

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

PRINTED: 03/24/2010
FORM APPROVED
OMB NO. 0938-0891

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188250	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2010
NAME OF PROVIDER OR SUPPLIER OAKMONT MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE, P O BOX B22 FLATWOODS, KY. 41138	
(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 160	Continued From page 1 was sent with the check to the responsible party after the resident expired or was discharged. Interview on 03/11/10 at 4:15 PM with the Administrator, revealed the Office Manager should have kept a copy of the ledger and a copy of the letter and check which was sent to the responsible party after a resident expired or was discharged. She stated, she was unaware the Office Manger was not ensuring there was a copy of the record to refer to. The Administrator stated she was aware the funds needed to be conveyed to the responsible party within thirty (30) days of the residents expiration; however, there was no documented evidence this was done.	F 160	: had discharged or explred had their funds returned to them within 30 days of discharge or death. The business office staff was educated on March 15, 2010 by the administrator regarding the procedures of returning resident's funds within 30 days of discharge or death. A cover letter, copy of the ledger and a money order for the amount remaining in the account will be mailed to the resident, responsible party or executor of estate prior to 30 days from discharge from the facility. A copy will be maintained in the resident's file in the business office. An audit will be completed monthly of resident personal funds to ensure funds have been returned within 30 days of discharge/death and that there is documentation in resident file. This audit will be done monthly for 6 months by the office manager or designee. The results of the above-mentioned audits will be reviewed by the Quality Assurance Committee on a monthly basis for 6 months to determine compliance.	
F 367 SS-D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending phycsician. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide therapeutic diets as prescribed by the attending physician for two (2) of twenty-two (22) sampled residents. The findings include: Review of the facility "Therapeutic Diets" policy revealed it was the policy of the facility to provide therapeutic diets when prescribed by the physician and to serve these diets as ordered. "A tray identification system is established to ensure that each resident received his/ her diet as ordered.	F 367		March 15, 2010

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NAME OF PROVIDER OR SUPPLIER OAKMONT MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE, P O BOX 822 FLATWOODS, KY 41139		
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F 367	<p>Continued From page 2</p> <p>1. Observation of meal service in the main dining room on 03/10/10 at 1:00 PM, revealed Resident #18 had been served his/her tray and had received a regular piece of pork tenderloin which had been cut into pieces. Review of the tray ticket, revealed the resident was to receive a Regular-Mechanical Soft Diet with Ground Meat. Review of the Physician's Orders dated 03/10 revealed an order for a Mechanical Soft Diet with Ground Meat.</p> <p>Interview on 03/10/10 at 1:00 PM with Certified Medical Technician (CMT) #3 who was passing trays in the dining room revealed Resident #18 had received the incorrect diet, and the resident was to have ground meat. She further stated, the staff passing trays in the dining room were to check the trays against the tray ticket to ensure the residents received the correct diet.</p> <p>2. Further observation of meal service in the main dining room on 03/10/10 at 1:05 PM, revealed Resident #19 had been served his/her tray and had received a regular piece of pork tenderloin which had been cut into pieces. Review of the tray ticket, revealed the resident was to receive a No Added Salt Mechanical Soft Diet with Ground Meat. Review of the Physician's Orders dated 03/10, revealed an order for a No Added Salt Mechanical Soft Diet with Ground Meat.</p> <p>Further interview on 03/10/10 at 1:05 PM with CMT #3 who was passing trays in the dining, revealed Resident #19 had also received the incorrect diet. She stated the resident was to have ground meat.</p>	F 367	<p>It is and was on the day of survey the policy of Oakmont Manor to provide therapeutic diets as prescribed by the attending physician. There were no adverse effects to sample residents #2 and #22.</p> <p>On March 11, 2010 the dietary staff was educated by the dietary manager to ensure that the tray served to a resident matches the diet ordered by the physician.</p> <p>On March 16, 2010, the SRNAs were educated by the Administrator and Director of Nursing regarding the procedure of checking diet card and tray for accuracy prior to serving the tray to the resident.</p> <p>On March 17, 2010, the dietary staff was educated by the dietary manager and the dietician regarding the procedure of ensuring that diet order matches the tray going out to be served to the resident.</p> <p>Dietary manager and/or designee will perform three audits weekly for six months to ensure the tray served to the resident follows the diet ordered by the physician.</p>		

