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

PRINTED: 02/25/2015
FORM APPROVED
OMB NO. 0938-0391

RECEIVED APR 2015 OFFICE OF GENERAL INSPECTOR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185142		02/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR HEALTH CARE CENTER	401 INDIANA AVE MAYFIELD, KY 42066

(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 A Recertification Survey was conducted on 02/10/15 through 02/12/15 with deficiencies cited at the highest Scope and Severity of a "D".	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *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 provisions of federal and state law.*	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined the facility failed to promote care for one (1) of fifteen (15) sampled residents (Resident #1), in a manner and in an environment that maintains or enhances a resident's dignity and respect by ensuring a dignity bag cover was on Resident #1's urinary catheter during transport throughout the facility. The findings include: Review of the facility's policy titled, Quality of Life, dated 04/20/12, revealed the facility refrains from practices demeaning to residents such as keeping urinary catheter bags uncovered. Record review revealed the facility admitted Resident #1 on 02/04/10 with diagnoses which included Urinary Retention status post suprapubic catheter placement. Review of the admissions Minimum Data Set	F 241	F 241 All residents have the potential to be affected by a failure to promote care in an environment that enhances dignity and respect. A dignity cover was placed on Resident #1's catheter bag on 2/10/2015 by LPN Charge Nurse. Other resident's having a catheter were reviewed by the RN Unit Manager and Director of Nursing Services on 2/10/2015 to ensure that a dignity bag was in place. No issues were noted. Education was initiated to all nursing staff by the Staff Development Coordinator on 02/10/2015 regarding the use of dignity bags. Residents having catheters will be reviewed by the RN Unit Manager 3 times weekly for one month thereafter, then 2 times weekly for one month, then weekly for one month to ensure that dignity bags are in place.	03/10/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 4/3/15

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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F 241	Continued From page 1 (MDS) assessment, dated 05/30/14, revealed the facility assessed Resident #1's cognition as cognitively intact with a Brief interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable. Observation of Resident #1, on 02/11/15 at 9:35 AM and 10:00 AM, revealed a urinary catheter bag viewable from hallway without a dignity bag cover. Interview with Certified Nurse Aide (CNA) #2, on 02/11/15 at 2:00 PM, revealed the facility uses a dignity bag to cover urinary catheters. CNA #2 stated she usually placed catheter bags inside a dignity bag and secured the bag on the side of the bed away from the hallway. CNA #2 stated she forgot to place the catheter bag inside the dignity bag. Interview with CNA #1, on 02/11/15 at 1:55 PM, revealed urinary catheter bags should always be inside a dignity cover. Interview with the Director of Nursing Services (DON), on 02/10/15 at 11:40 AM, revealed urinary catheter bags should be placed in a dignity bag and secured on the side of the bed away from the hallway.	F 241	*This Plan of Correction is the center's credible allegation of compliance.* *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 provisions of federal and state law.* The Performance Improvement Committee, which consists of but is not limited to, Executive Director, Director of Nursing, Medical Director, RN Unit Manager, RN Staff Development Coordinator,Social Services Director, Activity Director, Rehab Director, Dietary Manager, Maintenance Director, and Environmental Services, will review the findings monthly for 3 months, and address any concerns with counseling and / or education. The Divisional Vice President and District Director of Operations will review any concerns from the QAPI committee.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246	F 246 All residents have the potential to be affected by failure to provide reasonable accommodations of individual needs and preferences. Resident #5's call light was placed within reach, and an audit was initiated by the Executive Director on 02/11/15. All resident rooms were reviewed to ensure that the call lights were within reach. Any identified concerns were resolved. Education to all staff was initiated by the Staff Development Coordinator on 02/11/2015.	3/10/15

