the thorough results of all investigations for resident #24, 25, 26, 27, 28, 29, and for all residents must be reported to the administrator or his designee and to other officials in accordance with state law (including state survey and certification agency) within 5 working days of the incident. (See Attachments A-Lost and Found Policy, B-Lost and Found Log, C-Abuse/Misappropriation Investigation )</p> <p>Inservice training was conducted on 5/7/10 by Administrator, Activity /Social Director, and Director of Clinical Services for the resident council and all residents. Fair Oaks Health Systems' Abuse Policy, and the revised Fair Oaks Health Systems' Lost and Found Policy and Log was reviewed and discussed ensuring for resident #24, 25, 26, 27, 28, 29, and for all residents that: all alleged violations involving mistreatment, neglect, abuse, or misappropriation of residents' property will be thoroughly investigated and reported immediately to the administrator (or his designee) of the facility and to other officials in accordance with state law through established procedures; and the thorough results of all investigations for resident #24, 25, 26, 27, 28, 29, and for all residents must be reported to the administrator or his designee and to other officials in accordance with state law (including state survey and certification agency) within 5 working days of the incident.</p> <p>CRITERIA IV Members of QA Committee will monitor monthly all alleged violations involving misappropriation of residents' property ensuring the alleged violations are</p>	

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F 225	<p>Continued From page 3</p> <p>On April 5, 2010, the facility was informed that residents #24 and #25 each were missing a watch. The Lost or Found log revealed the facility had informed the residents' family that the watches were not found and the facility would replace the watches.</p> <p>Interview on April 14, 2010, at 1:45 p.m., with the DON revealed the DON was involved in looking for lost/misplaced items. The DON stated an investigation was performed while looking for the residents' lost/misplaced items; however, the information was not written down.</p> <p>Review of the facility's Abuse Prohibition Policy revealed all incidents or suspected incidents of resident abuse, neglect, misappropriation of resident property, or injury of unknown origin would be investigated and reported to the State Licensing and Certification Agency, Division of Adult Protection Services, and/or Law Enforcement Officials.</p> <p>Review of the facility's policy entitled Lost or Found revealed all reports of resident misappropriation of property would be reported immediately to the charge nurse, DON, Administrator, and/or designee. If the missing items were not found within 24 hours, the Administrator would immediately report the violation to the proper authorities and begin an investigation into the missing item(s).</p>	F 225	<p>thoroughly investigated and reported immediately to the administrator (or his designee) of the facility and to other officials in accordance with state law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action was taken. These performance monitors will occur to ensure that solutions are sustained permanently, and provide a summary report on a quarterly basis to the Quality Assurance Committee to ensure the problem does not recur. The Quality Assurance Committee will review the findings and provide a written report to the Administrator with recommendations. The Administrator will assume responsibility and follow through on all Quality Assurance recommendations.</p> <p>CRITERIA V The problem will be completed by May 21, 2010.</p>	5/21/10
F 364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is</p>	F 364	<p>WRITTEN CREDIBLE ALLEGATION OF COMPLIANCE</p> <p>CRITERIA I On 4/13/10 palatability test conducted by two surveyors and the facility dietitian revealed the food was cool and unpalatable for two trays on B and C hallways. Fair Oaks Health Systems replaced immediately each tray prior to</p>	

