STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 was conducted on 05/08/12 through 05/11/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with deficiencies cited at the highest scope/severity of a "G," with the facility having an opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of	F 280	1. A fall risk assessment was completed on Resident #9 and a chair pad alarm was implemented as a fall intervention while surveyors were still in the facility during the annual survey. The care plan has been reviewed and updated to reflect the new intervention related to fall prevention. 2. All residents have the potential to be affected by the deficient practice. 3. A fall risk assessment will be completed on all residents. All fall interventions will be reviewed to ensure they are appropriate and in place. The care plan will be updated, if indicated, to reflect current interventions in place related to fall prevention. LPN #1 was verbally educated by the DON that all falls must have an appropriate/effective intervention put in place. A list of acceptable fall interventions was given to LPN #1. The list was also placed in the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 6/1/12

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 280	Continued From page 1 the facility's policy/procedure, it was determined the facility failed to ensure the comprehensive care plan was revised by a team of qualified persons for one resident (#9), in the selected sample of seventeen (17) residents. Resident #9 sustained two falls; however, no new interventions to prevent further falls were added to the care plan. Findings include: A review of the facility's policy/procedure, Reassessments and Care Plan Review, undated, revealed when a change occurred in the resident's condition, the care plan would be reviewed and updated as indicated. A record review revealed the facility admitted Resident #9 on 04/20/12 with diagnoses to include Dementia, Osteoporosis, Lumbago, and Kyphosis. A review of the admission Minimum Data Set (MDS), dated 05/02/12, revealed the facility identified the resident as severely cognitively impaired and required limited assistance with transfers and could ambulate independently. A review of the Fall Incident Investigations, dated 04/21/12 and 05/07/12, revealed Resident #9 sustained a fall on 04/21/12 with no injury, and on 05/07/12 with injury that required emergency care. A review of the "Potential for Injury" Resident Care Plan, dated 05/03/12, revealed no new interventions were put in place on 04/21/12 or 05/07/12.	F 280	alert charting books at both nursing stations and given to both Registered Nurse (RN) Unit Supervisors. A mandatory in-service by the Director of Nursing (DON) is scheduled for June 8, 2012 for all Licensed Nurses and Interdisciplinary Team (IDT) members who attend morning Interdisciplinary meetings. Licensed Nurses will be educated on proper protocol and procedure related to falls and implementing appropriate and effective interventions based on the root cause of the fall with emphasis placed on the fact that the Charge Nurse must put an intervention in place immediately after all falls. The care plan must be revised and updated to reflect the fall intervention put in place. Licensed Nurses and IDT members will be educated on acceptable/effective intervention ideas that may be implemented with falls. The list of interventions ideas will also be given to the IDT members so they are aware of what interventions are considered appropriate or effective and they can assist in determining if the interventions put in place by the Charge Nurse is appropriate when the fall is discussed in the interdisciplinary meeting the next day following a fall. 4. Post falls the Licensed Practical	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 280	Continued From page 2 An interview with Licensed Practical Nurse (LPN) #1, on 05/10/12 at 3:40 PM, revealed her job included the review of resident falls to ensure appropriate interventions were in place. She revealed the resident ambulated without assistance and no new interventions were put in place to prevent another fall. She stated that she was "not sure what she could do." An interview with the Director of Nursing (DON), on 05/10/12 at 4:30 PM, revealed a new intervention should be initiated after every fall, even if there was no injury. The charge nurse should initiate an intervention after a fall, to the best of her ability, to prevent another fall. She revealed the intervention should be discussed the next day in the interdisciplinary meeting, to determine if the intervention was appropriate or if something else should be initiated. She verified there were no new interventions to prevent falls for Resident #9.	F 280	Nurse (LPN) Fall Coordinator or RN Unit Supervisor will complete the fall risk assessment, ensure that an effective intervention has been put in place and the care plan has been revised and updated to reflect the new fall intervention. The intervention will be discussed the next day in the interdisciplinary meeting to determine if the intervention implemented is effective. If it's determined by the IDT the intervention isn't appropriate/effective a new intervention will be implemented at that time. Within seven days of the initial IDT meeting the fall will be reviewed again to ensure the interventions are still appropriate/effective. The LPN Quality Improvement Coordinator (QIC) will review five falls monthly post the second review with IDT to ensure compliance is sustained. 5. Completion Date: June 18, 2012	06/18/12
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure services were provided that met professional standards of quality for one resident (#2), in the selected sample of seventeen (17) residents. The facility did not document a bowel movement for Resident #2 until nine days after admission; and the resident's	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 281	Continued From page 3 bowel status was not assessed on the admission Minimum Data Set (MDS). Findings include: A review of the facility's policy/procedure, "Bowel Management," undated, revealed the purpose of the routine bowel protocol was to facilitate early identification and reduced episodes of constipation. The resident's bowel movements would be documented, per occurrence, by caregivers on the bowel flow sheet. The day shift medication person would review the bowel record daily and place a resident on a list if there was no bowel movement for three days. The afternoon medication person would administer laxatives, per physician's order, to prevent constipation. A record review revealed the facility admitted Resident #2 on 01/16/12. A review of the admission MDS, dated 01/20/12, revealed the facility identified the resident as cognitively intact. There was no documented evidence that the resident's bowel status was assessed. A review of the Nurse's Assistant Flowsheet, undated, was provided as the bowel and bladder record for January 2012. There was no bowel movement charted on the flowsheet until 01/25/12, nine days after the resident's admission to the facility. An interview with Registered Nurse (RN) #2, on 05/10/12 at 10:45 AM, revealed she completed the resident's initial MDS, on 01/16/12. She revealed the resident's bowel status was not assessed, as there was no documentation of a bowel movement during the seven day	F 281	1. A bowel assessment has been completed on Resident #2. The bowel flow sheet has been reviewed and documentation is complete and reflects regular bowel movements. The Medication Administration Record (MAR) was reviewed and documentation reflects resident is receiving a laxative daily per physician's order. 2. All residents have the potential to be affected by the deficient practice. 3. All resident bowel flow sheets will be reviewed and interventions implemented, if, indicated, per physician orders to ensure residents are having regular bowel movements at least every three days. The LPN Staff Development Coordinator (SDC) will in-service all Nursing Staff/ Direct Caregivers on the dates of June 8th and June 12, 2012 regarding proper procedure/protocol of bowel management and documentation. 4. The day shift medication aide will complete a list daily of any resident that hasn't had a bowel movement within the last three days that list will be given to the afternoon medication aide to administer laxatives per physician order. If the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	186234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 281	Continued From page 4 assessment period. She revealed the charge nurse was notified; however, she did not know what happened with the situation. An interview with the West Unit Supervisor, on 05/11/12 at 11:25 AM, revealed she did not have a system to ensure staff filled out the bowel records daily. She revealed she expected the medication aides to monitor the bowel movements, per the policy. An interview with the Director of Nursing (DON), on 05/10/12 at 4:30 PM, revealed she reviewed the medical record for Resident #2, but could not find where any laxatives were administered in January 2012. She expected the staff to follow the policy related to bowel management. She revealed the medication aides do the initial monitoring and the unit managers should make random checks, but there was no specific monitoring system utilized to ensure the policy was being followed.	F 281	resident doesn't have an order for laxatives the medication aide must inform the Charge Nurse so the physician can be notified. The day shift medication person will give a copy of the laxative list to the day shift Charge Nurse to review and follow up on the subsequent day to ensure protocol has been followed. The RN Unit Supervisor will do a visual check of all bowel flow sheets weekly for two months followed by the LPN Quality Improvement Coordinator (QIC) or licensed designee reviewing twenty bowel flow sheets monthly to ensure compliance is maintained. 5. Completion Date: June 18, 2012	06/18/12
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and procedure, it was determined the facility failed to ensure care was provided according to the plan of care for one resident (#6), in the selected sample of	F 282	1. The two SRNA's directly involved with disabling disconnecting the alarms on Resident #6 on stated incident date of 4/30/12 were verbally in-serviced by the LPN SDC and the Administrator to NEVER disable or disconnect an alarm and trust a family member to alert them they are leaving. The education was completed with the SRNA's immediately after being made aware of the incident by the state inspectors during the annual survey. A fall risk assessment has	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 282	Continued From page 5 seventeen (17) residents, related to safety alarms being disconnected by staff during a family visit. The resident was found in the floor after family members left the facility and the resident was sent to the hospital for an evaluation. Findings include: A review of the facility's policy and procedure, "Reassessments and Care Plan Review," (no date), revealed documentation to include "Staff must assess and plan care to support each resident's life-long patterns, current interests, strengths and needs." The policy/procedure also included that care plans should "Be followed as an important guideline for providing good care for the resident." A record review revealed the facility admitted Resident #6 on 06/25/10 with diagnoses to include Alzheimer's Disease, Anemia, Arthritis and Osteoarthritis. A review of the annual Minimum Data Set (MDS) assessment, dated 03/19/12, revealed the facility determined the resident had cognitive impairment and required extensive assistance with activities of daily living and had poor safety awareness. Resident #6 was assessed at high risk for falls and sustained multiple falls with implementation of interventions after each fall to prevent reoccurrence. The resident utilized a bed mat alarm and a mat alarm to the side of the bed to alert staff of any attempts by the resident to get out of bed unassisted. The alarms were checked for placement and function by the nurse every two hours and documented on the Safety/Alarm Check flow sheet. An observation, on 05/08/12 at 4:15 PM, revealed	F 282	been completed on Resident #6 and the care plan has been reviewed and updated to reflect current interventions in place. The residents POA requested that the resident only be allowed to have supervised family visits with her sister after learning the sister had failed to alert staff she was leaving the residents room. Physical Therapy (PT) has evaluated Resident #6 and she is currently receiving PT five times per week. 2. All residents have the potential to be affected by the deficient practice. 3. The LPN SDC will in-service all SRNA's/Direct Caregivers on the dates of June 8th and June 12, 2012 on the proper procedure/protocol related to ensuring implemented fall interventions are carried out and the residents plan of care is followed. Emphasis will be placed on the importance of ensuring all alarms are in place and in proper working order. Education will also include procedure for proper documentation on the Safety/Alarm flow sheet to ensure the alarms have been checked every two hours and are in working order. 