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F 367	Continued From page 3 Interview on 03/10/10 at 1:30 PM with the Dietary Manager, revealed Resident #18 and Resident #19 had received regular consistency pork tenderloin meat on their trays, even though the tray ticket had stated ground meat. She further stated this should have been caught in the kitchen on tray line. Continued interview revealed she observed tray line once a week.	F 367	Results of these audits will be reviewed by the Quality Assurance Committee on a monthly basis for six months to determine compliance.	March 17, 2010
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure food was handled, distributed, and served under sanitary conditions. The findings include: Review of the facility "Dietary Food Handling Policy and Procedure" revealed utensils must be	F 371	It is and was on the day of survey the policy of Oakmont Manor to ensure that food is handled, distributed, and served under sanitary conditions. There were no adverse effects to any residents related to the practice identified in food handling. Cook was educated on 3/10/10 by dietary manager and dietician that utensils must be handled in such a way as to avoid touching surfaces with which food will come into contact. On March 17, 2010, the dietary staff was educated on proper food handling policy and procedures by the dietary manager and dietician.	

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F 371	Continued From page 4 handled in such a way as to avoid touching surfaces with which food will come in contact. Observation of tray line on 03/10/10 at 11:45 AM revealed the cook used tongs to place baked potatoes on plates, and repeatedly placed the tongs back into the baked potatoes, with the handle of the tongs touching the potatoes. Interview on 03/10/10 at 1:15 PM with the cook who was serving on tray line, revealed she had been the cook since 08/09 and did not realize the handle of the tongs should not touch the food Interview on 03/10/10 at 1:30 PM with the Dietary Manager, revealed she watched tray line once a week and had not noted the problem with the cook placing the handle of the tongs back in the food. Interview on 03/10/10 at 12:45 PM with the Dietician who was watching tray line on 03/10/10 at 11:45, revealed she could not see where the tongs on the baked potatoes were placed from where she was standing. She stated she audited meal service once a week and audited the tray line once a month. She stated the cook should have been careful to ensure the handle of the tongs did not touch the baked potatoes. Review of the facility "Dietary Food Handling Policy and Procedure" revealed utensils must be handled in such a way as to avoid touching surfaces with which food will come in contact.	F 371	The dietary manager and/or designee will audit food handling procedures three times weekly for four months to ensure proper technique is being followed. Results of aforementioned audits will be reviewed by Quality Assurance Committee monthly for four months to determine compliance. March 17, 2010	
F 431 SS-E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		

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NAME OF PROVIDER OR SUPPLIER OAKMONT MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE, P O BOX 822 FLATWOODS, KY 41139
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F 431	<p>Continued From page 5</p> <p>of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to label all drugs and biologicals in accordance with accepted professional principles, and failed to ensure all expired drugs and biologicals were disposed.</p>	F 431	<p>It is and was on the day of survey the policy of Oakmont Manor to label all drugs and biological and ensure that expired drugs and biological are disposed. There were no adverse effects to any residents related to the practice identified.</p> <p>An audit of the medication rooms was conducted on March 9, 2010 by the Unit Coordinator to ensure that all drugs and biologicals were labeled appropriately and that any expired drugs and biological were disposed of.</p> <p>The CMTs were educated on March 16, 2010 and the nurses were educated on March 19, 2010 by the Administrator and Director of Nursing on the proper procedure for labeling/dating drugs and biological. Nurses were also educated to check expiration date prior to administration of such meds and biological.</p>	
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F 431	<p>Continued From page 6</p> <p>The findings include:</p> <p>Observation on 03/09/10 at 2:45 PM of the South Hall medication refrigerator revealed a vial of Novolin Regular Insulin and a vial of Tuberculin Serum was opened, undated, and available for resident use. Further observation revealed a vial of Influenza Vaccine with an open date of 01/17/10 (opened 49 days prior to observation).</p> <p>Interview with Licensed Practical Nurse (LPN) #1 at time of observation, revealed the Insulins, Tuberculin Serums, and Influenza Vaccines were to be dated when opened and were only to be used for thirty days from the date opened.</p> <p>Observation on 03/09/10 at 2:55 PM of the North Hall medication refrigerator revealed a vial of Influenza Vaccine opened, undated and available for resident use. Further observation revealed a vial of Lantus Insulin with an open date of 01/26/10 (opened 42 days prior to observation), and a vial of Novolog Insulin with an open date of 01/26/10 (opened 42 days prior to observation).</p> <p>Interview with Licensed Practical Nurse (LPN) #2, at the time of observation, revealed the vial of Influenza Vaccine should have been dated when opened and was only good for thirty (30) days after opened. Further interview revealed the Insulins were expired and were only good for thirty (30) days after opening. Continued interview revealed the Unit Coordinator was responsible for checking the medications to ensure expired medications were discarded.</p> <p>Interview on 03/09/10 at 3:00 PM with the North</p>	F 431	<p>An audit will be performed weekly for six months by the unit coordinator to ensure that all drugs and biologicals are labeled/dated appropriately and that any expired drugs/biological are disposed of.</p> <p>The results of this audit will be reviewed by the Quality Assurance Committee on a monthly basis for six months to determine compliance.</p> <p style="text-align: right;">March 19, 2010</p>	