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F 364	<p>Continued From page 4</p> <p>palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide residents food that was palatable and at the proper temperature during the breakfast meal on April 13, 2010. Two (2) test tray observations conducted for separate facility hallways revealed that eggs, sausage, and pancakes were served to residents cold and unpalatable on both the B and C hallways.</p> <p>The findings include:</p> <p>A group interview conducted with ten alert and oriented residents on April 12, 2010, at 3:40 p.m. Eastern Daylight Savings Time (EDST), revealed three of ten residents, residents #18, #30, and #31 complained that breakfast was often cold when served to the residents.</p> <p>Observations of the breakfast meal services on April 13, 2010, revealed resident trays were delivered to the B hall at 8:23 a.m. EDST, and the last breakfast tray was removed by staff seven minutes later. At 8:30 a.m. EDST, temperature observations revealed the following food temperatures of the food served on the tray: eggs - 85 degrees Fahrenheit. The temperature of the sausage and pancakes was unattainable due to the consistency of the food. A palatability test conducted by two surveyors revealed the eggs, sausage, and pancakes, were cold and unpalatable.</p>	F 364	<p>service, ensuring that all residents receive food that is palatable, attractive, and at the proper temperature. Fair Oaks Health Systems LLC will ensure for all residents on B and C hallways, resident # 18, 30, 31 and for all residents receive and the facility provide food prepared by methods that conserve nutritive value, flavor, and appearance, and food that is palatable, attractive, and at the proper temperature.</p> <p>Fair Oaks Health Systems ordered and installed a Dish warmer system to ensure proper point of service temperatures for resident # 18, 30,31, residents' on B and C Hallways, and for all residents. (Completion date 4/23/10).</p> <p>CRITERIA II Fair Oaks Health Systems revised the Temperature at Point of Service Meal Audit to ensure for resident #18, 30, 31, residents' on B and C hallways, and for all residents that the breakfast meal be palatable and hot food point of service temperature of at least 115 degrees Fahrenheit. (Completion date 4/29/10)</p> <p>CRITERIA III Inservice training was conducted on 5/5/10 by Facility Dietitian, Administrator, Director of Clinical Service and Dietary Manager for all Dietary Staff. The Dish Warmer System was reviewed and discussed to ensure for resident # 18, 30, 31, residents' on B and C hallways, and for all residents receive and the facility provide food prepared by methods that conserve nutritive value, flavor, and appearance, and food that is palatable, attractive, and at the proper temperature.</p> <p>Inservice training was conducted on 5/5/10 by Facility Dietitian, Administrator, Director of Clinical Service and Dietary Manager for all Dietary Staff. A Temperature at Point of Service meal audit was reviewed and discussed ensuring for resident # 18, 30, 31, residents' on B and C hallways, and for all residents that the breakfast meal be palatable and hot food point of service temperature at a temperature of at least 115 degrees Fahrenheit.</p> <p>Inservice training was conducted on 5/13/10 by Facility Dietitian, Administrator, Director of Clinical Service and Dietary Manager for all Nursing Staff. The Dish Warmer System was reviewed and discussed to ensure for resident # 18, 30, 31, residents' on B and C hallways, and for all residents receive and the facility provide food prepared by methods that conserve nutritive value, flavor, and appearance, and food that is palatable, attractive, and at</p>	