4. Charge Nurses will visually check the Safety/Alarm flow sheet every shift for completed documentation reflecting the SRNA's have checked alarms on their shift. The RN Unit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 282	Continued From page 6 Resident #6 was in a reclining chair with the foot rest up. A large portion of the resident's left forehead, temple and cheek had blue/green and yellow discolorations. The resident did not respond when spoken to. A review of the "Nurse's Assistant Assignment" form, dated 03/26/12, revealed the resident was to have a chair pad alarm, a bed pad alarm and a floor pad alarm. A review of the "Safety/Alarm Check" form, dated 04/30/12, revealed the nurse verified the resident's alarms were functional and in place every two hours, except at 7:30 AM, 9:30 AM, 11:30 AM and 1:30 PM. There were no nurse's initials for these time frames and those sections were blank. A review of a nurse's note, dated 04/30/12 at 3:30 PM revealed Resident #6 was found on the floor at the end of the bed and had a purple raised area on the left side of his/her left eye and a skin tear on the left knee and had a complaint of back pain. The resident was sent to the hospital for an evaluation. A review of the fall investigation, dated 04/30/12, revealed the resident's alarms had been disconnected as family had been visiting and the alarms were not "engaged" when the family left, and the staff were educated. A review of the resident's care plan for potential for falls, dated 05/04/12, revealed interventions for a bed pad alarm, a chair pad alarm and a floor pad alarm.	F 282	Supervisor will do a weekly visual check of the Safety/Alarm flow sheets for two months followed by the LPN QI Coordinator or designated Quality Improvement (QI) Committee member completing 20 monthly visual checks of the Safety/Alarm flow sheet to monitor for sustained compliance. 5. Completion Date: June 18, 2012	06/18/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 282	Continued From page 7 An interview with State Registered Nurse Aide (SRNA) #11, on 05/10/12 at 5:00 PM, revealed, on 04/30/12, she had placed an extra chair in Resident #6's room for visiting family members and placed the chair so the mat alarm would not sound. SRNA #11 stated she disabled the laser motion alarm and explained to the family members to tell someone when leaving. Resident #6 still had the bed and floor alarms functioning at that time. On 05/11/12 at 11:05 AM, SRNA #11 revealed the SRNAs were suppose to follow the SRNA assignment sheet. An interview with Certified Medication Aide (CMA) #3, on 05/10/12 at 5:15 PM, revealed, on 04/30/1,2 sometime around 3:00 PM, Resident #6's family members were having difficulty understanding what the alarms were for, so she disconnected the bed and floor alarms. CMT #3 stated she told the family members multiple times to alert the staff when they left, so the alarms could be turned back on. The family members left the facility without alerting the staff, and another SRNA found the resident on the floor. CMA #3 stated the resident was to have the alarms on and SRNAs were suppose to follow those instructions. An interview with the Director of Nursing (DON), on 05/09/12 at 11:20 AM, revealed she did not know why Resident #6's alarms were disconnected by the SRNAs, and that the SRNAs were responsible to ensure the alarms were on and functioning. Additionally, the DON revealed the resident had care plan interventions for safety alarms and she expected the staff to ensure those interventions were implemented.	F 282		
F 323	483.25(h) FREE OF ACCIDENT	F 323	1. The two SRNA's directly involved with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 323 SS=D	Continued From page 8 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 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 the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents for two residents (#6 and #9), in the selected sample of seventeen (17) residents. Two staff members disconnected two different safety alarms being utilized by Resident #6 and failed to reconnect them, and the resident sustained a fall that required hospitalization. Resident #9 sustained two falls and no new interventions were implemented to prevent reoccurrence. Findings include: Review of the facility's policy and procedure, "Resident Falls," undated, revealed prevention information that listed "alarms" as an intervention. Review of the facility's policy and procedure, "Resident Alarms," undated, revealed "An alarm	F 323	disabling/disconnecting the alarms on Resident #6 were verbally in-serviced by the LPN SDC and the Administrator to NEVER disable or disconnect an alarm and trust a family member to alert them they are leaving. The education was completed immediately after being informed of the incident by the state inspectors during the annual survey. A fall risk assessment has been completed on Resident #6 and the care plan has been reviewed and updated to reflect current interventions in place. The residents POA requested the resident only be allowed to have supervised family visits with her sister after learning the sister had failed to alert staff she was leaving the residents room. Physical Therapy (PT) evaluated Resident #6 and she is currently receiving PT five times per week. A fall risk assessment was completed on Resident #9 and fall interventions have been implemented. The care plan has been reviewed and updated to reflect the new interventions related to fall prevention. 2. All residents have the potential to be affected by the deficient practice. 3. A fall risk assessment will be completed on all residents. All fall interventions will be reviewed to ensure they are appropriate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 323	Continued From page 9 assists in providing mobility and ease of movement while promoting quality of life, dignity and safety with emphasis on quality of care." The procedure section listed the following three procedures: identify residents at risk for falls and those who would benefit from the use of an alarm device, test the alarm for functioning and monitor the alarm periodically to ensure that it is still working. A record review revealed the facility admitted Resident #6 on 06/25/10 with diagnoses to include Alzheimer's Disease, Anemia, Arthritis and Osteoarthritis. A review of the annual Minimum Data Set (MDS) assessment, dated 03/19/12, revealed the facility determined the resident to be cognitively impaired and required extensive assistance with activities of daily living with poor safety awareness. Resident #6 was assessed at high risk for falls and sustained multiple falls with the facility implementing interventions after each fall to prevent reoccurrence. The resident utilized a bed mat alarm and a mat alarm to the side of the bed to alert the staff of any attempts by the resident to get out of bed unassisted. The alarms were checked for placement and function by the nurse every two hours and documented on the Safety/Alarm Check flow sheet. An observation, on 05/08/12 at 4:15 PM, revealed Resident #6 sitting in a reclining chair with the foot rest up. A large portion of the resident's left forehead, temple and cheek had blue/green and yellow discolorations. The resident did not respond when spoken to.	F 323	and in place. The care plan will be revised and updated, if indicated, to reflect current interventions and ensure they are in place related to fall prevention. LPN #1 has been has been verbally educated by the DON that all falls have to have an appropriate intervention put in place. A list of acceptable fall intervention ideas was given to LPN #1. The list was also placed in the alert charting books at both nursing stations and given to both RN Unit Supervisors. Licensed Nurses and Interdisciplinary Team (IDT) members that attend morning meetings will be in-serviced by the DON on June 8, 2012. Education to include: Proper proper procedure and protocol related to falls and implementation of appropriate and effective interventions based on trying to determine the root cause of the fall with emphasis placed on the fact that the Charge Nurse must put an intervention in place immediately after all falls. Followed by revising and updating the care plan to reflect the intervention they put in place. The IDT members will be educated on acceptable/effective intervention ideas that may be implemented with falls so they are aware of what interventions are considered effective and they can assist in determining if the intervention put in place by the nurse is appropriate when discussed in the interdisciplinary meetings	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	186234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 323	Continued From page 10 A review of the nurse's note, dated 04/30/12 at 3:30 PM, revealed Resident #6 was found on the floor at the end of the bed and had a purple raised area on the left side of the left eye and a skin tear on the left knee with a complaint of back pain. The resident was sent to the hospital for an evaluation. A review of the fall investigation, dated 04/30/12, revealed the resident's alarms were disconnected while the resident's family was visiting. The alarms were not "engaged" when the family left the facility, and the staff were educated. An interview with State Registered Nurse Aide (SRNA) #11, on 05/10/12 at 5:00 PM, revealed, on 04/30/12, she placed an extra chair in Resident #6's room for visiting family members and placed the chair so the mat alarm would not sound. SRNA #11 stated she disabled the laser motion alarm and explained to the family members to inform someone when they left the facility. Resident #6 still had the bed and floor alarms functioning at that time. An interview with Certified Medication Aide (CMA) #3, on 05/10/12 at 5:15 PM, revealed on 04/30/12, sometime around 3:00 PM, Resident #6's family members were having difficulty understanding what the alarms were for, so she disconnected the bed and floor alarms. CMT #3 told the family members multiple times to alert the staff when they left so the alarms could be turned back on. The family members left without alerting the staff and another SRNA found the resident on the floor. An interview with the Director of Nursing (DON),	F 323	the next day following a fall. They will also be provided a copy of the list of acceptable fall intervention ideas. The LPN SDC will in-service all SRNA's/ Direct caregivers June 12, 2012 on the proper procedure/protocol related to ensuring implemented fall interventions are carried out and they are following the residents plan of care. Emphasis will be placed on the importance of ensuring all alarms are in place and functioning properly. Education will also include procedure for proper documentation on the Safety/ Alarm flow sheet to ensure alarms are are checked every two hours and are in working order. 4. Post Falls the LPN Fall Coordinator or RN Unit Supervisor will complete the fall risk assessment, ensure that an effective/ appropriate intervention has been implemented, and the care plan has been revised and updated to reflect the new interventions. The interventions will be discussed the next day in the Interdisciplinary meeting to determine if the intervention placed was effective. If it's determined by the IDT the intervention is not appropriate a new intervention will be implemented. Within seven days of the initial IDT	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 323	Continued From page 11 on 05/09/12 at 11:20 AM, revealed she did not know why Resident #6's alarms were disconnected by the SRNAs, and the SRNAs were responsible to ensure the alarms were on and functioning. 2. A record review revealed the facility admitted Resident #9 on 04/20/12 with diagnoses to include Dementia, Osteoporosis, Lumbago, and Kyphosis. A review of the Fall Risk Assessment, dated 04/20/12, revealed the resident was not at high risk for falls. A review of the Fall Incident Investigation, dated 04/21/12 at 8:25 PM, revealed Resident #9 was ambulating in the hallway and stumbled over another resident's wheelchair. The resident sustained no injury and there were no new interventions added to prevent any further falls. Further review of the Fall Risk Assessment, dated 04/23/12, revealed the facility assessed the resident at high risk for falls. A review of the admission MDS, dated 05/02/12, revealed the facility identified the resident as severely cognitively impaired and required limited assistance with transfers and could ambulate independently. A review of the Fall Incident Investigation, dated 05/07/12 at 4:30 PM, revealed Resident #9 was found sitting next to another resident's wheelchair. The resident had an injury to the posterior head and a deep laceration to the left elbow. He/she was sent to the emergency room	F 323	meeting the fall will be reviewed again to ensure the interventions placed are still effective and appropriate. The LPN QI Coordinator will review five random monthly falls post the second review with IDT to ensure compliance is sustained. Charge Nurses will visually check the Safety/Alarm flow sheets every shift for completed documentation reflecting the SRNA's have checked alarms on their shift. RN Unit Supervisors will do a weekly visual check of the Safety/Alarm flow sheets for two months followed by the LPN QIC or designated QI Committee member completing twenty monthly visual checks of the Safety/Alarm flow sheets to monitor for sustained compliance. 5. Completion Date: June 18, 2012	06/18/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 323	Continued From page 12 for treatment. A review of the General Instructions from the hospital, dated 05/07/12, revealed the resident was evaluated for a laceration and contusion to the scalp and a laceration on the left forearm. Both injuries required staples for repair. There were no evidence of new interventions put in place to prevent further falls. An interview with Licensed Practical Nurse (LPN) #1, on 05/10/12 at 3:40 PM, revealed her job included the review of resident falls to ensure appropriate interventions were in place. She viewed the videotape of the resident's fall that occurred on 05/07/12. She revealed the resident was trying to move in between two residents' wheelchairs, tripping over his/her own feet. She revealed the resident fell onto one of the residents in the wheelchair, landing on the floor. She revealed the resident walked without assistance and no new interventions were put in place to prevent another fall. She stated that she was "not sure what she could do." An interview with the DON, on 05/10/12 at 4:30 PM, revealed a new intervention should be initiated after every fall, even if there was no injury. The charge nurse should initiate an intervention after a fall, to the best of her ability, to prevent another fall. She revealed the intervention should be discussed the next day in the interdisciplinary meeting, to determine if the intervention was appropriate or if something else should be initiated. She verified there were no new interventions to prevent falls for Resident #9.	F 323		
