

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

PRINTED: 07/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/20/2013
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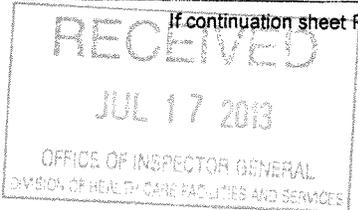
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS A standard survey was initiated on 06/18/13 and concluded on 06/20/13 with deficiencies cited at the highest scope and severity of a "D". A Life Safety Code Survey was initiated and concluded on 06/19/13 with deficiencies cited at the highest scope and severity of an "E" with the facility having the opportunity to correct deficiencies before remedies would be recommended for imposition.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provision of federal and state law.	
F 371 SS=D	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 and interview it was determined the facility failed to distribute food under sanitary conditions. Observation during a mealtime revealed two (2) staff touched with bare hands the food of two (2) unsampled residents of sixteen (16) sampled and two (2) Unsampled Residents (Resident A and Resident B). The findings include: The facility had no policy advising staff not to touch food with their bare hands.	F 371	F371 The Staff Development Coordinator and/or DON will educate CNA #1 and #2 not to touch resident's food with their bare hands and on the proper way to serve residents by 7/30/13. The Staff Development Coordinator, DON and/or Dietary Director will in-service all Dietary and Nursing staff on the proper way to serve residents without touching their food by 7/30/13. The Staff Development Coordinator, DON and/or Unit Manager will also in-service Nursing Staff on the proper way to wash their hands and to wash and/or sanitize their hands in between delivering the resident's food. The DON and/or Unit Manager(s) will audit one meal service daily x 5 x 8 weeks, then one meal service 3x weekly x 8 weeks, then one meal weekly x 8 weeks to ensure that all residents are served properly. The DON will report the results of the audits to the QA committee monthly for further review and recommendation. All corrective measures will be completed by 7/31/13.	7/31/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Doreen M. Edwards* TITLE: *Administrator* (X6) DATE: *7/17/13*

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.

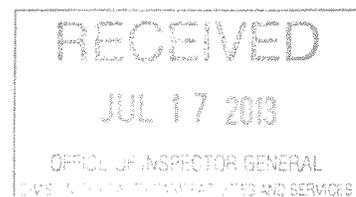


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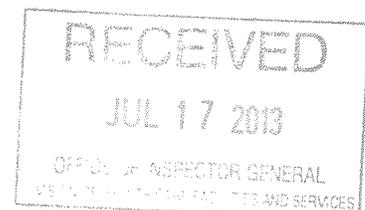
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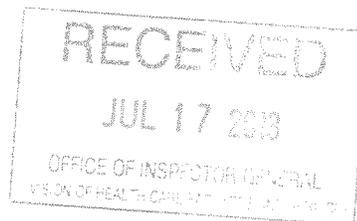
F 371	<p>Continued From page 1</p> <p>Observation on 06/19/13 at 8:00 AM in the dining room revealed Certified Nursing Assistant (CNA) #2 picked up the toast of Unsampled Resident B and applied butter to the toast with her bare hands.</p> <p>Observation on 06/19/13 at 8:10 AM in the dining room revealed CNA #1 picked up a portion of the bacon sandwich for Unsampled Resident A with her bare hands.</p> <p>Interview with CNA #1 on 06/19/13 at 2:25 PM revealed she had an orientation when she was hired by the facility and she was trained on infection control practice. However, she did not remember having been trained not to touch the residents' food with her bare hands by the facility. CNA #1 stated she was aware she touched Unsampled Resident A's food with her bare hands after she had done so and she thought she remembered from her basic CNA training that it was wrong because it could cause the spread of infection.</p> <p>Interview with CNA #2 on 06/19/13 at 2:30 PM revealed the facility did not train her not to touch residents' food with her bare hands; however, she stated she had been trained in another facility not to touch residents' food with her bare hands and she had just forgotten during the breakfast meal on 06/19/13. CNA #2 stated she was not to touch residents' food with her bare hands because it could spread infection from one resident to another.</p> <p>Interview with the Infection Control Nurse on 06/20/13 10:30 AM revealed she did train all of</p>	F 371		
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F 371	Continued From page 2 the nursing staff on infection control on hire and she did train the CNA's not to touch residents' food with their bare hands as they could cause the spread of infection. She stated she had a new position in the facility but she had done no staff monitoring in the dining room when she was in charge of infection control.	F 371			
F 441 SS=D	Interview with the Director of Nursing (DON) on 06/20/13 at 2:30 PM revealed the nursing staff were trained on hand hygiene on hire and at least quarterly and they were trained not to touch food with their bare hands to prevent the spread of infection. She stated she had a nurse monitor in the dining room during mealtime and she was not aware of any problem with staff touching residents' food with their bare hands. The DON further stated it was her responsibility to ensure the nursing staff did their jobs correctly and the staff would be retrained. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	F441 On 06/20/13, the DON and/or licensed nurse changed Resident #3 and Resident #11 catheter bags and cleaned the areas in which they touched. They also gave Resident #3 and Resident #11 dignity bags to cover their catheters to prevent contamination. On 06/20/13, the DON and/or Unit Manager identified all residents with catheters to ensure that they have dignity bags to prevent contamination. The Staff Development Coordinator, DON and/or Unit Manager will in-service all nursing staff by 7/30/13 to ensure that all residents with catheters have dignity bags to prevent contamination and to refrain from allowing them to touch the floor. The DON, Unit Manager and/or licensed nurse will audit all resident's catheters daily x 5 days x 8 weeks, 3x weekly x 8 weeks, then 1 x weekly x 8 weeks to ensure proper catheter care to prevent contamination. All corrective measures will be achieved by 7/31/13.	7/31/13	