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F 246	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the resident call system in resident rooms was readily available for one (1) of fifteen (15) sampled residents (Resident #5), related to Resident #5 unable to locate resident call light. The findings include: Review of the facility ' s policy titled, "Call Light, Use Of " , dated 09/26/03, revealed the resident call light should be positioned within reach of the resident. Record review revealed the facility admitted Resident #5 on 08/30/12 with diagnoses which included Congestive Heart Failure, Airway Obstruction, Senile Delusion, Abnormal Electrocardiogram, Convulsions, and Anxiety State. Review of the admissions Minimum Data Set (MDS) assessment, dated 11/24/14, revealed the facility assessed Resident #5's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of three (03) indicating the resident was not interviewable. Observation, on 02/10/15 at 9:50 AM, revealed Resident #5's call light was wrapped around the side rail near the wall with the call light button hanging toward the floor between the bed and the wall.	F 246	*This Plan of Correction is the center's credible allegation of compliance.* *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 provisions of federal and state law.* The RN unit Manager will review resident rooms 3 times weekly for one month thereafter, then 2 times weekly for one month, then weekly for one month to ensure that the call lights are within reach. Any identified concerns will be addressed with staff members as needed. The Performance Improvement Committee, which consists of but is not limited to, Executive Director, Director of Nursing, Medical Director, RN Unit Manager, RN Staff Development Coordinator, Social Services Director, Activity Director, Rehab Director, Dietary Manager, Maintenance Director, and Environmental Services will review findings for three months as needed. The Divisional Vice President and the District Director of Clinical Operations will review any concerns identified by the QAPI committee.	

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F 246	Continued From page 3 Observation of Resident #5, on 02/10/15 at 9:55 AM, revealed he/she was in the wheelchair in her/his room, and was unable to reach the call light. Observation, on 02/10/15 at 10:20 AM, revealed Certified Nurse Aide (CNA) #1 asked Resident #5 to press the call light button and Resident #5 replied, "I do not know where it is". Interview, on 02/10/15 at 10:30 AM with CNA #1, revealed Resident #5 would press the call light button when he/she was in bed. CNA #1 stated the call light always stays on the side rail near the wall. CNA #1 revealed the call light should be within reach at all times. Interview, on 02/10/15 at 10:40 AM with the Nurse Unit Manager, revealed staff should ensure call lights are within residents' reach at all times. Interview, on 02/10/15 at 11:30 AM with the Director of Nursing (DON), revealed she expected call lights to be within residents' reach at all times.	F 246		
F 441 SS=D	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			

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F 441	Continued From page 4 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens 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, record review and review of facility policy and procedure, it was determined the facility failed to 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 for one (1) of fifteen (15) sampled residents (Resident #1) and two (2) unsampled residents (Resident A and	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *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 provisions of federal and state law.* F441 All residents have the potential to be affected by an environment that fails to be maintained as safe, sanitary, and comfortable. LPN #1 was provided education by the Staff Development Coordinator on 2/12/2015 regarding proper infection control practices during medication administration. All licensed staff were educated regarding infection control during medication administration on 02/26/2015 by the Staff Development Coordinator and the Director of Nursing Services. New hires will receive the same education during the orientation process. Resident #1 had a new catheter bag implemented on 02/11/2015 by a licensed staff member. All other residents having catheters had the bags replaced on 02/11/2015 by a licensed staff member. The attached Infection Control Rounds tool will be completed by the Staff Development Coordinator or RN Unit Manager 3 times weekly for one month beginning 3/6/15, then 2 times weekly for one month, and weekly for one month to ensure compliance.	3/10/15