F 327 SS=G	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION	F 327	1. Residents #14 and #16 no longer reside in the facility therefore no corrective action could be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 327	Continued From page 13 The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and procedure, it was determined the facility failed to ensure eight (8) residents (#2, #5, #8, #9, #10, #12, #14, and #16), in the selected sample of seventeen (17) residents, were provided sufficient fluid intake to maintain proper hydration. Additionally, the facility failed to monitor the 24 hour total fluids ingested and intervene prior to Resident #8 being hospitalized for dehydration. The facility failed to ensure the resident consumed the 2400 to 2800 milliliters (ml) of fluids required daily, by as much as 300 to 1000 mls a day. The resident was admitted to the hospital, on 12/12/11, with diagnoses of Metabolic Encephalopathy due to Dehydration and Acute Renal Failure. However, even after returning from the hospital with these diagnoses, the facility failed to monitor the 24 hour fluid intake and ensure the requirements were met. Findings include: A review of the facility's policy and procedure, "Hydration Fluid Intake Policy," dated 08/05/09, revealed each resident's fluid requirement would have been determined at the time of admission by the Dietary Supervisor or the physician order. Fluid intake would have been documented each 24 hour period and totaled to include meals, snacks, medication pass, and activity functions.	F 327	accomplished by the deficient practice. Residents #2, #5, #8, #9, #10, and #12 have been assessed for signs and symptoms of dehydration utilizing a new form titled Signs and Symptoms of Dehydration Checklist. Signs and Symptoms to assess for the absence or presence of on the checklist include dry skin, cracked lips, thirst, poor skin turgor, fever, loss of appetite, nausea, dizziness, increased confusion, decreased blood pressure, increased pulse, constipation, concentrated urine, and lab values within the past month that may indicate dehydration. The form includes a description of what lab values may indicate dehydration: Increased Blood Urea Nitrogen (BUN); an elevated BUN: Creatinine Ratio (in presence of a normal Creatinine); elevated Hematocrit; elevated Potassium (K+); elevated Chloride (Cl-); elevated Urine Specific Gravity; and/or Serum Osmolality; (Sodium can be increased, normal, or low, depending on the underlying cause of the dehydration). The affected residents lab values are being checked if they haven't had recent labs completed that would show indicators of possible dehydration.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 327	Continued From page 14 Staff members were to be alert for signs and symptoms to immediately report, such as decreased or absent urine output, decreased tears or complaints of dry eyes, dry chapped lips, tongue dryness, substantial muscle wasting, and sunken eyes or edema. Expected outcomes, in providing adequate hydration, included decreased infections, decreased constipation and decreased acute confusion. 1. A record review revealed the facility admitted Resident #8 on 10/06/11, and was re-admitted on 12/14/11, with diagnoses to include Acute Cerebrovascular Accident (CVA,) Dysphasia and muscle weakness. Upon the resident's first admission to the facility, the resident's lab values, which determined kidney function, were within normal limits, and blood tests revealed a test for Blood, Urea, Nitrogen (BUN) of 15 (normal value 7-18 mg/dl) and a Creatinine level of 0.8 (normal value 0.8-1.4 mg/dl.) On 12/12/11, the facility transferred Resident #8 to the local hospital having symptoms of confusion, weakness and difficulty responding to verbal and tactile stimuli. The BUN, at the hospital, was 59 mg/dl and Creatinine level was 1.69 mg/dl. The resident was diagnosed with Metabolic Encephalopathy due to Dehydration, Dehydration and Acute Renal Failure. Intravenous fluids (IVFs) were administered and the resident returned to the facility on 12/14/11. Observations of the resident, on 05/08/12 at 9:30 AM, 3:30 PM, and 05/09/12 ,at 9:15 AM and 11:15 AM, revealed the resident was propelling independently around the facility and sitting in the lobby, in the dining area and sometimes in the room. The water pitcher in the room remained	F 327	The physician is being notified of lab results and if there is a presence of any signs and symptoms that may indicate dehydration. All affected resident have also had a Dehydration Risk Assessment completed with care plans revised and updated if indicated. An encourage fluids list with the affected residents names on it is placed at the nurses stations daily to alert everyone to encourage them to drink extra fluids. The DM or designee is picking the lists up daily and totaling their 24 hour fluid intake. Their meal fluid intake is being documented on the consumption record and all between meal fluids (all between meal fluids intake including med pass fluids, snack fluids, & activity fluids) are being documented on an extra fluid flow sheet. Any refusals to drink fluids by the resident are being documented and the Charge Nurse is made aware of the refusal. The Charge Nurse is responsible for documenting and notifying the physician if the resident continues to refuse to drink. The Dietary Manager (DM) or his designee is recording the 24 hour totals of the affected resident's fluid intake. The total daily fluid intake is being monitored by the DM or designee daily. Charge Nurses are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 327	Continued From page 15 full and was kept at the sink area. An interview with State Registered Nurse Aide (SRNA) #9, on 05/10/12 at 2:65 PM, revealed the SRNAs were suppose to document the amount of fluids consumed on the Dietary Intake Records and the Extra Fluid Sheets, but was unaware of exactly how much fluid the resident required, as this was not written on the SRNA's assignment sheet or the SRNA care plan. She stated the resident was difficult to understand and was not sure if he/she would ask for a drink or say if he/she was thirsty. The SRNA checked the water pitcher in the resident's room and stated it was full and the resident probably did not drink from the pitcher. The SRNA was unsure if the resident was able to hold the pitcher or pour a drink into a cup. A review of the quarterly Minimum Data Set (MDS), dated 05/09/12, revealed the facility assessed the resident as moderately cognitively impaired and required the extensive assistance of two staff members with dressing, hygiene and bathing and the extensive assistance of one staff member for transfers. A review of the care plan for the potential fluid volume deficit, related to the decreased sense of thirst, dated 10/22/11, revealed the resident was to be provided adequate fluids every shift and staff members to encourage fluid intake between meals and throughout the shift. A review of the Monthly Nutrition at Risk Review, dated 11/01/11, and review of the Medical Nutritional Therapy Assessment, dated 10/11/11, revealed the Registered Dietician/Licensed	F 327	monitoring the consumption records every shift to ensure the documentation is completed for the affected residents. The DM or designee is documenting the recommended daily fluid requirements per the calculations of the Registered Dietician/Licensed Dietician (RDLD) on the residents care plan and Nurse Assistant Assignment Sheet/Flow sheet so SRNA's are aware of the residents recommended amount of daily fluids. 2. All residents have the potential to be affected by the deficient practice. 3. All residents will be assessed for dehydration utilizing the new Signs and Symptoms of Dehydration checklist and the physician will be notified if indicated by the assessment results. A new Hydration policy and procedure is being developed. A new consumption record that includes all meals fluids and extra fluids (all in between meal fluids) in one area has been developed. The form includes a space for 24 hour fluid totals. The Midnight Charge Nurse, DM or designee will be responsible for totaling the 24 hour fluid consumption. The subsequent day, the DM or designee will be responsible for monitoring the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	186234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 327	Continued From page 16 Dietician (RDLD) required the resident to have 2400-2800 mls of fluid every day. A review of the Dietary Intake Records and the Extra Fluids Sheets, dated December 2011, revealed there was no evidence the fluids were totaled during the 24 hour periods and on the Extra Fluid Sheets, there were no fluids administered on Saturday or Sunday. A review of the meal ticket, distributed on the resident's tray every shift, did not mention the required fluid needs. A review of the Nurse Aide Assignment Sheets revealed the SRNAs were to provide adequate fluids every shift and monitor the fluid intake at meals; however, there was no evidence of the required daily fluid needs. The physician's order, dated December 2011, and January 2012 through May 2012, required the staff members to monitor the approximate amounts of fluids taken each shift, yet did not reveal how many mls that may have been. A review of the hospital History and Profile, from the hospital, just prior to the resident's admission to the facility, on 10/06/11, revealed the resident "had a tendency to not drink enough adequate fluids." An interview with Licensed Practical Nurse (LPN) #6, on 05/09/12 at 1:18 PM, revealed the Dietary Manager and the hydration nurse were responsible for totaling up the daily fluid needs and informing the charge nurse know if there was a problem. An interview with the RDLD, on 05/10/12 at 11:20 PM, revealed the Dietician recommended Resident #8 to require between 2400 and 2800 mls of fluid per day, based on the resident's weight and height and body mass index. After returning from the hospital and on the dietician's	F 327	totals and compiling an encourage fluids list of residents names that fall below the minimum recommended daily fluids of 1500 cc for the elderly per current standards of practice. The list will be placed at the nurses stations to make everyone aware of the resident's fluid needs. The DM or designee will inform Unit Supervisors and DON of any noted fluid consumption concerns. Within 24 hours of admission the DM or RDLD will compute the resident's daily fluid requirements and that number will be documented on the care plan and the Nurse Assistant Assignment/Flow sheet. The DM or designee will also maintain a list of all resident names and their current recommended daily fluid requirements per RDLD computation in the front of the consumption record book at each nurses station and the dining room. The RDLD will be notified with any concerns of dehydration by DM or Nursing Staff for any recommendations she may have. The Hydration Aides and SRNA's are responsible for documenting any water pitcher consumption. A list with fluid amounts of several routine fluids and foods that are considered liquids such as ice cream, soups, jello etc. used in the facility has been placed in the front	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 327	Continued From page 17 next visit, on 12/27/11, it was determined the resident required 2520 mls and this was increased again, on 03/12/12, to 2670 mls every day. However, the dietician stated it was the Dietary Manager's job to compile the 24 hour totals for each resident, the Dietary Department's job to provide the fluids, and the charge nurses' job to let the Dietician know when changes needed to be made and fluids needs were not being met. An interview with the Dietary Manager (DM) and review of the Dietary Intake Records and the Extra Fluid Sheets, on 05/10/12 at 3:05 PM, revealed the DM did not write the 24 hour totals on any of the paperwork and stated he knew the residents were getting enough fluids, but did not have any documentation to prove this, as they were always in groups and activities and fluids were passed several times a day. He also stated he had problems for some time in getting the SRNAs, on the wings, to fill out the Extra Fluids Sheets and stated "they were just not made to do it." The DM stated he was aware of the diagnoses of Dehydration for Resident #8, upon returning from the hospital, on 12/14/11, and stated he may have added another eight ounces of fluids to the resident's meal tray, but could not find a record of this intervention. An interview with LPN #7, on 05/10/12 at 3:50 PM, revealed the nurse stated when she was the midnight nurse, she used to total up all the 24 hour fluid totals and keep them on a clipboard and the DM and the Dietician were suppose to review them. Since she went to work on the day shift, she thought the DM was keeping up with this.	