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F 431	<p>Continued From page 7</p> <p>Hall Unit Coordinator revealed the Director of Nursing (DON) was responsible for ensuring the expired medications were discarded.</p> <p>Interview on 03/11/10 at PM at 3:25 PM with the DON revealed the nurses and Certified Medical Technicians should have been checking for expired medications.</p> <p>Interview on 03/11/10 at 9:20 AM with the facility pharmacist, revealed multi-dose vials such as Insulin, Tuberculin Serum, and Influenza Vaccine should have been dated when opened. She further stated Insulin was good for twenty-eight (28) days after opening, and Tuberculin Serum and Influenza Vaccine were good for thirty (30) days after opening. Continued interview revealed the pharmacist technician checked the medication room including the cabinets, refrigerator, and medications carts once a month for expired medications.</p> <p>Review of the facility "Medication Storage in the Facility" policy revealed "outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal". The policy further stated, medication storage conditions were monitored on a monthly basis and corrective action taken if problems were identified.</p> <p>Review of the facility "Vials and Ampules of Injectable Medications" policy revealed, "the date opened and the initials of the first person to use the vial are recorded on multidose vials on the vial label or an accessory label affixed for that purpose".</p>	F 431		

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F 456 SS=D	<p>483.70(o)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure essential equipment was in safe operating condition.</p> <p>The findings include:</p> <p>Observation of the initial kitchen tour on 03/09/10 at 8:45 AM, revealed the walk in freezer had a build up of ice on the floor, under a shelf.</p> <p>Interview at that time with the Dietary Manager, revealed the freezer had an automatic defroster; however, on occasion ice would build up on the floor and Maintenance would need to be contacted to break up the ice. Further interview with the Dietary Manager and record review revealed a Work Order had been sent to maintenance on 02/23/10; however, maintenance had not responded to the Work Order as of 03/09/10.</p>	F 456	<p>It is and was on the day of survey the policy of Oakmont Manor to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>Ice was removed from floor of walk-in freezer by maintenance department on March 9, 2010.</p> <p>The maintenance director was educated by the administrator on March 18, 2010 regarding following up on work requisition requests. The maintenance department developed a preventative maintenance program to monitor for ice build-up in the walk-in freezer in dietary. If ice is found it will be removed when identified. Dietary manager will notify maintenance of any ice build-up in freezer between monthly checks.</p> <p>The preventative maintenance program to monitor for ice in freezer will be completed monthly for six months by the maintenance department.</p> <p>The results of the preventative maintenance audit will be reviewed by the Quality Assurance Committee to determine compliance.</p>	
F 466 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 466		March 17, 2010

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F.465	Continued From page 9 by: Based on observation and interview, it was determined the facility failed to ensure a safe environment for residents, staff, and the public. The findings include: Observation on 03/11/10 at 2:00 PM revealed the outside courtyard had fourteen (14) 12 x 12 inch tiles in a row which were cracked, and one of the tiles was broken in half, with the other half missing causing a dip. Interview on 03/11/10 at 3:55 PM with a maintenance staff member, revealed the tiles had cracked during the winter due to shoveling snow off the courtyard. He stated he was aware of the situation, and it was a safety hazard. He further stated, he had considered placing a cone and a sign in front of the broken tiles. Continued interview, revealed he had reported the broken tiles to the Maintenance Director and no decision had been made as to whether the tiles would be replaced. He stated, they were waiting on better weather to do something about the repairs.	F 465	It is and was on the day of survey the policy of Oakmont Manor to provide a safe, functional, sanitary, and comfortable environment for residents, staff and public. There were no adverse effects to anyone related to the practice identified. On March 12, 2010, maintenance placed a cone and tape across broken tiles in courtyard of C-patio to ensure safety. Fourteen broken tiles have been removed by the maintenance director from C-patio and new tiles are being laid and grout repaired around new tiles. An audit will be conducted monthly by maintenance department to ensure there are no broken tiles in courtyard on C-patio. These audits will be conducted for six months. The results of the aforementioned audits will be reviewed by the Quality Assurance Committee monthly for six months to determine compliance.	April 7, 2010

