

CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/16/2011 |
| NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF FRANKLIN | | | STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135 | |
| (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 AMENDED A standard health survey was initiated on 06/14/11 and concluded on 06/16/11 with deficiencies cited at the highest scope and severity of an E. A Life Safety Code survey was conducted on 06/14/11 with deficiencies cited at the highest scope and severity of an F. An abbreviated survey was initiated on 06/14/11 and concluded on 06/16/11 investigating KY#00016061. KY# 00016061 was found to be unsubstantiated with a deficiency cited. | F 000 | Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare requirements. | |
| F 252 SS=D | 483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a homelike environment for one (1) unsampled resident in the resident's bedroom. The findings include: The facility did not present a policy regarding providing a homelike environment for the residents. Observation of room 109B, on 06/14/11 at 10:35am, revealed a space devoid of any | F 252 | F252 1. The resident in Room 109B was transferred on 6/15/11 and is no longer a resident of the center. 2. The facility will evaluate all resident rooms for a homelike environment. This evaluation will be completed by the Life Enrichment Director and the Social Services Director by 07/27/2011. Any rooms identified as not having a homelike environment will have decorative items placed by either the family, resident or center with emphasis on resident preference. 3. The department heads assigned to each resident room as a Caring Partner will be educated on assuring a homelike environment by the Administrator by 07/27/2011. The Caring Partner program is a program that assigns a department head to each resident to facilitate communication with all residents and families. 4. The Social Services Director and or the Life Enrichment Director will examine each occupied room weekly for twelve (12) weeks to assure a homelike environment per the resident and/or family preference. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. Completion Date: July 27, 2011 | 7/27/11 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

[Signature]

X Administrator X 07/09/11

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.

RECEIVED
JUL 14 2011
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

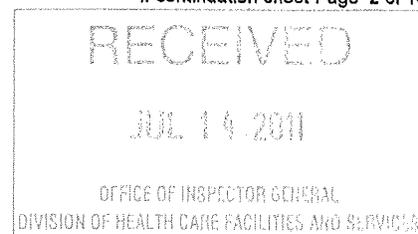
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FORM APPROVED
OMB NO. 0938-0391

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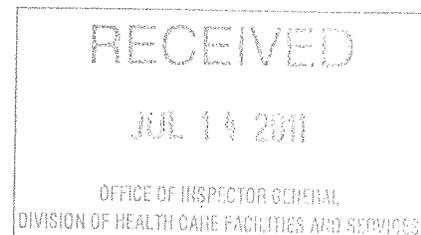
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| NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF FRANKLIN | STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEBY ST. FRANKLIN, KY 42135 |
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| F 252 | <p>Continued From page 1</p> <p>resident's personal belongings or homelike furnishings including no picture on the walls, decorative bedding, or any personal mementos.</p> <p>Interview with Licensed Practical Nurse (LPN) #5 during general tour of the facility on 06/14/11 at 10:45am, revealed the resident in room 109B was out of the facility and in the hospital on that date.</p> <p>Interview with the Social Services Director, on 06/16/11 at 10:25am, revealed she thought 109B looked Institutional. The reason for this was the resident's husband had recently passed away. The resident had been discharged in May 2011, then readmitted, and the resident's family had not brought in the resident's personal belongings. The Social Services Director stated that she and the Activities Director shared the responsibility for making a homelike environment in the residents' rooms but stated she did not have a budget for this. However, the Social Servicers Director did reveal she had some decorative items for residents' rooms that had been donated to the facility.</p> <p>Interview with the Activities Director on 06/16/11 at 10:30am revealed she did not have the responsibility to provide a homellke environment for the residents.</p> <p>Interview with the Administrator, on 06/16/11 at 5:00pm, revealed the reason 109B was devoid of a homelike environment was the resident had been discharged and readmitted in May 2011, the family had taken the personal items home, and the family had not had an opportunity to return the personal items.</p> | F 252 | | |
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| F 253 SS=E | <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain resident equipment, specifically six (6) wheelchairs and four (4) sets of toilet grab bars, in good repair.</p> <p>The findings include:</p> <p>Observation of eight resident rooms (Room 108 through Room 117) on 06/14/11 at 10:25am revealed two (2) resident wheelchairs with rusted metal armrests exposed and three (3) sets of toilet handrails loose.</p> <p>Observation on 06/15/11 from 9:00am to 10:00am revealed Room 116 with a wheelchair with frayed armrests exposing the foam underlayment and with sharp edges of the armrests exposed. Room 141 observation revealed a wheelchair with a loose backrest and duct tape covering the back of the chair, observation of Room 142 revealed two (2) loose toilet handrails, observation of Room 213 revealed a wheelchair with both armrests frayed with foam underlayment exposed, and observation of Room 226 revealed a wheelchair with one armrest frayed and the foam underlayment exposed.</p> | F 253 | <p>F253</p> <p>1.The wheelchairs in Rooms #116, #141, #213, and #226 were repaired, or had their armrests replaced by the Maintenance Director on 06/27/2011 and 06/28/2011. The toilet handrails in Room #142, and those which were in Rooms #108 - #117, have been tightened down or replaced by the Maintenance Director by 07/27/2011.</p> <p>2. The maintenance director has completed a 100% inventory of wheelchairs in the building to identify any in need of repair. Any identified as needing repair will be repaired or replaced by 07/27/2011. A 100% audit of toilet handrails will be completed by the Maintenance Director by 07/27/2011 to identify any loose toilet handrails. Any identified as being loose will be secured by 07/27/2011.</p> <p>3.The Maintenance Director will be re-educated by the Administrator by 07/27/2011 regarding completing a monthly wheel chair check to assure any needing repairs are repaired as well as a monthly check of bathroom handrails to assure all are secure.</p> <p>4.The Administrator will validate the results of the monthly bathroom handrail and wheel chair audits by conducting monthly audits for three (3) months of twenty (20) wheelchairs and twenty (20) bathroom handrails to assure all necessary repairs have been made and bathroom handrails are secure. The results of the wheelchair and bathroom handrail audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.</p> <p>Completion Date: July 27, 2011</p> | 7/27/11 | |