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F 441	Continued From page 5 Resident B). During a medication pass, the Licensed Practical Nurse (LPN) dropped medications on top of the medication cart for Resident A and Resident B and placed them back in the medication cup with other medications to be administered. In addition, Resident #1's urinary catheter bag was touching the floor. The findings include: Review of the facility policy and procedure, titled "Infection Prevention and Control Program", dated 11/2006, revealed an infection prevention and control program was implemented to identify and reduce the risk of acquiring and transmitting infections among residents and staff. It is maintained to provide a safe, sanitary, and comfortable environment that involves each department. 1. Record review revealed the facility admitted Unsampled Resident A, on 09/28/12, with diagnoses which included Hyperlipidemia, Unspecified Deficiency Anemia, Acute Cerebrovascular Disease, and Hypertension. Review of Resident A's Physician's orders, dated 02/06/15, revealed the following medications were ordered: Lovastatin 20 milligrams (mgs) (cholesterol), Toprol XL 25 mgs, Toprol XL 50 mg (blood pressure), Namenda XR 28 mgs (dementia), Niacin 250 mgs (supplement), Zyprexa 7.5 mgs (antipsychotic), Prilosec 20 mgs (acid reflux), Miralax 17 grams (gms) (laxative); Proair HFA 90 microgram (mcg) Inhaler 1 puff (respiratory), Propranolol 10 mgs (blood pressure), Spiriva 18 mcg Inhaler 1 capsule (respiratory), Flomax 0.4 mgs (prostate), Theophylline ER 200 mgs (respiratory) and	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *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 provisions of federal and state law.* The PI committee will review these tools monthly until substantial compliance is maintained. Any identified concerns will be addressed with education and / or counseling. The Performance Improvement Committee, which consists of but is not limited to, Executive Director, Director of Nursing, Medical Director, RN Unit Manager, RN Staff Development Coordinator, Social Services Director, Activity Director, Rehab Director, Dietary Manager, Maintenance Director, and Environmental Services will review findings for three months as needed. The Divisional Vice President and District Director of Clinical Operations will review any concerns identified by the QAPI committee.	

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F 441	Continued From page 6 Trazadone 50 mgs (antidepressant). 2. Record review revealed the facility admitted Unsampled Resident B, on 07/09/12, with diagnoses which included, Osteoarthrosis, Chronic Airway Obstruction, Unspecified Labyrinthitis, Paroxysmal Supraventricular Tachycardia, and Hypertension. Review of Unsampled Resident B's Physician's orders, dated 01/28/15, revealed the following medications were ordered: Burnex 10 mgs (diuretic), Lopid 600 mgs (hyperlipidemia), Midrin 10 mgs (low blood pressure), Namenda XR 28 mgs (dementia), Prilosec 20 mgs (acid reflux), Evista 60 mgs (osteoporosis), Vitamin D 3 5000 Units (osteoporosis), Xarelto 10 mgs (fast heart beat), and Tylenol 325 mgs two (2) tablets (pain). Observation of a medication pass, on 02/11/15 at 8:35 AM, revealed LPN #1 administered medication to Unsampled Resident A and during the preparation of the medications she dropped two (2) of the medications on top of the medication cart and proceeded to pick them up and place them back in the medication cup to be administered. Further observation revealed when LPN #1 administered Unsampled Resident B's medication she dropped one (1) of the medications on top of the medication cart. Interview with LPN #1, on 02/11/15 at 8:45 AM, revealed she would not usually use any medications that may have been contaminated and she was not sure why she was going to on this date. She revealed she would normally destroy the pills and prepare new ones to be given. She acknowledged that dropping the medication on top of the cart and proceeding to	F 441		

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F 441	Continued From page 7 use them could be an infection control issue. Interview with the Director of Nursing and Registered Nurse (RN) #1, on 02/12/15 at 2:56 PM, revealed they would expect the nurse to destroy the contaminated medications and pull new ones to be given. They stated any medication that touches anything except the medication cup should be placed in a sharps container for destroying because that would be an infection control issue. 3. Review of the facility's policy titled, Indwelling Catheters, dated 08/31/12, revealed documentation to include, interventions should be in place to reduce the likelihood of an infection. Record review revealed the facility admitted Resident #1 on 02/04/10 with diagnoses which included Urinary Retention status post suprapubic catheter placement. Observation of Resident #1, on 02/11/15 at 9:35 AM and 10:00 AM, revealed a urinary catheter bag touching the floor. Interview with Certified Nurse Aide (CNA) #1, on 02/11/15 at 1:55 PM, revealed a urinary catheter bag should never drag the floor. CNA #1 stated she was nervous and forgot to hang the urinary catheter so the bag was not touching the floor. Interview with CNA #2, on 02/11/15 at 2:00 PM, revealed a urinary catheter bag should never touch the floor. CNA #2 stated she was unsure why the urinary bag was left touching the floor. Interview with the Director of Nursing (DON), on 02/11/15, revealed a urinary catheter bag should	F 441		