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F 364	Continued From page 5 Additional observations on April 13, 2010, revealed trays arrived on the C hall at 8:28 a.m. EDST, and the last tray was retrieved by staff at 8:40 a.m. EDST, an elapsed time of 12 minutes. Observations of food temperatures obtained by the Facility Dietitian revealed the pureed sausage temperature at 113 degrees Fahrenheit and the pureed pancake temperature at 103 degrees Fahrenheit. A palatability test conducted by two surveyors and the Facility Dietitian revealed the food was cool and unpalatable.  An interview conducted with the Facility Dietitian on April 13, 2010, at 8:55 a.m. EDST, revealed hot foods should be served to residents at a temperature of at least 115 degrees Fahrenheit. Further interview revealed that the Dietitian had audited the point of service temperature for resident trays weekly and had not identified any concerns regarding the point of service temperatures for resident trays.  A review of the facility policy titled "Minimum Temperature at Point of service to Resident" with no date revealed the minimum point of service temperature of hot food was 115 degrees Fahrenheit.  A review of the six undated weekly point of service temperature audits revealed no evidence the breakfast meal had been audited for point of service temperatures.	F 364	the proper temperature.  Inservice training was conducted on 5/13/10 by Facility Dietitian, Administrator, Director of Clinical Service and Dietary Manager for all Nursing Staff. A Temperature at Point of Service meal audit was reviewed and discussed ensuring for resident # 18, 30, 31, residents' on B and C Hallways, and for all residents that the breakfast meal be palatable and hot food point of service temperature at a temperature of at least 115 degrees Fahrenheit.  CRITERIA IV Members of QA Committee will monitor weekly audit utilizing the revised Temperature at Point of Service Meal Audit randomly monitoring residents breakfast trays ensuring minimum Temperature of hot food at Point of Service for Residents to be 115 degrees Fahrenheit. These performance monitors will occur for one quarter to ensure that solutions are sustained permanently. The QA Committee will review the Temperature at Point of Service Meal Audits on a quarterly basis to ensure that the problem does not recur. The Quality Assurance Committee will review the findings and provide a written report to the Administrator with recommendations. The Administrator will assume responsibility and follow through on all Quality Assurance recommendations. (See Attachment D-Temperature at Point of Service Meal Audit).  CRITERIA V The problem will be completed by May 13, 2010.	5/13/10	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465	WRITTEN CREDIBLE ALLEGATION OF COMPLIANCE  CRITERIA I Fair Oaks Health Systems LLC will ensure the facility provides a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Fair Oaks Health Systems LLC will ensure for the identified areas and for all residents the doors throughout the facility are		