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F 441	Continued From page 3 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility policy and record review, it was determined the facility failed to maintain a safe environment for two (2) of sixteen (16) sampled and two (2) unsampled residents with indwelling catheter (Resident #3 and Resident #11). The indwelling catheters for Resident #3 and Resident #11 were allowed to lay on the floor. In addition, one (1) of three (3) Certified Nurses Aides (CNA) failed to practice hand hygiene for three (3) trays delivered. The findings include:	F 441	F441 Continued The Staff Development Coordinator will educate CNA #3 on proper hand hygiene by 7/30/13. The Staff Development Coordinator, DON and/or Dietary Director will in-service all Nursing staff on proper hand hygiene by 7/30/13. The Staff Development Coordinator, DON and/or Unit Manager will also in-service Nursing Staff on the proper way to wash their hands and to wash and/or sanitize their hands in between delivering the resident's food and performing other care related tasks. The Unit Manager(s) and/or DON will audit proper hand hygiene for 50% of all scheduled nursing staff daily x 5 days x 8 weeks. The DON and/or Unit Manager will then audit proper hand hygiene for 25% of all scheduled nursing staff 3x weekly x 8 weeks, then 25% of all scheduled nursing staff weekly x 8 weeks to prevent cross contamination. The DON will report the results of these audits to the QA committee monthly for further review and recommendation. All corrective measures will be achieved by 7/31/13.	7/31/13



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F 441	<p>Continued From page 4</p> <p>Review of the facility's policy for handwashing, undated revealed the staff and residents will wash their hands as necessary to prevent the spread of infections or germs. The policy identified appropriate time for staff to wash their hands was before handling a resident's food or food tray.</p> <p>Review of the facility's policy for catheter, closed urinary bag, undated, revealed the policy was for a closed urinary drainage would provide a reservoir to continuously collect urine from the bladder via the indwelling catheter. The policy rule was to keep the bag off of the floor and never allow the drainage bag or tubing to touch the floor.</p> <p>Observation of Resident #11, on 6/18/13 at 3:07 PM, revealed the resident sat in his/her wheelchair at the nurses station near the entrance of the hallway. The catheter urine collection bag hung from the wheelchair and laid on the floor along with the tubing. The drain port of the bedside drainage bag laid on the floor. The bag and tubing dragged on the floor as the resident was pushed to his/her room by staff.</p> <p>Clinical record review revealed Resident #11 was admitted to the facility on 06/17/13 at 7:15 PM with the diagnosis of Disorders of the Urethra and Urinary Tract, Altered Mental Status, Epilepsy, Neoplasms of the Bone and Metastatic Melanoma.</p> <p>Observation of CNA #3, on 06/19/13 at 8:10 AM, revealed the aide stood at the tray cart on Lakeview Avenue wearing gloves while she prepared a cup of coffee with creamer and sweetener. A lid was placed on the cup of coffee</p>	F 441			