F 327	of the consumption books as well as the amount of fluids the water pitchers contain. A conversion list from ounces to cc's is also on that list. MDS has been instructed to notify IDT and Nursing with anyone that triggers CAA's on hydration so the physician can be notified and any orders or interventions can be implemented to prevent dehydration. The LPN Admission Coordinator has been educated to notify IDT and Nursing with any admission or returning admission that has a diagnosis of dehydration so interventions can he implemented as indicated or ordered by the physician to maintain hydration and prevent dehydration from occurring. Interventions may include intake and output records, place on alert charting for fluid intake, encouraging fluids, etc. All Nursing staff, Dietary/Hydration Aides, Direct Care Staff will be in-serviced on the dates of June 8th and June 12th 2012 by the DON, LPN SDC, and DM regarding the proper procedure and protocol regarding the systemic changes being put in place as written above. 4. The Charge Nurse will monitor the consumption records every shift for completed documentation of fluid intake. The DM or designee will monitor 24 hour fluid totals daily	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	186234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 327	Continued From page 18 An interview with Registered Nurse (RN) #1, on 05/11/12 at 11:00 AM, revealed after the resident was readmitted to the facility from the hospital, with the diagnosis of Dehydration, the RN was unaware of any new interventions implemented to ensure the resident was meeting the required amount of fluids. There were no changes to the resident's care plan, the resident was not placed on alert charting or increased monitoring to ensure the resident received the required fluids, and the consumption records were still not totaled at the end of the 24 hours. The RN stated "everyone was responsible to ensure the recommendations of the dietician was carried out." The RN stated she thought once the resident received IVFs at the hospital, the problem with Dehydration "was taken care of." An interview with the Director of Nursing (DON), on 05/10/12 at 11:40 AM, revealed "whoever gave fluids to a resident" was suppose to document the amount on the Dietary Intake Records and the Extra Fluid Sheets. The Extra Fluid Sheet was a new form that was created, approximately four or five months ago, to ensure fluids, at other times of the day, besides the mealtimes, were being monitored. The DON stated it was the charge nurses' responsibility to ensure this form was being filled out. The required daily amount of fluids required should have been spelled out on the care plan and the physician's orders, as well as the resident's meal ticket, and should have been totaled every day to ensure the need was met. An interview with Physician #1, on 05/10/12 at 5:15 PM, revealed the physician was unaware of	F 327	and on the subsequent day compile an encourage extra fluids list and place it at both nurses stations for all residents that consume less than 1500 cc daily. The RN Unit Supervisor will review new admissions and readmissions for any diagnosis of dehydration and ensure interventions have been implemented as indicated or ordered and review the care pan to ensure it has been updated to reflect the residents condition. The LPN SDC will visually check the consumption records weekly for two months to monitor compliance with fluid consumption documentation followed by The LPN QI Coordinator or Designee visually checking 20 random consumption records monthly to monitor for sustained compliance of fluid documentation and clinical record maintenance. MDS Coordinators will monitor care plan to ensure problem, goals, and approaches related to hydration/dehydration are reflected with the residents quarterly and annual assessment. Any non-compliance will be reported to the DON or Designee. 5. Completion Date: June 18, 2012	06/18/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 327	Continued From page 19 any infection or other condition that would have caused the Acute Renal Failure, outside of the CVA that would have caused the resident trouble eating, swallowing or talking and would cause the resident to be less likely to be compliant with the fluid requirements. 2. A record review revealed the facility admitted Resident #2 on 01/16/12, with a re-admission date of 04/06/12. Diagnoses included Urinary Tract Infection, Congested Heart Failure, Hypertension, and Diabetes Mellitus. A review of the quarterly MDS, dated 04/26/12, revealed the facility assessed the resident as cognitively intact and could eat independently with tray setup. A review of the Dehydration Risk Assessment, dated 04/09/12, revealed Resident #2 had the following conditions that increased the resident's risk for dehydration: Congestive Heart Failure, Depression, age greater than 85 years old, female gender, physical immobility, recent changes in the ability to carry out activities of daily living, urinary incontinence, falling episodes, lethargy/weakness, greater than four medications, and diuretic use. A review of the Dietary Intake Record, dated April 2012, revealed the resident received fluids daily, ranging from (480-1110 ml) in April. A review of the Resident Care Plan, dated 05/03/12, revealed the resident had a potential for fluid volume deficit related to diuretic use and decreased fluid intake. Interventions included to provide adequate fluids of 1790 ml daily. 3. A record review revealed the facility admitted	F 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	186234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 327	Continued From page 20 Resident #9 on 04/20/12 with diagnoses to include Hypertension and Dementia. A review of the admission MDS, dated 05/02/12, revealed the facility identified the resident as severely cognitively impaired and could eat independently with tray setup. A review of the Dehydration Risk Assessment, dated 04/29/12, revealed Resident #9 had the following conditions that increased the resident's risk for dehydration: Dementia, age greater than 85 years old, female gender, lack of understanding about fluid needs, and the lack of understanding about the causes of dehydration. A review of the Dietary Intake Record, dated April 2012, revealed the resident received fluids daily, ranging from (270-1140 ml) in April. A review of the Resident Care Plan, dated 05/03/12, revealed the resident had a potential for fluid volume deficit. Interventions included to provide adequate fluids of 1500 ml daily. 4. A record review revealed the facility admitted Resident #14 on 04/20/12 with diagnoses to include Closed Fracture of the Upper End Tibia, Hypertension, and Urge Incontinence. A review of the admission MDS, dated 05/02/12, revealed the facility identified the resident as cognitively intact and could eat independently with tray setup. A review of the Dehydration Risk Assessment, undated, revealed Resident #14 had the following conditions that increased the resident's risk for dehydration: Female gender, physical immobility, falling episodes, and urinary incontinence.	F 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEOED 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 327	Continued From page 21 A review of the Dietary Intake Record, dated April 2012, revealed the resident received fluids daily, ranging from (240-1440 ml) in April. A review of the Resident Care Plan, dated 05/03/12, revealed the resident had the potential for fluid volume deficit. Interventions included to provide adequate fluids of 1893 ml daily. 5. A record review revealed the facility admitted Resident #10 on 10/12/09 with diagnoses to include Congestive Heart Failure, Anemia, Arthropathy and Alzheimer's Disease. A review of the physician's orders, dated 04/28/11, revealed "to monitor the approximate amounts of fluids taken each shift (required 1545 cc fluids)." A review of the Dehydration Risk Assessment, dated 03/05/12, revealed to encourage fluids each shift. A review of the resident's care plan, dated 03/15/12, revealed staff was to provide 1740 ml fluids daily to the resident. A review of the Dietary Intake Record, dated May 2012, revealed Resident #10 consumed 1620 ml of fluid on 05/01/12, 1375 ml of fluid on 05/02/12, 1425 ml of fluid on 05/03/12, and 945 ml of fluid on 05/04/12. Further review of the fluid intake recorded between 05/01/12 and 05/04/12 was below 1740 ml. An interview with State Registered Nurse Aide (SRNA#1) on 05/09/12 at 2:45 PM, revealed "When I give a resident a drink out of the water	F 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 327	Continued From page 22 pitcher I just "guesstimate" on what they get because I'm not really sure on how much they are really getting as there no real way to measure the fluid I give them." An interview with SRNA #3, on 05/09/12 at 2:55 PM, revealed "I tell my medication nurse when I give a resident a drink, so she can record it with her medication pass. Dietary is in charge of totaling the daily fluid intake, they should be able to tell how much a resident has received for each shift." An interview with Licensed Practical Nurse (LPN #1), on 05/09/12 at 2:48 PM, revealed "I record all fluids with the medication pass on the extra fluid sheet, all fluids are recorded on the consumption sheet where the resident eats their main meal at and the extra fluid sheet is kept at the nurse's station." 6. A record review revealed the facility admitted Resident #5 on 04/03/12 with diagnoses to include Muscle Weakness, Prostate Cancer, Anemia, Hypertension, Renal Insufficiency, Obstructive Uropathy, and Depression. A review of the physician's orders, dated 04/03/12, revealed "to monitor the approximate amounts of fluids taken each shift." A review of the Resident Care Plan, dated 04/19/12, revealed the staff was to provide 2460 ml daily. A review of the facility's Dietary Intake Record, dated April 2012 and May 2012, revealed Resident #5 consumed 1990 ml of fluid on	F 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 327	Continued From page 23 04/18/12 and 05/04/12. On 05/08/12, Resident #4 consumed 1830 ml of fluid, and the fluid intake recorded on 04/15/12, 04/19/12, and 04/24/12 was 1800 ml. The fluid intake recorded on 04/07/12, 04/09/12 through 04/14/12, 04/16/12 through 04/17/12, 04/20/12 through 04/23/12, 04/25/12 through 05/03/12, and 05/05/12 through 05/07/12, revealed the daily intake records was at or below 1770 ml each day. The minimum fluid intake recorded for Resident #5 was 1020 ml consumed on 04/08/12. A review of lab values for Resident #5, collected on 04/04/12, revealed a BUN of 25 with the lab normal reference range of 9-23, and the Creatinine level of 1.40 with the lab normal reference range of 0.5 - 1.1. 7. A record review revealed the facility admitted Resident #12 on 03/22/11 with diagnoses to include Alzheimer's, Diabetes, Anxiety, Abnormal Gait, Seizure Disorder, and Injury to Head. A review of the physician's orders, on 04/07/12, revealed "to monitor the approximate amounts of fluids taken each shift." A review of the Resident Care Plan, dated 04/19/12, and updated on 05/07/12, revealed the staff was to provide 1560 ml daily. A review of the facility's Dietary Intake Record, dated April 2012 and May 2012, revealed Resident #12 consumed 1220 ml of fluid on 04/18/12, and on 05/03/12 Resident #12 consumed 1160 ml of fluid. Fluid intake recorded on 04/24/12 and 04/25/12 was 1020 ml. The fluid intake recorded on 04/01/12 through 04/03/12,	F 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 327	Continued From page 24 04/07/12 through 04/09/12, 04/11/12, 04/14/12 through 04/17/12, 04/21/12 through 04/23/12, 04/26/12, 04/28/12 through 04/29/12, 05/05/12, and 05/08/12, revealed the daily intake records was below 500 ml each day. Resident #12 consumed between 500 ml and 1000 ml on 04/04/12 through 04/06/12, 04/10/12, 04/12/12 through 04/13/12, 04/19/12 through 04/20/12, 04/27/12, 04/30/12 through 05/02/12, 05/04/12, 05/06/12 through 05/07/12, and 05/09/12. The minimum fluid intake recorded for Resident #12 was 220 ml on 04/22/12. 