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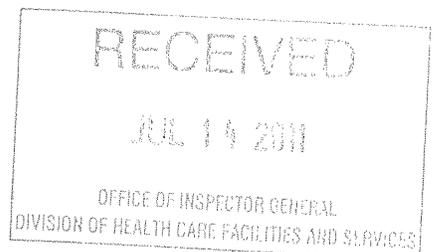
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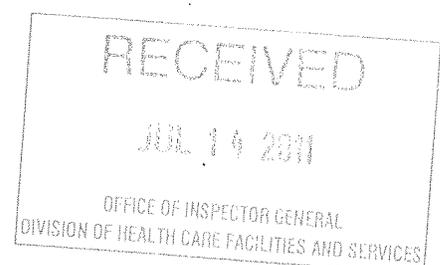
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| F 253 | Continued From page 3 Interview with Certified Nursing Assistant (CNA) #4, on 06/15/11 at 5:15pm, revealed she was aware of her responsibility to complete a maintenance work order for resident equipment in disrepair, however, CNA #4 stated sometimes it slipped her mind to do so. Interview with the Maintenance Director on 06/16/11 at 10:25am revealed the process for maintenance of resident equipment was for any staff to complete a work order to the maintenance department and when the work was completed the Administrator received a copy of the completed work order. He stated he did not have a system in place to routinely monitor resident equipment for maintenance needs and that he was unaware the loose toilet grab bars were unsafe. He also stated he could see that the loose grab bars would be a resident safety concern. Interview with the Administrator, on 06/16/11 at 10:45am, revealed he was aware of problems with the Maintenance Department when he went to the facility six (6) months ago and that was why he hired a new Maintenance Director. He was not aware of the number of wheelchairs in need of repair and he also stated he was not aware of the safety concerns with loose toilet grab bars. | F 263 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced | F 281 | | |



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| F 281 | <p>Continued From page 4</p> <p>by: Based on record review, and interview, it was determined the facility failed to follow a physician's order to collect a stool specimen for Clostridium Difficile for one (1) of nineteen (19) sampled residents, Resident #9.</p> <p>The findings include:</p> <p>Record review for Resident #9 revealed the resident was admitted to the facility on 04/15/11 with diagnoses of Diabetes Mellitus Type 2, Hypertension, and Hyperlipidemia. Review of physician orders for May 2011 revealed collection of a stool specimen was ordered on 05/18/11 with no laboratory results of that specimen in Resident #9's record.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 06/15/11 at 12:00pm, revealed "I hope it (the physician order) has not fallen through the cracks" and after checking with the laboratory for results of a stool specimen she stated "I guess it just was not done and I hate when this happens".</p> <p>Interview with the Director of Nursing (DON), on 06/16/11 at 3:20pm, revealed the nurse should have put the physician order for a stool specimen on the Treatment Administration Record for Resident #9 and completed a laboratory requisition. However, she stated it appeared this was not done. The DON stated the Nurse Manager should have checked that the order was transcribed correctly and then followed up on the laboratory results. She also stated she had a new Assistant Director of Nursing and this staff person would follow up on physician orders in the future. She stated the physician order was not</p> | F 281 | <p>F281</p> <p>1. The stool specimen for resident # 9 was negative for clostridium difficile and reported to the physician on 06/27/11.</p> <p>2. The facility has completed a 100% audit of all labs ordered in the past 60 days for all current residents at the facility to assure all ordered labs were completed. No concerns were identified. This audit was completed by the ADON on 06/16/2011.</p> <p>3. All licensed staff will be re-educated on the lab process for transcription of lab orders by the ETD(Education and Training Director), or DON or ADON. This education will be completed by 07/27/2011.</p> <p>4. The Director of Nursing or the Assistant Director of Nursing will audit ten (10) lab orders per week for twelve (12) weeks to assure all orders for labs were completed as ordered. The results of these audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.</p> <p>Completion Date: July 27, 2011</p> | 7/27/11 | |