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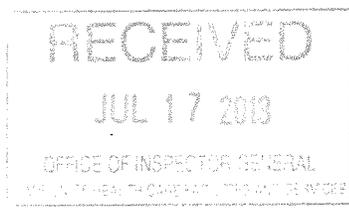
F 441	<p>Continued From page 5</p> <p>and shook vigorously. The tray was delivered to room 312. She removed her gloves and did not complete any hand hygiene. She approached the tray cart and obtained a second tray without hand hygiene prior to the retrieval of the tray and proceeded to room 313A. She moved the over the bed table, pulled back the covers, pulled the hand held bed control out of the covers and raised the bed. She rolled the over-the-bed table across the bed and set up the meal tray. Hand hygiene was not completed by the CNA. She proceeded to room 307 and adjusted the television. She exited room 307 without hand hygiene completed. She exited room 307 without hand hygiene completed. She obtained the Maxi Move lift located near room 306 and moved the lift into the spa. She did not complete hand hygiene before or after the lift was moved into the spa. At 8:25 AM, she proceeded to Evergreen Court and continued to pass breakfast meal service. She approached the tray cart and obtained a tray and poured a cup of coffee.</p> <p>Interview with CNA #3, on 06/19/13 at 2:55 PM, reported this was her first CNA position and the process was to sanitize your hands before taking a tray from the cart and after you deliver the tray. She reported germs can be taken from one room to another. She stated she should have slowed down and washed her hands between tray service.</p> <p>Interview with CNA #3 on 6/20/13 at 1:45 PM reported all urine collection bags should be off the floor and in dignity bags. She stated the urine collections bag should not be allowed on the floor since that was an infection problem. The residents could get an infection off of the floor.</p>	F 441		
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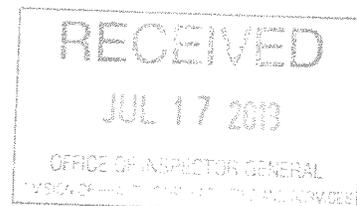
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OFFICE OF THE DIRECTOR GENERAL
HEALTH CARE SERVICES

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F 441	Continued From page 6 Interview with the Director of Nurses, on 06/20/13 at 2:50 PM, revealed the practice is to complete hand washing or hand gel before and after the use of gloves. Hand hygiene should be practiced when you go in and out of resident rooms, included upon delivery of meal trays. Hand hygiene was to be done before getting a tray out of the cart and after leaving the resident's room. In addition, anytime equipment was used. The equipment should be cleaned and hand hygiene should be practiced. Review, on 06/20/13, of the facility's policy titled Catheter, Closed Urinary Bag (undated), revealed catheter drainage bags or catheter tubing should never be allowed to touch the floor. Observation, on 06/19/13 at 12:30 PM, revealed Resident #3 had an indwelling catheter and tubing attached to a drainage bag covered with a dignity cover. Resident #3's bed was in a low position and the drainage bag was in contact with the floor. Additional observations on 06/19/13 at 2:20PM and 2:50 PM revealed Resident #3's indwelling catheter drainage bag continued to touch the floor. Observations, on 06/20/13 at 8:14 AM and 9:30 AM revealed Resident #3's indwelling catheter drainage bag touched the floor. Interview, on 06/20/13 at 1:45 PM with Licensed Practical Nurse (LPN #1), revealed indwelling catheter drainage bags should have a dignity cover in place and should not touch the floor.	F 441			