8. A closed record review revealed the facility admitted Resident #16 on 02/27/12 with diagnoses to include Sepsis, Congestive Heart Failure, Anemia, and Altered Mental Status. A review of the Resident Care Plan, dated 03/15/12, revealed the staff was to provide 1500 ml daily. A review of the facility's Dietary Intake Record, dated March 2012, revealed Resident #16 consumed the maximum fluid intake of 1200 ml on 03/16/12. A review of lab values for Resident #16, collected on 03/05/12, revealed a BUN of 30 with the lab normal reference range of 9-23. Interview with the West Wing Unit Supervisor, on 05/09/12 at 2:40 PM, revealed she completed the Dehydration Risk Assessment for each resident on the west wing. "Monitoring" meant the nursing staff who fed the resident each day entered the fluid intake information into the Dietary Intake Record and the kitchen documented the fluid intake each shift and totaled it.	F 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 327	Continued From page 25 Interview with LPN # 8, on 05/09/12 at 2:45 PM, revealed anyone who witnessed consumption from the bedside water pitcher documented the fluid intake on the Dietary Intake Record. An interview with SRNA #9, on 05/09/12 at 2:55 PM, revealed she documented fluids consumed during meals and in between meals by the residents on the facility's Consumption Record. SRNA #9 stated water at the bedside was documented on the Consumption Record and was a "guesstimate" according to information provided by each resident. Interview with the Hydration Dietary Aide, on 05/09/12 at 3:15 PM, revealed she filled the water pitchers at the bedside of each resident. She stated there was no process to record the fluid consumed from the bedside water pitcher. An interview with LPN #6, on 05/10/12 at 9:50 AM, revealed the process for fluid intake documentation in the Dietary Intake Record was completed by the nurse aide when the meal tray was picked up. She stated the Hydration/ Dietary Aide provided refilled the bedside water pitcher and entered the fluid consumption into the Extra Fluids sheet at the nurse's desk. The Hydration/ Dietary Aide also provided and recorded the intake from snacks. She stated if nursing staff provided a refill of the bedside water pitcher, the fluid intake would be documented on the Extra Fluids sheet. Interview with the Registered Dietician/Licensed Dietician and the Dietary Manager, on 05/09/12 at 3:25 PM, revealed the Dietician determined the amount of fluid intake for each resident based on	F 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 327	Continued From page 26 the individual body weight and she completed quarterly nutrition assessments to include calculation totals of the fluid intake records. The Dietician stated the bedside water pitchers were filled twice each day, but nursing refilled and documented what was consumed on the Dietary Intake Record. The Dietary Manager stated the residents wear getting adequate fluids, but it was not documented properly. He stated he also monitored the resident's labs and nursing assessments for indications of dehydration, but did not document the reviews. The Dietician and the Dietary Manager revealed there was a problem with the process of ensuring the resident's fluid intake goal was met.	F 327		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure	F 514	1. Resident #14 no longer resides in the facility therefore no corrective action could be accomplished by the deficient practice. Residents #2, #8, #9, and #10 have been assessed for signs and symptoms of dehydration utilizing a new form titled Signs and Symptoms of Dehydration Checklist. The affected residents have also had a Dehydration Risk Assessment completed with care plans revised and updated if indicated. The affected resident's fluid consumption is being recorded every shift. An encourage fluids list with the affected residents names on it is placed at the nurses stations daily to alert everyone to encourage them to drink extra fluids. The DM or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	186234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 514	Continued From page 27 records of five (5) residents (#2, #8, #9, #10, and #14), in the selected sample of seventeen (17) residents, were maintained in regard to monitoring fluid intake and 24-hour fluid totals. The facility failed to ensure the residents' fluid requirements were met in order to maintain proper hydration. Findings include: A review of the facility's policy/procedure, "Hydration Fluid Intake Policy," dated 08/05/09, revealed each resident's fluid requirement would be determined at the time of admission by the Dietary Supervisor or the physician's order. Fluid intake would be documented and totaled each 24-hour period, to include meals, snacks, medication pass, and activity functions. 1. A record review revealed the facility admitted Resident #8 on 10/06/11, and was re-admitted on 12/14/11, with diagnoses to include Acute Cerebrovascular Accident (CVA,) Dysphasia and muscle weakness. Upon the resident's first admission to the facility, the resident's lab values, which determined kidney function, were within normal limits, and blood tests revealed a test for Blood, Urea, Nitrogen (BUN) of 15 (normal value 7-18 mg/dl) and a Creatinine level of 0.8 (normal value 0.8-1.4 mg/dl.) On 12/12/11, the facility transferred Resident #8 to the local hospital having symptoms of confusion, weakness and difficulty responding to verbal and tactile stimuli. The BUN, at the hospital, was 59 mg/dl and Creatinine level was 1.69 mg/dl. The resident was diagnosed with Metabolic Encephalopathy due to Dehydration, Dehydration and Acute Renal Failure. Intravenous fluids (IVFs) were	F 514	designee is picking the lists up daily and totaling their 24 hour fluid intake. Their meal fluid intake is being documented on the consumption record and all between meal fluids (all between meal fluids intake including med pass fluids, snack fluids, & activity fluids) are being documented on an extra fluid flow sheet. Any refusals to drink fluids by the resident are being documented and the Charge Nurse is made aware of the refusal. The Charge Nurse is responsible for documenting and notifying the physician if the resident continues to refuse to drink. The Dietary Manager (DM) or his designee is recording the 24 hour totals of the affected resident's fluid intake. The total daily fluid intake is being monitored by the DM or designee daily. Charge Nurses are monitoring the consumption records every shift to ensure the documentation is completed for the affected residents. The DM or designee is documenting the recommended daily fluid requirements per the calculations of the Registered Dietician/Licensed Dietician (RDLD) on the residents care plan and Nurse Assistant Assignment Sheet/Flow sheet so SRNA's are aware of the residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	186234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 514	Continued From page 28 administered and the resident returned to the facility on 12/14/11. Observations of the resident, on 05/08/12 at 9:30 AM, 3:30 PM, and 05/09/12 ,at 9:15 AM and 11:15 AM, revealed the resident was propelling independently around the facility and sitting in the lobby, in the dining area and sometimes in the room. The water pitcher in the room remained full and was kept at the sink area. An interview with State Registered Nurse (SRNA) #9, on 05/10/12 at 2:55 PM, revealed the SRNAs were suppose to document the amount of fluids consumed on the Dietary Intake Records and the Extra Fluid Sheets, but was unaware of exactly how much fluid the resident required, as this was not written on the SRNA's assignment sheet or the SRNA care plan. She stated the resident was difficult to understand and was not sure if he/she would ask for a drink or say if he/she was thirsty. The SRNA checked the water pitcher in the resident's room and stated it was full and the resident probably did not drink from the pitcher. The SRNA was unsure if the resident was able to hold the pitcher or pour a drink into a cup. A review of the Monthly Nutrition at Risk Review, dated 11/01/11, and review of the Medical Nutritional Therapy Assessment, dated 10/11/11, revealed the Registered Dietician/Licensed Dietician (RDLD) required the resident to have 2400-2800 mls of fluid every day. A review of the Dietary Intake Records and the Extra Fluids Sheets, dated December 2011, revealed there was no evidence the fluids were totaled during the 24 hour periods and on the Extra Fluid Sheets, there were no fluids administered on	F 514	recommended amount of daily fluids. 2. All residents have the potential to be affected by the deficient practice. 3. A new consumption record that includes all meals, meal fluids, and extra fluids (all in between meal fluids) in one area has been developed. The form includes a space for 24 hour fluid totals. The Midnight Charge Nurse, DM or designee will be responsible for totaling the 24 hour fluid consumption. The subsequent day, the DM or designee will be responsible for monitoring the totals and compiling an encourage fluids list of residents names that fall below the minimum recommended daily fluids of 1500 cc for the elderly per current standards of practice. The list will be placed at the nurses stations to make everyone aware of the resident's fluid needs. The DM or designee will inform Unit Supervisors and DON of any noted fluid consumption concerns. Within 24 hours of admission the DM or RDLD will compute the resident's daily fluid requirements and that number will be documented on the care plan and the Nurse Assistant Assignment/Flow sheet. The DM or designee will also maintain a list of all resident names and their current recommended daily fluid	

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

PRINTED: 05/25/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 514	Continued From page 29 Saturday or Sunday. A review of the meal ticket, distributed on the resident's tray every shift, did not mention the required fluid needs. A review of the Nurse Aide Assignment Sheets revealed the SRNAs were to provide adequate fluids every shift and monitor the fluid intake at meals; however, there was no evidence of the required daily fluid needs. The physician's order, dated December 2011, and January 2012 through May 2012, required the staff members to monitor the approximate amounts of fluids taken each shift, yet did not reveal how many mls that may have been. A review of the hospital History and Profile, from the hospital, just prior to the resident's admission to the facility, on 10/06/11, revealed the resident "had a tendency to not drink enough adequate fluids." An interview with Licensed Practical Nurse (LPN) #6, on 05/09/12 at 1:18 PM, revealed the Dietary Manager and the hydration nurse were responsible for totaling up the daily fluid needs and informing the charge nurse know if there was a problem. An interview with the RDLD, on 05/10/12 at 11:20 PM, revealed the Dietician recommended Resident #8 to require between 2400 and 2800 mls of fluid per day, based on the resident's weight and height and body mass index. After returning from the hospital and on the dietician's next visit, on 12/27/11, it was determined the resident required 2520 mls and this was increased again, on 03/12/12, to 2670 mls every day. However, the dietician stated it was the Dietary Manager's job to compile the 24 hour totals for each resident, the Dietary Department's job to provide the fluids, and the charge nurses'	F 514	requirements per RDLD computation in the front of the consumption record book at each nurses station and the dining room. The Hydration Aides and SRNA's are responsible for documenting any water pitcher consumption. A list with fluid amounts of several routine fluids and foods that are considered liquids such as ice cream, soups, jello etc, used in the facility has been placed in the front of the consumption books as well as the amount of fluids the water pitchers contain. A conversion list from ounces to cc's is also on that list. All Nursing staff, Dietary/Hydration Aides, Direct Care Staff will be in-serviced on the dates of June 8th and June 12th 2012 by the DON, LPN SDC, and DM regarding the proper procedure and protocol regarding the systemic changes being put in place as written above. 4. The Charge Nurse will monitor the consumption records every shift for completed documentation of fluid intake. The DM or designee will monitor 24 hour fluid totals daily and on the subsequent day compile an encourage extra fluids list and place it at both nurses stations for all residents that consume less than 1500 cc daily. The LPN SDC will visually check the consumption records weekly for two months to	

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