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on March 10, 2010 for compliance with Title 42, Code of Federal Regulations, 483.70 and found the facility not in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at an " F "	K 000	It is and was on the day of survey the policy of Oakmont Manor to ensure corridor doors are properly maintained. There were no adverse effects to any resident related to the identified practice.	
K 018 88-D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/2 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. RECEIVED APR - 3 2010 BY: _____ This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridor doors were maintained to provide a suitable means of keeping doors	K 018	An audit was completed on proper closure of corridor doors on March 15, 2010 by the maintenance department to ensure that they were closing properly. A contractor has been contacted and will adjust the doors to ensure that they close properly. An audit will be completed monthly for six months by the maintenance department to ensure that corridor doors are closing properly. The results of this audit will be reviewed by the Quality Assurance Committee on a monthly basis for six months to determine compliance.	April 9, 2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Shanna Cunn</i>	TITLE <i>Administratrix</i>	(X6) DATE <i>4-2-10</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	Continued From page 1 closed.	K 018		
K 050 88=D	<p>The findings include:</p> <p>During the Life Safety Code tour on March 10, 2010 at 10:20 AM., with the Director of Maintenance, resident room doors G-3 and G-4 were noted not to be closing and latching due to the door and frame assembly not fitting correctly. The Director stated the doors were worked on about a year ago by an outside contractor. The Director stated he thought the walls were shifting which caused the doors not to fit correctly. The Director was not aware the doors were not working correctly.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 8 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to conduct fire drills to ensure staff was prepared for response to incidence of fire under different staffing levels and conditions to include resident levels of alertness. This failure affected all residents and staff in the facility.</p> <p>The findings include:</p>	K 050	<p>It is and was on the day of survey the policy of Oakmont Manor to conduct fire drills to ensure the staff is prepared for response to an incidence of fire.</p> <p>Fire drills will be conducted monthly on varying shifts at varying times to ensure staff is prepared to respond to an incidence of fire.</p> <p>The maintenance director and/or his designee will conduct fire drills monthly at varying times during the shift to ensure that staff is prepared to respond to an incidence of fire.</p> <p>The maintenance director and/or designee will document outcome of drills and any issues identified will be addressed with staff at the time of the drill. This will be completed on a monthly basis ongoing.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165250	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/10/2010
NAME OF PROVIDER OR SUPPLIER OAKMONT MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE, P O BOX 892 FLATWOODS, KY 41189	
(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 2	K 050	The fire drill report will be reviewed in a Quality Assurance meeting monthly ongoing to determine compliance and preparedness of staff to respond to incidence of fire.	March 31, 2010
K 052 88-D	<p>During the Life Safety Code survey on March 9, 2010, at 2:00 PM, with the Director of Maintenance, a record review revealed the facility had not been performing fire drills at unexpected times and varying conditions on the first shift as follows: Five (5) fire drills from January 2009, to January 2010, were conducted between 9:20 AM to 10:05 AM. The Director of Maintenance was not aware fire drills should be conducted at unexpected times and under varying conditions.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the building fire alarm system was maintained as required by NFPA standards.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on March 10,</p>	K 052	<p>It is and was on the day of survey the policy of Oakmont Manor to ensure the building fire alarm system was maintained.</p> <p>A smoke detector will be placed on the main fire panel in the laundry room on April 2, 2010 by Sentry Fire Protection.</p> <p>A monthly audit will be completed through the preventative maintenance program by the maintenance director and/or designee to ensure proper functioning of the smoke detector on the fire panel in the laundry room.</p>	

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NAME OF PROVIDER OR SUPPLIER OAKMONT MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE, P O BOX 822 FLATWOODS, KY 41189	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 3 2010 at 11:15 a.m., with the Director of Maintenance, revealed the main fire alarm panel located in the laundry room was not protected with a smoke or heat detector as required. The Director of Maintenance stated he was not aware fire alarm panels should be protected in this manner.	K 052	The results of this preventative maintenance audit will be reviewed by the administrator monthly and by the Quality Assurance Committee monthly for six months to determine compliance.	
K 056 88-E	Reference: NFPA 72 1999 edition. 1-5.6* Protection of Fire Alarm Control Unit(s). In areas that are not continuously occupied, automatic smoke detection shall be provided at the location of each fire alarm control unit(s) to provide notification of fire at that location. Exception: Where ambient conditions prohibit installation of automatic smoke detection, automatic heat detection shall be permitted. A-1-5.8 The intent of 1-5.8 is to have the fire alarm system respond before it is incapacitated by fire. There have been several fatal fires where the origin and path of the fire resulted in destruction of the control unit before a detector responded. CAUTION: The exception to 1-5.8 permits use of a heat detector if ambient conditions are not suitable for smoke detection. It is important to also evaluate whether the area is suitable for the control unit. The code intends that only one smoke detector is required at the control unit even when the area of the room would require more than one detector if installed according to the spacing rules in Chapter 2 NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard	K 056		April 2, 2010