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F 441	<p>Continued From page 7</p> <p>LPN #1 stated germs and debris on the floor could contaminate the bag, the tubing, and the drainage spigot. This would increase the resident's risk for infection. LPN #1 stated direct care staff was in-serviced on the management of indwelling catheters upon hire and as needed through monitoring by the staff development nurse.</p> <p>Interview, on 06/20/13 at 1:55 PM with Certified Nursing Assistant #1, revealed an indwelling catheter drainage bag should never touch the floor. The problem with allowing a catheter bag to touch the floor would be contamination of the bag, the tubing, and the drainage spigot, thereby increasing the resident's risk of infection.</p> <p>Interview, on 06/20/13 at 1:50 PM with Registered Nurse (RN) #1, Unit Manager (UM), revealed indwelling catheter drainage bags should be positioned to hang below the resident's bladder, at the side of the bed, and should not touch the floor. RN#1 stated her concern would be the contamination of the bag and other parts of the drainage system, which could affect Resident #3's health status by increasing his/her exposure to pathogens. RN #1 stated the direct care staff was in-serviced on the care and management of indwelling catheters and associated equipment upon hire, annually, and as needed. The UM and nurses assigned to each hallway would be responsible for ensuring catheter drainage bags did not come in contact with the floor.</p>	F 441			



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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1982 REMODELED: 2011</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story and a partial basement, Type V Protected.</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments.</p> <p>FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic, dry sprinkler system.</p> <p>GENERATOR: Type II 45KW generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 06/19/13. Christian Health Center - West was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Beverly M. Edwards* TITLE: *Administrative* (X6) DATE: *7/17/13*

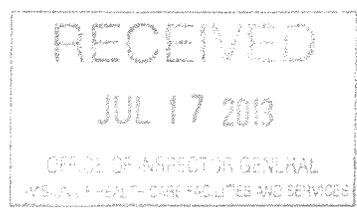
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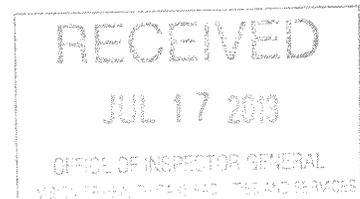
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<p>K 000</p> <p>K 066 SS=D</p>	<p>Continued From page 1 noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).</p> <p>Deficiencies were cited with the highest deficiency identified at E level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the two (2)</p>	<p>K 000</p> <p>K 066</p>	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provision of federal and state law.</p>	



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K 066	<p>Continued From page 2</p> <p>designated outdoor smoking areas, one (1) for Residents and one (1) for Staff, were properly equipped for safe smoking, in accordance with NFPA standards. The deficiency had the potential to affect residents, staff and visitors. The facility has ninety-two (92) certified beds and the census was eighty (80) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 06/19/13 between 3:30 PM and 3:45 PM, with the Maintenance Director revealed the two (2) designated, outdoor smoking areas for Residents and for Staff, did not have an approved metal container with a self-closing lid to empty the ash trays into, nor a fire extinguisher and a fire blanket readily available for usage.</p> <p>Interview, on 06/19/13 at 3:30 PM, with the Maintenance Director revealed he was not aware of the requirements of the designated, outdoor smoking areas to have an approved metal container with a self-closing lid to empty ash trays, a fire extinguisher and a fire blanket readily available for usage.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or</p>	K 066	<p>K66</p> <p>Christian Health Center West (CHCW) is currently a smoke free center for residents. However, CHCW has one resident that smokes and was a resident of the center before the above policy was reinstated. Therefore, he has been grandfathered to the above policy and is able to smoke. On 6/19/13, the Maintenance Director immediately contacted Fessco and ordered two self-closing containers with lids to dispose of ashes, two fire extinguishers and two fire blankets for the resident and staff smoking areas. The Maintenance Director picked up the self-closing containers and one fire extinguisher on 7/10/13 from Grainger and Home Depot, as these items were unable to be secured from Fessco. On 7/10/13, the Maintenance Director installed self-closing containers with lids to dispose of ashes, fire extinguishers and fire blankets in the resident and staff smoking areas. All Maintenance staff was in-serviced by the Maintenance Director on 6/19/13 to ensure that they understand that the resident and staff smoking areas must contain self-closing containers with lids to dispose of ashes, fire extinguishers and fire blankets for resident and staff safety. The Maintenance Director will audit the resident and staff smoking area weekly x 8, bi-monthly x 2, then monthly x 2 to ensure that the self-closing containers with lids to dispose of ashes, the fire extinguishers and fire</p>	7/11/13