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F 441	Continued From page 8 touch the floor.	F 441		

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	185142	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/10/2015

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1971 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type III (211) SMOKE COMPARTMENTS: Twelve (12) smoke compartments. FIRE ALARM: Complete fire alarm system with (57) smoke 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 02/10/15. The facility was found to be in compliance with the requirements for participation in Medicare and Medicaid. The facility has the capacity for one-hundred (100) beds and at the time of the survey, the census was seventy-three (73). The findings that follow demonstrate non-compliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000	RECEIVED APR 2015 OFFICE OF INSPECTOR GENERAL	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 4/3/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1	K 000	*This Plan of Correction is the center's credible allegation of compliance.* *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 provisions of federal and state law.*	
	Deficiencies were cited with the highest deficiency identified at "F" level.			
K 025 SS=E	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 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 observation 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 National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect eight (8) of twelve (12) smoke compartments, fifty-four (54) residents, staff and visitors. The facility has the capacity for one-hundred (100) beds and at the time of the survey, the census was seventy-three (73). The findings include: 1. Observation, on 02/10/15 at 1:50 PM, with the Maintenance Director and the Executive Director revealed a three (3) inch by three (3)	K 025	K 025 All residents have the potential to be affected when the facility fails to maintain smoke barriers that would resist the passage of smoke between smoke compartments. The Maintenance Director has identified and initiated repair on the 8 affected areas of the facility using materials that meet the fire resistance rating of not less than ½ hour. All work was completed 03/06/15 by the Maintenance Director. The Maintenance Director did house wide assessment of all smoke barriers 02/16/2015 repairs were completed by 03/06/2015. Facility Maintenance Director will monitor fire smoke walls with ¼ PM program to insure compliance with regulations. The Performance Improvement Committee which consists of but is not limited to Executive Director, Director of Nursing, Medical Director, Social Services Director, Activity Director, Rehab Director, Maintenance Director will review the maintenance PM logs as needed to assure compliance.	03/10/2015

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K 025	Continued From page 2 inch unsealed penetration located in the smoke barrier extending above the ceiling of the Lobby Hall. Interview, on 02/10/15 at 1:51 PM, with the Maintenance Director and the Executive Director revealed they were not aware of the penetration. 2. Observation, on 02/10/15 at 2:00 PM, with the Maintenance Director and the Executive Director revealed an unsealed penetration around a plumbing pipe located in the smoke barrier extending above the ceiling of the 200 Hall by Room #201. Interview, on 02/10/15 at 2:01 PM, with the Maintenance Director and the Executive Director revealed they were not aware of the penetration. 3. Observation, on 02/10/15 at 2:04 PM, with the Maintenance Director and the Executive Director revealed the drywall was missing on one side of the smoke barrier extending above the ceiling in the 200 Hall by the Rehabilitation Department. Interview, on 02/10/15 at 2:05 PM, with the Maintenance Director and the Executive Director revealed they were not aware of the penetration. 4. Observation, on 02/10/15 at 2:50 PM, with the Maintenance Director and the Executive Director revealed unsealed penetrations around pipes located in the smoke barrier extending above the ceiling of the 100 Hall by the Lounge. Interview, on 02/10/15 at 2:51 PM, with the Maintenance Director and the Executive Director revealed they were not aware of the penetrations.	K 025		