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NAME OF PROVIDER OR SUPPLIER OAKMONT MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE, P O BOX 822 FLATWOODS, KY 41139	
(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	<p>Continued From page 4</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure combustible canopies at the facility were sprinkler protected.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on March 9, 2010 at 10:00 AM, with the Director of Maintenance, a combustible canopy approximately 30' x 10', located at the front of the facility was noted not to be sprinkler protected. Combustible canopies exceeding four foot in width must be sprinkler protected. The Director of Maintenance was not aware of this requirement. During the survey an approximate 8' x 16' combustible canopy at the employee entrance was also noted not to be sprinkler protected.</p> <p>Reference: NFPA 13 1999 edition</p> <p>5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width.</p>	K 056	<p>It is and was on the day of survey the policy of Oakmont Manor to ensure that the building is sprinkler protected. The front porch canopy was constructed in 1980.</p> <p>A fire-retardant coating will be applied to the canopy at the employee entrance. The coating will comply with requirements of NFPA 703.</p> <p>The canopy located at the front of facility will be covered with a fire-retardant surface.</p> <p>Any attached canopies will be inspected by the maintenance department to ensure that if material is combustible it will be coated with a fire-retardant treatment approved by NFPA 703.</p> <p>The maintenance director and/or designee will inspect any attached canopy monthly to check for signs of deterioration or fire hazards. These inspections will be completed for six months.</p>	

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NAME OF PROVIDER OR SUPPLIER OAKMONT MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE, P O BOX 822 FLATWOODS, KY 41138	
(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 5 Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction. Reference: NFPA 101 2000 edition 10.2.6* Fire-Retardant Coatings. 10.2.6.1 The required flame spread or smoke development classification of existing surfaces of walls, partitions, columns, and ceilings shall be permitted to be secured by applying approved fire-retardant coatings to surfaces having higher flame spread ratings than permitted. Such treatments shall comply with the requirements of NFPA 703, Standard for Fire Retardant Impregnated Wood and Fire Retardant Coatings for Building Materials. 10.2.6.2 Fire-retardant coatings shall possess the desired degree of permanency and shall be maintained so as to retain the effectiveness of the treatment under the service conditions encountered in actual use.	K 056	The results of the abovementioned audits will be reviewed by the Quality Assurance Committee on a monthly basis for six months to determine compliance.	April 16, 2010
K 062 88-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 an interview, the facility failed to ensure the sprinkler system was maintained by NFPA standards.	K 062	A preventative maintenance program schedule has been completed per NFPA recommendations to monitor the facility's sprinkler fire pump assembly. The maintenance director and/or his designee will be trained by Sentry Fire to test the fire pump assembly. The maintenance director and/or designee will complete preventative maintenance on the fire pump assembly as scheduled.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186280	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/10/2010
NAME OF PROVIDER OR SUPPLIER OAKMONT MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE, P O BOX 822 FLATWOODS, KY 41139	
(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	<p>Continued From page 6</p> <p>The findings include:</p> <p>During the Life Safety Code survey on March 10, 2010, at 10:35 AM, with the Director of Maintenance, the Director revealed there was not a written preventive maintenance schedule for the facility's sprinkler fire pump assembly. The Director stated he was not comfortable operating the fire pump assembly. The Director stated the fire pump was tested about once a month. The fire pump is required to be tested by a properly trained individual. The facility was cited on January 21, 2009 partly for not maintaining the fire pump assembly.</p> <p>Reference: NFPA 25 1998 edition</p> <p>5-5.1*</p> <p>A preventive maintenance program shall be established on all components of the pump assembly in accordance with the manufacturer's recommendations. Records shall be maintained on all work performed on the pump, driver, controller, and auxiliary equipment. In the absence of manufacturer's recommendations for preventive maintenance, Table 5-5.1 provides alternative requirements.</p>	K 062	<p>An audit of the preventative maintenance for the fire pump assembly will be reviewed by the Administrator monthly ongoing.</p> <p>The results of the audit will be reviewed in the Quality Assurance Committee to determine compliance for six months.</p>	April 2, 2010