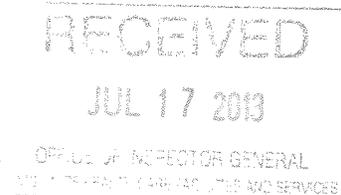


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - CHRISTIAN HEALTH CENTER - WEST B. WING _____	(X3) DATE SURVEY COMPLETED 06/19/2013
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203
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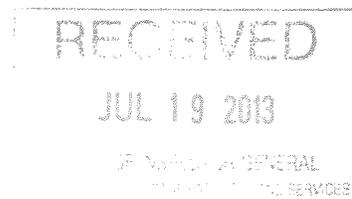
K 066	<p>Continued From page 3</p> <p>oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.</p> <p>Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.</p> <p>(2) Smoking by patients classified as not responsible shall be prohibited.</p> <p>Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.</p> <p>Reference: S & C Letter: 12-04-NH; Date: November 10, 2011 Subject: Alert: Smoking Safety in Long Term Care Facilities</p>	K 066	<p>blankets are all within the resident and staff smoking areas. The Maintenance Director will report the results of the audits to the QA committee monthly for further review and recommendation. All corrective measures were completed by 7/11/13.</p>	7/11/13
K 143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility</p>	K 143		



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

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FORM APPROVED
OMB NO 0938-0391

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K 143	<p>Continued From page 4</p> <p>wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association 8.6.2.5.2</p> <p>This STANDARD is not met as evidenced by. Based on observation and interview, it was determined the facility failed to ensure the oxygen storage room was protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility has ninety-two (92) certified beds and the census was eighty (80) on the day of the survey. The facility failed to ensure the room used for transferring oxygen did not have any electrical devices mounted less than five (5) feet above the floor.</p> <p>The findings include:</p> <p>Observation, on 06/19/13 at 12:50 PM, with the</p>	K 143	<p>K143</p> <ol style="list-style-type: none"> On 6/19/13, 7/8/13 and 7/9/13, the Maintenance Director contacted Dave Stout and Scott Traud, Electrician(s) to schedule a time to move the outlet in the oxygen room to ensure that it is located a minimum of 5 feet above the floor. Due to non-response from the Electrician(s); on 7/10/13, the Maintenance Director re-installed the outlet to ensure that it is located a minimum of 5 feet above the floor. On 6/19/13, the Maintenance Director inspected the oxygen room to identify all outlet(s) that are not at least 5 feet above the floor to ensure that he moves all outlet(s) requiring relocation to comply with the regulation. As of 7/10/13, all outlets in the oxygen room are a minimum of 5 feet above the floor. On 7/10/13, the Maintenance Director moved the outlet in the oxygen room from it's current location to comply with the requirement to be 5 feet above the floor. On 6/19/13, the Maintenance Director in-serviced all Maintenance staff to ensure that they understand that oxygen is transferred in the oxygen room, therefore the outlet(s) in the oxygen room must be at least 5 feet above the floor. Oxygen is not transferred in any additional areas within Christian Health Center West. <p style="text-align: right;">7/11/13</p>