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F 465	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Doors throughout the facility were scarred/splintered, anchors to toilets in all the shower rooms were uncovered with metal screws exposed, bumper guards in two (2) hallways had end caps missing exposing sharp metal edges, and a black "mold-like" substance was noted on a shower chair and a shower stall.</p> <p>The findings include:</p> <p>Observations of the facility during the environmental tour on April 12-14, 2010, revealed the following items in need of repair:</p> <ul style="list-style-type: none"> <li>-Doors on rooms 7, 10, 26, 34, and 39, as well as the fire door, for the D hallway were scarred/splintered and in need of repair.</li> <li>-Anchors for the toilets in the A hall shower room, the B hall shower room, the C hall shower room, the D hall shower room, and the E hall shower room were uncovered with metal screws left exposed, posing a risk for resident injury.</li> <li>-The wall bumper guard on the A hallway-beside the shower room entrance, and in the D hallway beside the entrance to rooms 38 and 42 had end caps missing, leaving a sharp metal edge exposed, which posed a risk for resident injury.</li> <li>-The A hall shower room had a black "mold-like"</li> </ul>	F 465	<p>kept unscarred/unsplintered; anchors to toilets in all the shower rooms are covered ensuring metal screws unexposed; bumper guards have end caps ensuring safe metal edges; a shower chair and a shower stall clean and free of a black "mold-like" substance; and baseboards are properly attached.</p> <p>Fair Oaks Health Systems repaired the doors on rooms 7, 10, 26, 34, and 39, as well as the fire door, for the D hallway. (Completion date 5/20/10).</p> <p>Fair Oaks Health Systems before the completion of the survey on 4/14/10 covered the anchors for the toilets in the A hall shower room, the B hall shower room, the C hall shower room, the D hall shower room, and the E hall shower room ensuring the metal screws were covered and protecting the resident from injury.</p> <p>Fair Oaks Health Systems before the completion of the survey on 4/14/10 repaired and replaced the bumper guard end cap on the A hallway beside the shower room entrance, and in the D hallway beside the entrance to rooms 38 and 42 ensuring no risk for resident injury.</p> <p>Fair Oaks Health Systems before the completion of the survey on 4/14/10 cleaned the tile and grout of the A hall shower room shower stall, walls, and floor removing the black "mold-like" substance.</p> <p>Fair Oaks Health Systems before the completion of the survey on 4/14/10 cleaned the A hall shower chair seat cushion removing the black "mold-like" substance.</p> <p>Fair Oaks Health Systems before the completion of the survey on 4/14/10 replaced the baseboards in the main dining room beneath each of the three air conditioner units.</p> <p>CRITERIA II The doors throughout the building were inspected ensuring all doors were safe, functional, sanitary, and comfortable environment for all residents, staff, and the public. (Completion date 5/21/10).</p> <p>All anchors for the toilets were checked and covered ensuring no metal screws left exposed and all anchors were safe, functional, sanitary, and comfortable environment for all residents, staff, and the public. (Completion date 5/13/10).</p> <p>All bumper guards end caps were checked ensuring</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>FAIR OAKS HEALTH SYSTEMS, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1 SPARKS AVENUE, P O BOX 740 JAMESTOWN, KY 42629</b>		
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F 465	<p>Continued From page 7</p> <p>substance on the tile and grout of the shower stall walls and floor.</p> <p>-The A hall shower chair had a black "mold-like" substance on the seat cushion.</p> <p>-The baseboards in the main dining room were pulled loose from the wall beneath each of the three air conditioner units.</p> <p>Interview with the Maintenance Supervisor (MS) on March 14, 2010, at 11:00 a.m., revealed the Maintenance Supervisor and assistant performed rounds every day to make sure the facility remained in good repair. The MS stated that repair forms were available at each of the three nursing stations and the kitchen for staff to complete if repairs were required. The MS stated that if repairs were related to resident care, or in the event of an emergency, the facility could contact either the MS or the assistant via cell phone. The MS did not know why the scarred/splintered doors, the end caps from the bumper guards, the exposed anchors on the toilets, the loose floor boards, or the black "mold-like" substance were present in the facility, or why the areas in need of repair/cleaning had not been identified by the MS or the assistant during maintenance rounds.</p>	F 465	<p>bumper guards were safe, functional, sanitary, and comfortable environment for all residents, staff, and the public. (Completion date 4/14/10).</p> <p>The shower room tile, grout, stalls, walls, and floor were cleaned ensuring all shower rooms were safe, functional, sanitary, and comfortable environment for all residents, staff, and the public. (Completion date 4/14/10).</p> <p>All shower chair seat cushions were cleaned ensuring the shower chair seat cushions were safe, functional, sanitary, and comfortable environment for all residents, staff, and the public. (Completion date 4/14/10).</p> <p>All baseboards were inspected ensuring no loose baseboards, and the baseboards were safe, functional, sanitary, and comfortable environment for all residents, staff, and the public. (Completion date 4/14/10).</p> <p><b>CRITERIA III</b> Inservice training was conducted on 5/5/10 by Administrator, Maintenance Supervisor, and Director of Clinical Services for all maintenance and housekeeping staff. The Maintenance log process was reviewed to ensure the facility was providing a safe, functional, sanitary, and comfortable environment for all residents, staff, and the public. Staff reviewed and discussed the maintenance log process and the proper procedure to ensure: the doors throughout the facility are kept unscarred/unsplintered; anchors to toilets in all the shower rooms are covered ensuring metal screws unexposed; bumper guards have end caps ensuring safe metal edges; a shower chair and a shower stall clean and free of a black "mold-like" substance; and baseboards are properly attached.</p> <p>Inservice training was conducted on 5/13/10 by Administrator, Maintenance Supervisor, and Director of Clinical Services for all staff. The Maintenance log process was reviewed to ensure the facility was providing a safe, functional, sanitary, and comfortable environment for all residents, staff, and the public. Staff reviewed and discussed the maintenance log process and the proper procedure to ensure: the doors throughout the facility are kept unscarred/unsplintered; anchors to toilets in all the shower rooms are covered ensuring metal screws unexposed; bumper guards have end caps ensuring safe metal edges; a shower chair and a shower stall clean and free of a black "mold-like" substance; and baseboards are properly attached.</p> <p style="text-align: right;">Cont--See Attachment 1</p>	5/21/10	