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K 025	Continued From page 3 5. Observation, on 02/10/15 at 3:04 PM, with the Maintenance Director and the Executive Director revealed an unsealed penetration around a pipe located in the smoke barrier extending above the ceiling of Room #400. Interview, on 02/10/15 at 3:05 PM, with the Maintenance Director and the Executive Director revealed they were not aware of the penetration. 6. Observation, on 02/10/15 at 3:06 PM, with the Maintenance Director and the Executive Director revealed an unsealed penetration around wires located in the smoke barrier extending above the ceiling of the 400 Hall by the Lounge. Interview, on 02/10/15 at 3:07 PM, with the Maintenance Director and the Executive Director revealed they were not aware of the penetration. The census of seventy-three (73) was verified by the Executive Director on 02/10/15. The findings were acknowledged by the Executive Director and verified by the Maintenance Director at the exit interview on 02/10/15. Actual NFPA Standard: Reference: NFPA 101 (2000 Edition).19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided	K 025		

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K 025	Continued From page 4 on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.	K 025	*This Plan of Correction is the center's credible allegation of compliance.* *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 provisions of federal and state law.*	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 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 the path of egress was free of conflicting signage in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect two (2) of twelve (12) smoke compartments, twenty-six (26) residents, staff and visitors. The facility has the capacity for one-hundred (100) beds and at the time of the survey, the census was seventy-three (73). The findings include: Observation, on 02/10/15 at 3:25 PM, with the	K 038	K 038 All residents have the potential to be affected when the facility fails to ensure a path of egress free of conflicting signage. The Maintenance Director removed the "STOP" sign on the cross corridor of the 100 hall lounge on 02/10/2015. House wide assessment of all other cross corridors were reviewed by the Maintenance Director on 02/10/2015 to ensure that all conflicting signage was removed. The Executive Director reviewed the signage changes during a staff meeting held 02/12/2015. Maintenance Director will monitor hallway egress for conflicting signage on daily PM rounds	3/10/15

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K 038	Continued From page 5 Maintenance Director and the Executive Director revealed a " STOP " sign on the cross corridor door of the 100 Hall by the Lounge. An " EXIT " sign was located directly above the cross corridor doors. Interview, on 02/10/15 at 3:26 PM with the Maintenance Director and the Executive Director confirmed the signage was conflicting. The census of seventy-three (73) was verified by the Executive Director on 02/10/15. The findings were acknowledged by the Executive Director and verified by the Maintenance Director at the exit interview on 02/10/15. Actual NFPA Standard: Reference: NFPA 101 (2000 Edition) 19.2.10 Marking of Means of Egress. 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10. Exception: Where the path of egress travel is obvious, signs shall not be required in one-story buildings with an occupant load of fewer than 30 persons. Reference: NFPA 101 (2000 Edition) 7.10 MARKING OF MEANS OF EGRESS 7.10.1 General. 7.10.1.1 Where Required. Means of egress shall be marked in accordance with Section 7.10 where required in Chapters 11 through 42. 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily	K 038	*This Plan of Correction is the center's credible allegation of compliance.* *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 provisions of federal and state law.* The Performance Improvement Committee which consists of but is not limited to Executive Director, Director of Nursing, Medical Director, Social Services Director, Activity Director, Rehab Director, Maintenance Director, Will review any finding from daily PM rounds and issues and corrected as needed.	

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K 038	Continued From page 6 visible from any direction of exit access.	K 038	*This Plan of Correction is the center's credible allegation of compliance.* *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 provisions of federal and state law.*	
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the facility had a written plan for the protection of all residents and for their evacuation in the event of an emergency, in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect twelve (12) of twelve (12) smoke compartments, all residents, staff and visitors. The facility has the capacity for one-hundred (100) beds and at the time of the survey, the census was seventy-three (73). The findings include: Observation, on 02/10/15 at 3:30 PM, with the Maintenance Director and the Executive Director revealed the facility failed to provide written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge and for their evacuation from the building when necessary. Interview, on 02/10/15 at 3:30 PM, with the Maintenance Director and the Executive Director revealed they were not aware of the requirements.	K 048	K 048 All residents have the potential to be affected when the facility fails to provide a plan of protection in the event of an emergency requiring evacuation from the facility to areas of refuge. Executive Director immediately updated existing floor plans to show evacuation route facility wide 2/10/15. The Emergency evacuation plan was located in the Emergency Response Plan Book maintained at the nurse's station 2/10/15. In the event of an emergency, staff members are to follow the evacuation plan outlined in the Emergency Response Book. Evacuation from affected smoke compartment would be to the next unaffected smoke compartment, the first point of evacuation outside the facility is the back parking lot; in addition, the facility has an agreement with a local church for off site evacuation. A copy of the off site evacuation agreement is located in the Executive Directors Office. Emergency evacuation plans, evacuation drills, fire drills will be reviewed at monthly Safety Meetings, updates and or changes will be reviewed by the PI committee for continued compliance.	3/10/15