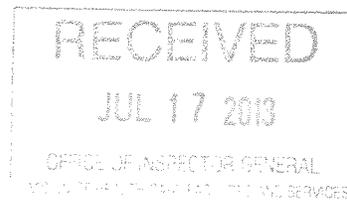


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K 143	Continued From page 4 wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the oxygen storage room was protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility has ninety-two (92) certified beds and the census was eighty (80) on the day of the survey. The facility failed to ensure the room used for transferring oxygen did not have any electrical devices mounted less than five (5) feet above the floor. The findings include: Observation, on 06/19/13 at 12:50 PM, with the	K 143	K143 1. On 6/19/13, 7/8/13 and 7/9/13, the Maintenance Director contacted Dave Stout and Scott Traud, Electrician(s) to schedule a time to move the outlet in the oxygen room to ensure that it is located a minimum of 5 feet above the floor. Due to non-response from the Electrician(s); on 7/10/13, the Maintenance Director re-installed the outlet to ensure that it is located a minimum of 5 feet above the floor. 2. On 6/19/13, the Maintenance Director inspected the oxygen room to identify all outlet(s) that are not at least 5 feet above the floor to ensure that he moves all outlet(s) requiring relocation to comply with the regulation. As of 7/10/13, all outlets in the oxygen room are a minimum of 5 feet above the floor. 3. On 7/10/13, the Maintenance Director moved the outlet in the oxygen room from its current location to comply with the requirement to be 5 feet above the floor. On 6/19/13, the Maintenance Director in-serviced all Maintenance staff to ensure that they understand that if oxygen is transferred in any area, the outlets in the room must be at least 5 feet above the floor.	7/11/13
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K 143 Continued From page 5

Maintenance Director revealed the storage room used to transfer oxygen had one (1) duplex receptacle installed below five (5) feet from the floor

Interview, on 06/19/13 at 12:50 PM, with the Maintenance Director revealed he was unaware the duplex receptacle could not be below five feet from the floor if the storage room was used to transfer oxygen.

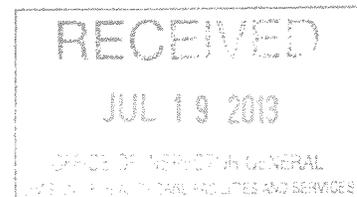
Reference:
NFPA 99 (1999 edition).

4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement).
(a) * Nonflammable Gases (Any Quantity; In-Storage, Connected, or Both)
1. Sources of heat in storage locations shall be protected or located so that cylinders or compressed gases shall not be heated to the activation point of integral safety devices. In no case shall the temperature of the cylinders exceed 130°F (54°C). Care shall be exercised when handling cylinders that have been exposed to freezing temperatures or containers that contain cryogenic liquids to prevent injury to the skin.
2. * Enclosures shall be provided for supply systems cylinder storage or manifold locations for oxidizing agents such as oxygen and nitrous oxide. Such enclosures shall be constructed of an assembly of building materials with a fire-resistive rating of at least 1 hour and shall not communicate directly with anesthetizing locations.

K 143 4. The Maintenance Director will audit the oxygen room 1 x monthly x 6 months to ensure that the duplex receptacle in the oxygen room is at least 5 feet above the floor. The Maintenance Director will report the results of these audits to the QA committee monthly for further review and recommendation.