PRINTED: 05/25/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 514	Continued From page 30 job to let the Dietician know when changes needed to be made and fluids needs were not being met. An interview with the Dietary Manager (DM) and review of the Dietary Intake Records and the Extra Fluid Sheets, on 05/10/12 at 3:05 PM, revealed the DM did not write the 24 hour totals on any of the paperwork and stated he knew the residents were getting enough fluids, but did not have any documentation to prove this, as they were always in groups and activities and fluids were passed several times a day. He also stated he had problems for some time in getting the SRNAs, on the wings, to fill out the Extra Fluids Sheets and stated "they were just not made to do it." The DM stated he was aware of the diagnoses of Dehydration for Resident #8, upon returning from the hospital, on 12/14/11, and stated he may have added another eight ounces of fluids to the resident's meal tray, but could not find a record of this intervention. An interview with LPN #7, on 05/10/12 at 3:50 PM, revealed the nurse stated when she was the midnight nurse, she used to total up all the 24 hour fluid totals and keep them on a clipboard and the DM and the Dietician were suppose to review them. Since she went to work on the day shift, she thought the DM was keeping up with this. 2. A record review revealed the facility admitted Resident #2 on 01/16/12, with a re-admission date of 04/06/12. Diagnoses included Urinary Tract Infection, Congested Heart Failure, Hypertension, and Diabetes Mellitus. A review of the quarterly MDS, dated 04/26/12, revealed the	F 514	monitor compliance with fluid consumption documentation followed by The LPN QI Coordinator or Designee visually check 20 random consumption records monthly to monitor for sustained compliance of fluid documentation and clinical record maintenance. Any non-compliance will be reported to the DON or Designee. 5.Completion Date: June 18, 2012	06/18/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 514	Continued From page 31 facility assessed the resident as cognitively intact and could eat independently with tray setup. A review of the Dehydration Risk Assessment, dated 04/09/12, revealed Resident #2 had the following conditions that increased the resident's risk for dehydration: Congestive Heart Failure, Depression, age greater than 85 years old, female gender, physical immobility, recent changes in the ability to carry out activities of daily living, urinary incontinence, falling episodes, lethargy/weakness, greater than four medications, and diuretic use. A review of the Dietary Intake Record, dated April 2012, revealed the resident received fluids daily, ranging from (480-1,110 ml) in April. A review of the Resident Care Plan, dated 05/03/12, revealed the resident had a potential for fluid volume deficit related to diuretic use and decreased fluid intake. Interventions included to provide adequate fluids of 1790 ml daily. 3. A record review revealed the facility admitted Resident #9 on 04/20/12 with diagnoses to include Hypertension and Dementia. A review of the admission MDS, dated 05/02/12, revealed the facility identified the resident as severely cognitively impaired and could eat independently with tray setup. A review of the Dehydration Risk Assessment, dated 04/29/12, revealed Resident #9 had the following conditions that increased the resident's risk for dehydration: Dementia, age greater than 85 years old, female gender, lack of understanding about fluid needs, and the lack of	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 514	Continued From page 32 understanding about the causes of dehydration. A review of the Dietary Intake Record, dated April 2012, revealed the resident received fluids daily, ranging from (270-1140 ml) in April. A review of the Resident Care Plan, dated 05/03/12, revealed the resident had a potential for fluid volume deficit. Interventions included to provide adequate fluids of 1500 ml daily. 4. A record review revealed the facility admitted Resident #14 on 04/20/12 with diagnoses to include Closed Fracture of the Upper End Tibia, Hypertension, and Urge Incontinence. A review of the admission MDS, dated 05/02/12, revealed the facility identified the resident as cognitively intact and could eat independently with tray setup. A review of the Dehydration Risk Assessment, undated, revealed Resident #14 had the following conditions that increased the resident's risk for dehydration: Female gender, physical immobility, falling episodes, and urinary incontinence. A review of the Dietary Intake Record, dated April 2012, revealed the resident received fluids daily, ranging from (240-1440 ml) in April. A review of the Resident Care Plan, dated 05/03/12, revealed the resident had the potential for fluid volume deficit. Interventions included to provide adequate fluids of 1893 ml daily. 5. A record review revealed the facility admitted Resident #10 on 10/12/09 with diagnoses to include Congestive Heart Failure, Anemia, Arthropathy and Alzheimer's Disease.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 514	Continued From page 33 A review of the physician's orders, dated 04/28/11, revealed "to monitor the approximate amounts of fluids taken each shift (required 1545 ml fluids)." A review of the Dehydration Risk Assessment, dated 03/05/12, revealed to encourage fluids each shift. A review of the resident's care plan, dated 03/15/12, revealed staff was to provide 1740 ml fluids daily to the resident. A review of the Dietary Intake Record, dated May 2012, revealed Resident #10 consumed 1620 ml of fluid on 05/01/12, 1375 ml of fluid on 05/02/12, 1425 ml of fluid on 05/03/12, and 945 ml of fluid on 05/04/12. Further review of the fluid intake recorded between 05/01/12 and 05/04/12 was below 1740 ml. An interview with SRNA #1, on 05/09/12 at 2:45 PM, revealed "When I give a resident a drink out of the water pitcher I just "guesstimate" on what they get because I'm not really sure on how much they are really getting as there no real way to measure the fluid I give them." An interview with SRNA #3, on 05/09/12 at 2:55 PM, revealed "I tell my medication nurse when I give a resident a drink, so she can record it with her medication pass. Dietary is in charge of totaling the daily fluid intake, they should be able to tell how much a resident has received for each shift." An interview with LPN #1, on 05/09/12 at 2:48	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	186234	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(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 514	Continued From page 34 PM, revealed "I record all fluids with the medication pass on the extra fluid sheet, all fluids are recorded on the consumption sheet where the resident eats their main meal at and the extra fluid sheet is kept at the nurse's station." An interview with the Director of Nursing (DON,) on 05/10/12 at 11:40 AM, revealed "whoever gave fluids to a resident" was suppose to document the amount on the Dietary Intake Records and the Extra Fluid Sheets. The Extra Fluid Sheet was a new form that was created, approximately four or five months ago, to ensure fluids, at other times of the day, besides the mealtimes, were being monitored. The DON stated it was the charge nurses' responsibillty to ensure this form was being filled out. The required daily amount of fluids required should have been spelled out on the care plan and the physician's orders, as well as the resident's meal ticket, and should have been totaled every day to ensure the need was met.	F 514		

RECEIVED JUN 2012 OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1972 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type III (200) SMOKE COMPARTMENTS: Eight (8) smoke compartments FIRE ALARM: Complete fire alarm system with smoke and heat detectors SPRINKLER SYSTEM: Complete automatic wet sprinkler system. GENERATOR: Type II generator. Fuel source is natural gas. A standard Life Safety Code survey was conducted on 5/08/12. Calvert City Convalescent Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for ninety five (95) beds with a census of eighty two (82) 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	6/1/12

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, in accordance with NFPA standards. The deficiency had the potential to affect three (3) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety five (95) beds and the	K 018	K018 (1) The beds in rooms 223, 221, 210, and 206 were re-arranged in order to allow free movement of corridor doors on 5/15/12. (2) All residents are identified as having potential to be affected by the same deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 2 census was eighty two (82) on the day of the survey. The findings include: Observation, on 05/08/12 between 10:30 AM and 12:00 PM, with the Maintenance Supervisor revealed the corridor doors to room# 223, 221, 210, and 206 were blocked by the resident beds. Interview, on 05/08/12 between 10:30 AM and 12:00 PM, with the Maintenance Supervisor confirmed the observation of the doors not closing due to the beds blocking the doors from closing. Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 60, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.	K 018	(3) All resident room furniture has been re-arranged to assure beds, or any furniture, do not block corridor doors. All nursing, housekeeping, and maintenance staff will be in-serviced by the Administrator on room furniture arrangement to avoid corridor door blockage by 6/18/12. (4) Housekeeping staff will survey all resident rooms at least one time weekly to assure compliance. (5) Corrective action will be completed by 6/18/12.	6/18/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 3 Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two	K 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 4 separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety five (95) beds and the census was eighty two (82) on the day of the survey. The findings include: Observations, on 05/08/12 between 9:45 AM and 10:45 AM, with the Maintenance Supervisor revealed the smoke partitions, extending above the ceiling had multiple penetrations due to wires, block chipping out, regular quick foam, and conduit. All eight smoke barrier walls were penetrated and the spaces around the penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. The fire quick foam that was used does not have a Fire Resistive Rating therefore is not approved for use in the smoke barrier.	K 025	K025 (1) The improper material used to fill penetrations in smoke barrier walls was removed and appropriate fire rated caulk was re-applied to all penetrations in the smoke barrier walls with work completed on 5/29/12. (2) All residents are identified as having potential to be affected by the same deficient practice. (3) All work to be performed in the attic area around smoke barrier walls will require review and approval of the Administrator before work begins including any fire rated caulk to be utilized on the project. (4) Maintenance staff will survey smoke protective barriers every six month and report findings to the Administrator. (5) Corrective action completion date 5/29/12.	5/29/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	186234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 5 Interview, on 05/08/12 between 9:45 AM and 10:45 AM, with the Maintenance Supervisor revealed he was not aware of the penetrations and that he had thought all the smoke barrier walls were sealed properly with the fire quick foam. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least	K 027		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027	Continued From page 6 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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross -corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect six (6) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety five (95) beds and the census was eighty two (82) on the day of the survey. The findings include: Observation, on 05/08/12 between 9:45 AM and 10:30 AM, with the Maintenance Supervisor revealed the cross-corridor doors, located at room# 101 and 111, would not close completely when tested. This was due to the doors not having a coordinator to ensure the door without the t-astragal would close first after the initial close. Interview, on 05/08/12 between 9:45 AM and 10:30 AM, with the Maintenance Supervisor revealed he was unaware the doors needed a	K 027	K027 (1) The cross-corridor doors located at room 101 & 111 and 201 & 219 were adjusted on 5/11/12 to assure proper closure. (2) All residents are identified as having potential to be affected by the same deficient practice. (3) A contracted technician will service all cross-corridor doors quarterly and report findings to the Administrator. (4) Door gap testing for cross-corridor doors will be conducted by maintenance staff during each fire drill. (5) Corrective action completed by 5/11/12.	5/11/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027	Continued From page 7 coordinator to ensure the doors would close properly in the event of an emergency. Observation, on 05/08/12 between 9:45 AM and 10:30 AM, with the Maintenance Supervisor revealed the cross-corridor doors located at room #201 and 219, would not close completely when tested. This left a gap of approximately one-quarter of an inch or greater between the pair of doors and would not resist the passage of smoke. Interview, on 05/08/12 between 9:45 AM and 10:30 AM, with the Maintenance Supervisor revealed he was unaware the doors would not close all the way leaving a gap between the doors in the closed position and acknowledged the doors would not resist the passage of smoke in the event of an emergency. NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke. Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 027		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027	Continued From page 8 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 029 SS=E	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 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 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 five (5) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety five (95) beds and the census was eighty two (82) on the day of the survey.	K 029	K029 (1) Items 1 thru 7 identified as deficient practices were corrected as follows: (1) a new door was ordered on 5/18/12 and is scheduled for installation with closure by 6/18/12; (2) a new latch and knob was installed on 5/18/12; (3) door with out vents in the central bath area are to be installed by 6/7/12; (4) a door header is scheduled to be installed by 6/15/12; (5) a door was ordered on 5/18/12 and is scheduled to be installed by 6/18/12; (6) door closures were installed on east and west wing housekeeping closets on 5/10/12; (7) a closure was installed on the MDS door on 5/11/12.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 9 The findings include: Observation, on 05/08/12 between 11:00 AM and 3:00 PM, with the Maintenance Supervisor revealed: 1) The dry storage area in the kitchen did not have a door installed with a closer. 2) The other dry storage area with the records did not have a latch in the door that would keep the door sealed. 3) The storage areas in the central baths had a vent through the door to allow for a pressure relief. These vents are not allowed in a hazardous storage area. 4) The clean linen areas on the east and west wing had a gap above the door approximately 12 " from the ceiling. 5) Schedulers ' office has hazardous storage with no door closer and a mail slot through the door. 6) The two housekeeping closets on the east and west wing had no door closer installed. 7) The MDS area needs a door closer on the door that leads in the corridor. The storage in the area makes it a hazardous storage area thus needing a door closer to keep the door closed. Interview, on 05/08/12 between 11:00 AM and 3:00 PM, with the Maintenance Supervisor revealed he was not aware the areas listed above were considered hazardous storage thus requiring a door, a self-closer, and seperation. Reference:	K 029	(2) All residents are identified as having potential to be affected by the same deficient practice. (3) Any modification or changes to any door in the facility must be reported to the Administrator before the modification occurs. (4) Maintenance staff will survey all doors quarterly to assure compliance and report the findings to the Administrator. (5) Corrective action to be completed by 6/18/12.	6/18/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 10 NFPA 101 (2000 Edition). 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 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), 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=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 11 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and Interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety five (95) beds and the census was eighty two (82) on the day of the survey. The findings include: Observation, on 05/08/12 between 11:00 AM and 3:00 PM, with the Maintenance Supervisor revealed the egress doors had no code posted at the doors or no delay. The doors would not open unless the fire alarm went off or the code was entered to open the doors. Interview, on 05/08/12 between 11:00 AM and 3:00 PM, with the Maintenance Supervisor revealed he was unaware the doors could not be locked and dependent upon the fire alarm to release the doors.	K 038	K038 (1) Exit codes were posted at all egress doors on 5/21/12. "No Exit" signs were properly installed on 5/15/12. (2) All residents are identified as having potential to be affected by the deficient practice. (3) The CCCC Emergency Policy has been changed to include the posting of exit codes at all egress doors and the posting of appropriate signs at all egress doors. (4) Maintenance staff will verify monthly during fire drills that exits codes are posted on egress doors and that appropriate signs are displayed at all egress doors. (5) Completion date 5/21/12.	5/21/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	186234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 12 Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device	K 038		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 13 required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.	K 038		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 14 7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.	K 038		
K 045 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by:	K 045		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 045	Continued From page 15 Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety five (95) beds and the census was eighty two (82) on the day of the survey. The findings include: Observation, on 05/08/12 between 11:00 AM and 3:00 PM, with the Maintenance Supervisor revealed the exterior exits for the entire building did not have 2 lights for exterior illumination . Interview, on 05/08/12 between 11:00 AM and 3:00 PM, with the Maintenance Supervisor revealed was unaware the lighting at the outside of the exits must have more than one bulb. Exit lighting must be arranged so the failure of a single bulb will not leave the exit in complete darkness. Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045	K045 (1) A licensed electrician has been contracted to install proper lighting for exterior illumination at all exterior exits. (2) All residents are identified as having potential to be affected by the deficient practice. (3) Any alteration to exterior illumination at exterior doors will require Administrator approval. (4) Exterior illumination at external exits will be tested monthly for proper operation by maintenance department personnel. (5) Corrective action to be completed by 6/18/12.	6/18/12
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.	K 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 16 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 record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety five (95) beds and the census was eighty two (82) on the day of the survey. The findings include: Fire Drill review, on 05/08/12 at 10:10 AM, with the Maintenance Supervisor revealed the fire drills were not being conducted at unexpected times under varied conditions on all shifts. There were no drills being held for the 2 weekend shifts being done quarterly. Further observation showed there was no fire drill held on the 3rd shift for the 3rd quarter. Interview, on 05/08/12 at 10:10 AM, with the Maintenance Supervisor revealed he was unaware the fire drills were not being conducted as required and that the facility must include a fire	K 050	K050 (1) Fire Drill schedules have been changed to include all shifts during each calendar quarter and at unexpected times. One 3rd shift drill was not conducted in the 3rd quarter of 2011. Other 3rd shift drills have been timely. (2) All residents are identified as having potential to be affected by the deficient practice. (3) The fire drill policy has been changed to include all shifts and for a monthly report to be provided to the Administrator. (4) The Quality Assurance Committee will monitor fire drill reports and report the findings at the Quarterly QA Committee meeting. (5) Completion date 5/31/12.	5/31/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 17 drill for their separate weekend shift quarterly. 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 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety five (95) beds and the census was eighty two (82) on the day of the survey.	K 056	K056 (1) The "old smoking area" porch was removed on 5/16/12. The breeze way roof was removed on 5/29/12. (2) All residents are identified as having potential to be affected by the deficient practice. (3) Any modifications to the facility must be reviewed by the Administrator prior to any work activity. (4) The Administrator and a member of the maintenance staff will conduct monthly surveys of the building monitoring sprinkler protection.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILOING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 18 The findings include: Observation, on 05/08/12 between 11:00 AM and 3:00 PM, with the Maintenance Supervisor revealed a closet in the Business Office that did not have sprinkler protection. Further observation showed that the old smoking area had a porch roof that extends over four feet with no sprinkler protection and the breeze way for the dining room exit was enclosed with no sprinkler protection. The final observation revealed the center aisle of the dry storage area with the records did not have sprinkler protection. Interview, on 05/08/12 between 11:00 AM and 3:00 PM, with the Maintenance Supervisor revealed he was not aware that the areas listed did not have proper sprinkler protection. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The	K 056	(5) Correction plan completion date is 5/29/12.	5/29/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 19 requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. Reference: NFPA 13 (1999 edition) 5-13.8.1. 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 056		
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 periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety five (95) beds and the census was eighty two (82) on the day of the survey.	K 062	K062 (1) The deficient practices 1 thru 5 have been addressed as follows: (1) Storage within 18" of the ceiling atop all resident's closets was removed 5/30/12; (2) The office, referenced as room 219, was cleared of storage within 18" of the sprinkler head on 5/25/12; (3) The Human Resource Office closet had storage within 18" of the ceiling removed on 5/9/12. (4) New gauges on the sprinkler riser were installed 5/24/12;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 20 The findings Include: Observation, on 05/08/12 between 11 AM and 3:00 PM, with the Maintenance Supervisor revealed: 1) The closets located in the resident rooms throughout the facility have combustible storage located within 18" of the ceiling. The closets must keep 18" clear on top because they are not sprinkler protected. 2) The office in room# 219 had storage within the 18" of the sprinkler head. 3) The Human Resources Office closet had storage within 18" of the sprinkler head. 4) There is no documentation showing when the gauges on the sprinkler riser were last changed or recalibrated 5) There is no documentation showing when the last internal pipe inspection was performed on the sprinkler system. Interview, on 05/08/12 between 11 AM and 3:00 PM, with the Maintenance Supervisor revealed he was not aware the sprinkler system was not being maintained per NFPA standards. Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.	K 062	(5) A internal pipe inspection was performed on the sprinkler system on 5/31/12. (2) All residents are identified as having potential to be affected by the deficient practice. (3) All staff will be in-serviced by the Administrator on proper storage and the 18" limitation by 6/18/12. The fire sprinkler system maintenance policy has been changed to include annual sprinkler riser gauge re-calibration and internal pipe inspections every 3 years. (4) Maintenance personnel will conduct monthly surveys on facility storage practices and the 18" compliance. Maintenance will review with the Administrator policy requirements for fire sprinkler maintenance quarterly and make reports when work is	6/18/12 date completion date 5/31/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 21 Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3	K 062	completed to the Administrator. (5) Correction action to be completed 5/31/12.	5/31/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	186234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 22 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10 9-4.2.1 9-4.2.1 Inspection. Valves shall be inspected internally every 5 years to verify that all components operate properly, move freely, and are in good condition.	K 062		