**Attachment 1**

Continued F465 from page 8 of 8

**CRITERIA IV**

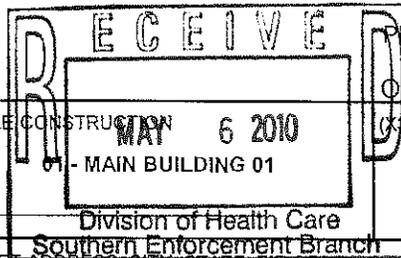
Members of QA Committee will randomly audit: maintenance log process; the doors throughout the facility are kept unscarred/unsplintered; anchors to toilets in all the shower rooms are covered ensuring metal screws unexposed; bumper guards have end caps ensuring safe metal edges; a shower chair and a shower stall clean and free of a black "mold-like" substance; and baseboards are properly attached. These performance monitors will occur monthly to ensure that solutions are sustained and identified items are repaired. Members of QA Committee will provide a summary report on a quarterly basis to the Quality Assurance Committee to ensure the problem does not recur. The Quality Assurance Committee will review the findings and provide a written report to the Administrator with recommendations. The Administrator will assume responsibility and follow through on all Quality Assurance recommendations.

**CRITERIA V**

The problem will be completed by May 21, 2010.

 Dan/Adam 5/14/2010

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NAME OF PROVIDER OR SUPPLIER  FAIR OAKS HEALTH SYSTEMS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE, P O BOX 740 JAMESTOWN, KY 42629
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K 000	INITIAL COMMENTS	K 000		
K 012 SS=D	<p>A life safety code survey was initiated and concluded on April 12, 2010, for compliance with Title 42, Code of Federal Regulations, 483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure a combustible canopy at the front of the facility was sprinkler-protected as required.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on April 12, 2010, at 12:30 p.m., with the Director of Maintenance, a combustible canopy approximately 30 feet by 10 feet, located at the front of the facility was noted not to be sprinkler-protected. Combustible canopies exceeding four feet in width must be sprinkler-protected. Interview revealed the Director of Maintenance was not aware of this requirement.</p> <p>Reference: NFPA 13 (1999 Edition).</p> <p>5-13.8.1</p>	K 012	<p>WRITTEN CREDIBLE ALLEGATION OF COMPLIANCE</p> <p>Fair Oaks Health Systems will ensure a combustible canopy at the front of the facility was sprinkler-protected as required.</p> <p>Fair Oaks Health Systems has added to the canopy at the front of the facility a sprinkler system ensuring the area protected as required per NFPA 13 (1999 Edition).</p> <p>Inservice training was conducted by Administrator and Director of Clinical Services for Fair Oaks Health Department Heads, Nursing Staff, Maintenance, Laundry, Dietary, and Housekeeping staff. Staff reviewed and discussed the front canopy and the sprinkler-protected fire system as required by NFPA Standards.</p> <p>Members of the QA Committee will randomly audit the front canopy sprinkler. These audits will occur on a monthly basis and provide a summary report on a quarterly basis to the Quality Assurance Committee to ensure the problem does not recur. The Quality Assurance Committee will review the findings and provide a written report to the Administrator with recommendations. The Administrator will assume responsibility and follow through on all Quality Assurance recommendations.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 5/5/10
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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 012	Continued From page 1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 012	The problem will be completed by May 18, 2010	5/18/10
K 025 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the fire/smoke barrier walls in the attic area on the A, B, C, and D wings of the facility.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on April 12, 2010, at 1:00 p.m., with the Director of Maintenance, an unapproved makeshift door in the fire/smoke barrier wall was noted in the attic above the cross corridor doors in the A wing corridor. This door was easily opened with the push of a finger. Doors in fire/smoke barriers must be an approved device designed for this specific purpose. Interview with the Director of</p>	K 025	<p>WRITTEN CREDIBLE ALLEGATION OF COMPLIANCE</p> <p>Fair Oaks Health Systems will ensure the fire/smoke barrier walls in the attic area on the A, B, C, and D wings of the facility are constructed and installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire Doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies.</p> <p>Fair Oaks Health Systems secured and sealed the Fire/smoke barrier walls in the attic area on the A, B, C, and D wings of the facility per NFPA 80, Standard for Fire Doors and Fire Windows ensuring smoke barriers are constructed to provide for all residents at least one half hour fire resistance rating in accordance with 8.3.</p> <p>Inservice training was conducted by Administrator and Director of Clinical Services for Maintenance, Fair Oaks Health Systems' Department Heads, and all staff. Staff reviewed and discussed the Fire/Smoke barrier in the attic areas that are constructed to provide for all residents at least one half hour fire resistance rating in accordance with 8.3, as required by NFPA Standards.</p>	