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K 048	Continued From page 7 The census of seventy-three (73) was verified by the Executive Director on 02/10/15. The findings were acknowledged by the Executive Director and verified by the Maintenance Director at the exit interview on 02/10/15. Actual NFPA Standard: Reference: NFPA 101 (2000 edition) 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator ' s position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply.	K 048	*This Plan of Correction is the center's credible allegation of compliance.* *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 provisions of federal and state law.*	
K 147 SS=D	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 National Fire Protection Association (NFPA)	K 147	K 147 All residents have the potential to be affected when the facility fails to ensure electrical wiring is maintained in accordance with the NFPA standards. The Maintenance Director repaired the open junction box in the attic above room 400 on 02/13/2015. The Maintenance Director removed the water pump from power strip from the break area on under cabinet02/10/2015	3/10/15

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K 147	Continued From page 8 standards. The deficiency had the potential to affect three (3) of twelve (12) smoke compartments, fifty-six (56) residents, staff and visitors. The facility has the capacity for one-hundred (100) beds and at the time of the survey, the census was seventy-three (73). The findings include: Observation, on 02/10/15 at 3:04 PM, with the Maintenance Director and the Executive Director revealed an open electrical junction box located in the attic above Room #400. Interview, on 02/10/15 at 3:05 PM, with the Maintenance Director and the Executive Director revealed they were not aware of the open junction box in the attic. Observation, on 02/10/15 at 3:35 PM, with the Maintenance Director and the Executive Director revealed a water pump was plugged into a power strip in the sink cabinet located in the Employee Break Room. Interview, on 02/10/15 at 3:36 PM, with the Maintenance Director and the Executive Director revealed they were aware of the power strip; however, they were not aware it was being misused. Observation, on 02/10/15 at 3:50 PM, with the Maintenance Director and the Executive Director revealed a broken receptacle in the wall located in Room #305. Interview, on 02/10/15 at 3:51 PM, with the Maintenance Director and the Executive Director revealed they were not aware of the broken	K 147	*This Plan of Correction is the center's credible allegation of compliance.* *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 provisions of federal and state law.* The Maintenance Director replaced the broken receptacle on wall in room 305 on 02/12/2015. Maintenance Director conducted a house wide assessment of power strips, junction boxes and receptacles 2/13/15. The Maintenance Director will conduct facility rounds on monthly PM checking junction boxes, power strips and receptacles, to insure electrical wiring is maintained in accordance with the NFPA standards. The Performance Improvement Committee which consists of but is not limited to Executive Director, Director of Nursing, Medical Director, Social Services Director, Activity Director, Rehab Director, Maintenance Director, will review the Maintenance PM rounds to ensure that facility repairs are timely, affective and maintain compliance with NFPA standards.	

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K 147	Continued From page 9 receptacle. The census of seventy-three (73) was verified by the Executive Director on 02/10/15. The findings were acknowledged by the Executive Director and verified by the Maintenance Director at the exit interview on 02/10/15. Actual NFPA Standard: Reference: NFPA 101 (2000 Edition) 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. Reference: NFPA 70 (1999 Edition) 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces 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	K 147		

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K 147	Continued From page 10 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. Reference NFPA 70 (1999) edition 370.28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147		