K 072 SS=D	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	K 072		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	Continued From page 23 access in accordance with NFPA standards. The deficiency had the potential to affect two(2) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety five (95) beds and the census was eighty two (82) on the day of the survey. The findings include: Observation, on 05/08/12 between 11:00 AM and 3:00 PM, with the Maintenance Supervisor revealed 2 lifts stored in the corridor plugged in to charge from 11:00 AM to 3:00 PM located in the corridor next to room# 215. Further observation showed storage of clothes racks, a cabinet, and a linen cart in the laundry exit hall. Interview, on 05/08/12 between 11:00 AM and 3:00 PM, with the Maintenance Supervisor revealed the facility routinely stored the lifts and the items in the laundry exit in the corridor. 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	(1) The two lifts stored in the corridor were moved on 5/8/12 to a storage location outside the corridor. The storage clothes rack, the cabinet, and the linen cart in the laundry exit hall were moved outside the corridor on 5/9/12. (2) All residents are identified as having potential to be affected by the deficient practice. (3) All staff will be in-serviced by the Administrator on corridor passage impediments by 6/18/12. (4) The Administrator or his designee will daily survey all corridors for compliance. (5) Corrective action to be completed by 6/18/12.	6/18/12
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no	K 073	K073	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 073	Continued From page 24 combustible decorations were used in the facility, according to NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety five (95) beds and the census was eighty two (82) on the day of the survey. The findings include: Observation, on 05/08/12 between 11:00 AM and 3:00 PM, with the Maintenance Supervisor revealed several stuffed animals and fake floral arrangements throughout the facility with no flame retardant applied. Interview, on 05/08/12 between 11:00 AM and 3:00 PM, with the Maintenance Supervisor revealed they were unaware decorations were required to be treated with a fire retardant spray; and to have a written policy for documentation that wreaths and other decorations are being treated. Reference: NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073	K073 (1) Families are being notified by letter to remove all stuffed animals and fake floral arrangements no later than 6/15/12. On 6/15/12 housekeeping and maintenance staff will clear the building of all combustible stuffed animals and fake floral arrangement not in compliance with NFPA standards. 2. All residents are identified as having potential to be affected by the deficient practice. 3. Upon admittance families will be educated on NFPA standards related to stuffed animals and fake floral arrangements and facility policy not to admit such items. Annually, families will be notified by letter of the policy. 4. Housekeeping will monitor daily resident rooms for inappropriate items in violation of NFPA regulations. 5. Corrective action to be completed by 6/15/12.	6/15/12
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.	K 074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 074	Continued From page 25 Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the privacy curtains, located within the shower rooms, were in accordance with NFPA standards. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety five (95) beds and the census was eighty two (82) on the day of the survey. The findings include: Observation, on 05/08/12 between 11:00 AM and 3:00 PM, with the Maintenance Supervisor revealed the privacy curtains within the shower rooms located on the east and west wings, were of a solid fabric hung approximately 12" below the ceiling. The solid fabric would obstruct the spray pattern of the automatic sprinklers in the event of a fire.	K 074	K074 (1) Privacy curtains in shower rooms on the east and west wings in accordance with NFPA standards were ordered on 5/15/12 and will be installed by 6/30/12. (2) All residents are identified as having potential to be affected by the same deficient practice. (3) Ordering responsibility for NFPA compliance items has been changed to become the responsibility of maintenance personnel who are familiar with NFPA standards. (4) Maintenance staff will conduct monthly surveys of all privacy curtains to assure compliance. (5) Corrective action to be completed by 6/30/12.	6/30/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 074	Continued From page 26 Interview, on 05/08/12 between 11:00 AM and 3:00 PM, with the Maintenance Supervisor revealed he was unaware the shower curtains must contain 18" of mesh or be hung 18" below the sprinkler head so that the top of the curtain does not obstruct the spray pattern of the sprinkler heads. NFPA 13 Cubicle curtains; Reference to: NFPA 13 Standard for the Installation of Sprinkler Systems 1998 Edition 19.3.5.5 For the proper operation of sprinkler systems, cubicle curtains and sprinkler locations need to be coordinated. Improperly designed systems might obstruct the sprinkler spray from reaching the fire or might shield the heat from the sprinkler. Many options are available to the designer including, but not limited to, hanging the cubicle curtains 18 in. (46 cm) below the sprinkler deflector; using a ½-in. (1.3-cm) diagonal mesh or a 70 percent open weave top panel that extends 18 in. (46 cm) below the sprinkler deflector; or designing the system to have a horizontal and minimum vertical distance that meets the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. The test data that forms the basis of the requirements of NFPA 13 is from fire tests with sprinkler discharge that penetrated a single privacy curtain.	K 074		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	Continued From page 27 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety five (95) beds and the census was eighty two (82) on the day of the survey. The findings include: Observation, on 05/08/12 at 2:30 PM, with the Maintenance Supervisor revealed a lock (hook and latch type) was installed on the egress side of the white privacy fence outside the dining room exit. Observation also showed that after the gate was opened once we could not unlock the gate to get away from the facility. Interview, on 05/08/12 at 2:30 PM, with the Maintenance Supervisor confirmed that we could not open the gate from the inside. Interview also showed he was also unaware locks could not be placed on the egress side of any gate or dolor. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130	K130 (1) The white privacy fence and gate were removed from the property on 5/15/12. (2) All residents are identified as having potential to be affected by the same deficient practice. (3) The facility policy has been changed to reflect that no lock can be placed on the egress side of any gate or door. (4) Maintenance personnel will conduct survey each six months to assure compliance. 5. Corrective action was completed on 5/15/12.	5/15/12
K 141 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas	K 141		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	186234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 141	Continued From page 28 where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to properly mark areas that contained oxygen storage in accordance with NFPA standards. The deficiency had the potential to affect four (4) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety five (95) beds and the census was eighty two (82) on the day of the survey. The findings include: Observation, on 05/08/12 between 11:00 AM and 3:00 PM, with the Maintenance Supervisor revealed two (2) storage closets and two (2) medication rooms with oxygen storage. The doors to the storage rooms and medication rooms did not have a sign indicating oxygen was stored in the room. Furthermore the rack area was not properly marked to determine if the cylinders were full or empty. Interview, on 05/08/12 between 11:00 AM and 3:00 PM, with the Maintenance Supervisor revealed he had not noticed there were no signs for oxygen storage in the rooms. NFPA: 99, 1999 8-6.4.1.7 All labeling shall be durable and withstand	K 141	K141 (1) The two storage closets and two medication rooms with oxygen storage had signs installed indicating oxygen storage in the rooms on 5/9/12. The improperly marked rack area was marked to determine if cylinders were full or empty on 5/11/12. (2) All residents are identified as having potential to be affected by the same deficient practice. (3) All staff will be in-serviced by the Administrator on properly marking oxygen storage areas in accordance with NFPA standards by 6/18/12. (4) Maintenance personnel will conduct monthly surveys to assure compliance. (5) Corrective action to be completed by 6/18/12.	6/18/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 141	Continued From page 29 cleansing or disinfection. 8-6.4.2* Signs. Precautionary signs, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed wherever supplemental oxygen is in use, and in aisles and walkways leading to that area. They shall be attached to adjacent doorways or to building walls or be supported by other appropriate means.	K 141	K147 (1) The deficient practices noted as items 1 thru 20 were addressed as follows: (1) The power strips in room 109 were removed on 5/15/12; (2) The camera extension cord by the east wing house-keeping closet was removed on 5/8/12; (3) The extension cord and power strip in room 221 was removed on 5/9/12; (4) The power strip in room 220 was removed on 5/9/12; (5) The power strip in the west wing med room was removed on 5/9/12; (6) the power strip in room 212 was removed on 5/9/12; (7) The power strip in the QI office was removed on 5/9/12; (8) The extension cord in the MDS office was removed on 5/9/12; (9) The power strip in the DON office was removed on 5/10/12; (10) The extension cord in room 118 was	
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 eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety five (95) beds and the census was eighty two (82) on the day of the survey. The findings include: Observations, on 05/08/12 between 11:00 AM and 3:00 PM, with the Maintenance Supervisor revealed: 1) A power strip was plugged into another power strip located in room# 109. 2) An extension cord was plugged into a camera in the attic by the east wing housekeeping closet.	K 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 30 3) A refrigerator was plugged into a power strip and a brown extension cord was plugged in room# 221. 4) A refrigerator was plugged into a power strip in room# 220. 5) A refrigerator was plugged into a power strip in the west wing med room. 6) A mini nebulizer and an oxygen concentrator were plugged into a power strip in room# 212. 7) A refrigerator and a microwave were plugged into a power strip in the QI office. 8) A coffee pot was plugged into an extension cord in the MDS office. 9) A power strip was plugged into a multi-plug adapter in the Director of Nursing office. 10) An extension cord was plugged into a refrigerator in room# 118. 11) An extension cord was plugged in at the east wing nurses ' station. 12) An extension cord was plugged into the camera in the east wing med. Room. 13) A refrigerator was plugged into a power strip in the soiled linen room in hall 6. 14) Two (2) extension cords in use for electronics in room# 213. 15) An oxygen concentrator was plugged into a power strip in room# 216. 16) A refrigerator was plugged into a power strip and an extension cord was plugged into television in room# 217. 17) An extension cord was plugged into the wall in the Human Resources office. 18) A suction machine was plugged into a power strip in room# 114. 19) Two (2) extension cords were in use in the Social Services office. 20) The Hydro Collator was plugged into a standard plug in the Therapy area.	K 147	removed on 5/10/12; (11) The extension cord at the east wing nurses station was removed on 5/10/12; (12) The camera extension cord in the east wing med room was removed 5/10/12; (13) The power strip in the soiled linen room in hall 6 was removed on 5/10/12; (14) The extension cords in room 213 for electronics were removed on 5/10/12; (15) The power strip in room 216 was removed on 5/9/12. (16) The power strip and extension cord in room 217 was removed on 5/9/12. (17) The extension cord in the HR office was removed on 5/9/12; (18) The power strip in room 214 was removed on 5/8/12; (19) The extension cords in the Social Service Office were removed on 5/9/12; (20) The plug in therapy was changed to a GFI receptacle on 5/29/12. (2) All residents are identified as having potential to be affected by the same deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVERT CITY CONVALESCENT CENTER	1201 FIFTH AVE CALVERT CITY, KY 42029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 31 Interview, on 05/08/12 between 11:00 AM and 3:00 PM, with the Maintenance Supervisor revealed he was not aware the extension cords were only for temporary use, or the power strips were being misused. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D 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.	K 147	(3) All staff will be in-serviced by the Administrator on electrical wiring and equipment by 6/18/12. Information regarding extension cord and power strip utilization at the Center will be provided upon admission to families. A letter has been sent to families to inform regarding power strips and extension cord utilization in the facility. (4) Housekeeping will monitor weekly all rooms for power strips and extension cords. A member of the maintenance staff will monitor quarterly. (5) Corrective action to be completed by 6/18/12.	6/18/12