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K 025	Continued From page 2 Maintenance revealed the B, C, and D wings of the facility had the same type of unapproved doors in the fire/smoke barrier walls in the attic area. The Director of Maintenance stated the fire/smoke barriers would be properly sealed.  Reference: NFPA 101 (2000 Edition).  8.2.3.1.2 Fire barriers used to provide enclosure, subdivision, or protection under this Code shall be classified in accordance with one of the following fire resistance ratings: (1) 2-hour fire resistance rating (2) 1-hour fire resistance rating (3) * 1/2-hour fire resistance rating  8.2.3.2 Fire Protection-Rated Opening Protectives.  8.2.3.2.1 Door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following. (a) * Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies. Exception: The requirement of 8.2.3.2.1(a) shall not apply where otherwise specified by 8.2.3.2.3.1.	K 025	Members of the QA Committee will randomly audit the fire/smoke barrier walls. These audits will occur on a monthly basis and provide a summary report on a quarterly basis to the Quality Assurance Committee to ensure the problem does not recur. The Quality Assurance Committee will review the findings and provide a written report to the Administrator with recommendations. The Administrator will assume responsibility and follow through on all Quality Assurance recommendations.  The problem will be completed by May 7, 2010	5/7/10
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested	K 062	WRITTEN CREDIBLE ALLEGATION OF COMPLIANCE  Fair Oaks Health Systems will ensure the required automatic sprinkler systems are	

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K 062	<p>Continued From page 3</p> <p>periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on an interview and record review, the facility failed to maintain the sprinkler system throughout the facility by NFPA standards.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on April 12, 2010, at 12:15 p.m., with the Director of Maintenance, a review of a sprinkler inspection report revealed an interior pipe inspection was performed in 2005 (no month or day given). Sprinkler systems of this age require an interior pipe inspection every five years. Interview with the Director of Maintenance revealed the Director of Maintenance was not aware when the last interior pipe inspection had been performed.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure.</p>	K 062	<p>continuously maintained in reliable operating condition and are inspected and tested periodically (per NFPA 25 – 1998 Edition). Fair Oaks Health Systems shall examine internally for obstructions where conditions exist that could cause obstructed piping at least every 5 years.</p> <p>Fair Oaks Health Systems has had the required automatic sprinkler systems inspected by a qualified personnel examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections. The sprinkler system during the inspection did not indicate the presence of sufficient material to obstruct sprinklers, and thus a complete flushing program was not indicated in accordance with 10-2.3 Flushing procedure. NFPA 25 (1998 Edition)</p> <p>Inservice training was conducted by Administrator, and Director of Clinical Services for Maintenance, Fair Oaks Health Systems' Department Heads, and all staff. Staff reviewed and discussed the maintenance for the Sprinkler System throughout the facility as required by NFPA Standards.</p> <p>Members of the QA Committee will randomly audit the maintenance for the Sprinkler System throughout the facility. These audits will occur on a monthly basis and provide a summary report on a quarterly basis to the Quality Assurance Committee to ensure the problem does not recur. The Quality Assurance Committee will review the findings and provide a written report to the Administrator with recommendations.</p>	
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K 062	Continued From page 4 If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.	K 062	The Administrator will assume responsibility and follow through on all Quality Assurance recommendations.  The problem will be completed by April 20, 2010	4/20/10