5. All corrective measures were completed by 7/11/13.

7/11/13



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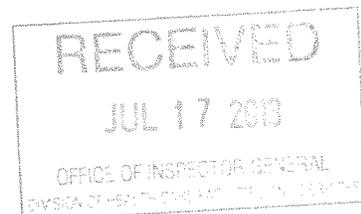
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K 143	<p>Continued From page 5</p> <p>Maintenance Director revealed the storage room used to transfer oxygen had one (1) duplex receptacle installed below five (5) feet from the floor.</p> <p>Interview, on 06/19/13 at 12:50 PM, with the Maintenance Director revealed he was unaware the duplex receptacle could not be below five feet from the floor if the storage room was used to transfer oxygen.</p> <p>Reference: NFPA 99 (1999 edition).</p> <p>4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement). (a) * Nonflammable Gases (Any Quantity; In-Storage, Connected, or Both) 1. Sources of heat in storage locations shall be protected or located so that cylinders or compressed gases shall not be heated to the activation point of integral safety devices. In no case shall the temperature of the cylinders exceed 130°F (54°C). Care shall be exercised when handling cylinders that have been exposed to freezing temperatures or containers that contain cryogenic liquids to prevent injury to the skin. 2. * Enclosures shall be p for supply systems cylinder storage or manifold locations for oxidizing agents such as oxygen and nitrous oxide. Such enclosures shall be constructed of an assembly of building materials with a fire-resistive rating of at least 1 hour and shall not communicate directly with anesthetizing locations.</p>	K 143	<p>4. The Maintenance Director will audit the oxygen room 1 x monthly x 6 months to ensure that the outlet(s) in the oxygen room is at least 5 feet above the floor. The Maintenance Director will report the results of these audits to the QA committee monthly for further review and recommendation.</p> <p>5. All corrective measures were completed by 7/11/13.</p>	7/11/13
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K 143	Continued From page 6 Other nonflammable (inert) medical gases may be stored in the enclosure. Flammable gases shall not be stored with oxidizing agents. Storage of full or empty cylinders is permitted. Such enclosures shall serve no other purpose. 3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation. 4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches and receptacles shall be installed in fixed locations not less than 152 cm (5 feet) above the floor as a precaution against their physical damage. 5. Storage locations for oxygen and nitrous oxide shall be kept free of flammable materials [also 4-3.1.1.2(a) 7]. 6. Cylinders containing compressed gases and containers for volatile liquids shall be kept away from radiators, steam piping, and like sources of heat. 7. Combustible materials, such as paper, cardboard, plastics, and fabrics, shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide. Racks for cylinder storage shall be permitted to be of wooden construction. Wrappers shall be removed prior to storage. Exception: Shipping crates or storage cartons for cylinders. 8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use. 9. Containers shall not be stored in a tightly closed space such as a closet [8-2.1.2.3(c)]. 10. Location of Supply Systems.	K 143			

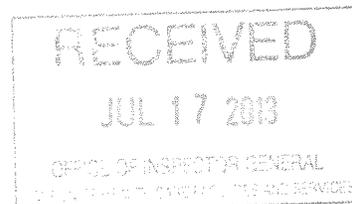


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K 143	<p>Continued From page 7</p> <p>a. Except as permitted by 4-3.1.1.2(a) 10c, supply systems for medical gases or mixtures of these gases having total capacities (connected and in storage) not exceeding the quantities specified in 4-3.1.1.2(b) 1 and 2 shall be located outdoors in an enclosure used only for this purpose or in a room or enclosure used only for this purpose situated within a building used for other purposes.</p> <p>b. Storage facilities that are outside, but adjacent to a building wall, shall be in accordance with NFPA 50, Standard for Bulk Oxygen Systems at Consumer Sites.</p> <p>c. Locations for supply systems shall not be used for storage purposes other than for containers of nonflammable gases. Storage of full or empty containers shall be permitted. Other nonflammable medical gas supply systems or storage locations shall be permitted to be in the same location with oxygen or nitrous oxide or both. However, care shall be taken to provide adequate ventilation to dissipate such other gases in order to prevent the development of oxygen-deficient atmospheres in the event of functioning of cylinder or manifold pressure-relief devices.</p> <p>d. Air compressors and vacuum pumps shall be located separately from cylinder patient gas systems or cylinder storage enclosures. Air compressors shall be installed in a designated mechanical equipment area, adequately ventilated and with required services.</p> <p>a. Walls, floors, ceilings, roofs, doors, interior finish, shelves, racks, and supports of and in the locations cited in 4-3.1.1.2(a) 10a shall be constructed of noncombustible or limited-combustible materials.</p>	K 143		
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K 143	Continued From page 8 b. Locations for supply systems for oxygen, nitrous oxide, or mixtures of these gases shall not communicate with anesthetizing locations or storage locations for flammable anesthetizing agents. c. Enclosures for supply systems shall be provided with doors or gates that can be locked. d. Ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than 5ft (1.5 m) above the floor to avoid physical damage. e. Where enclosures (interior or exterior) for supply systems are located near sources of heat, such as furnaces, incinerators, or boiler rooms, they shall be of construction that protects cylinders from reaching temperatures exceeding 130°F (54°C). Open electrical conductors and transformers shall not be located in close proximity to enclosures. Such enclosures shall not be located adjacent to storage tanks for flammable or combustible liquids. f. Smoking shall be prohibited in supply system enclosures.	K 143			