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| F 281 | Continued From page 5 followed and it should have been. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to follow a restorative plan of care for one (1) of nineteen (19) sampled residents, Resident #4, who was to be up in the chair four (4) hours per day, seven days per week. The findings include: The facility did not produce a practice or policy regarding following a restorative plan of care. Observation of Resident #4 on 06/14/11 at 10:30am revealed the resident lying supine in his/her bed with eyes closed and even respirations. Observation of Resident #4 on 06/14/11 at 3:30pm revealed the resident lying on his/her right side in the bed. Record review for Resident #4 revealed an admission date of 05/10/06 with diagnoses of Mental Retardation, Senile Dementia, and a Left Above Knee Amputation due to complications of Diabetes Mellitus Type 2. The facility assessed Resident #4 as requiring a restorative nursing program to prevent a decline in range of motion | F 281 | F282 1. An observation by the Director of Nursing on 07/05/2011 noted the restorative plan of care for Resident #4 to be followed. 2. A 100% audit of all restorative careplans for current residents was completed by the Director of Nursing on 07/5/2011 as well as observation of all current restorative programs to assure the restorative plan of care was being followed. No concerns were identified. 3. The Restorative Aids will be re-educated by the Director of Nursing or Assistant Director of Nursing on following the restorative plan of care. This re-education will be completed by 07/27/11. 4. The Director of Nursing or the Assistant Director of Nursing will observe ten (10) restorative program per week for twelve (12) to assure restorative plans of care are being followed. The results of these observations will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. Completion Date: July 27, 2011 | | |
| F 282 SS=D | | | | | 7/27/11 |



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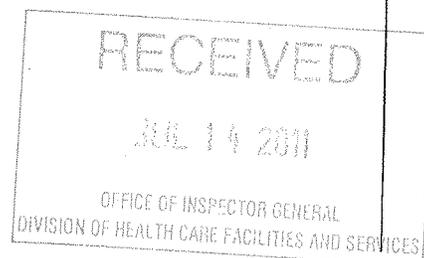
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| F 282 | <p>Continued From page 6</p> <p>on 08/10 and included this on the resident's Comprehensive Care Plan Review Summary. Review of Resident #4's Restorative Program History Report (dated 08/27/10) revealed "2. res will maintain current ROM thru next review by wearing B. knee splints when up in chair 4 hours per day 7 days a week. . .". Review of the Compressed ADL Report for Resident #4 , which documented the resident's transfer out of bed, revealed Resident #4 was gotten out of the bed six (6) times from 06/02/11 through 06/14/11. This document did not state how long Resident #4 was up when out of the bed on those six (6) occasions. CNA #5 stated Resident #4 was gotten out of the bed on night shift but only for the shower and then put back to bed.</p> <p>Interview with Certified Nursing Assistant (CNA) #5, on 06/14/11 at 11:00am, revealed Resident #4 was rarely gotten up in the Geri-chair for four (4) hours per day, she stated Resident #4 would not be gotten up in the Geri-chair on 06/14/11, and she stated it was not documented on the CNA care plan to do so.</p> <p>Observation of Resident #4, on 06/15/11 at 8:30am, 9:00am, 10:00am, 11:00am, and 12:00pm revealed the resident continued lying in the bed.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 06/15/11 at 1:00pm, revealed Resident #4 was not usually gotten up out of the bed on day shift and it was not on the CNA care plan for the resident to do so. She stated Resident #4 was on the restorative nursing program but she did not know she was to get out of the bed for four (4) hours daily.</p> | F 282 | | |
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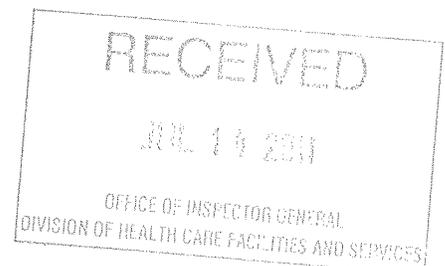
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| F 282 | Continued From page 7 Interview with CNA #4, on 06/15/11 at 5:15pm, revealed Resident #4 was usually not gotten up on evening shift and to her knowledge the only time the resident was gotten up was during night shift for the shower. Interview with the Director of Nursing, on 06/15/11 at 5:20pm, revealed most of the facility residents were gotten up out of the bed daily. She stated there was no reason Resident #4 was not gotten up daily and she did not know why she was not gotten up. | F 282 | | |
| 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, interview, record review and review of the facility's Dining Procedures policy, it was determined the facility failed to distribute and serve food under sanitary conditions. On two occasions one (1) Certified Nursing Assistant (CNA) and a Restorative Aid were observed touching food with bare hands. The findings include: | F 371 | F371 1. An observation by the Director of Nursing during meal service on 07/07/11 noted infection control practices to be properly followed. 2. An observation by the Director of Nursing during meal service on 07/08/11 noted infection control practices to be properly followed. 3. All direct care staff will be re-educated on infection control policy for during meal service. This re-education will be completed by the ETD, DON or ADON by 7/27/11. 4. The Director of Nursing, the Assistant Director of Nursing, or the Education and Training Director will observe meal service five (5) times per week for three (3) weeks, followed by three (3) times per week for three (3) weeks then weekly for six (6) weeks to assure meal service follow proper infection control practices. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. Completion Date: July 27, 2011 | 7/27/11 |



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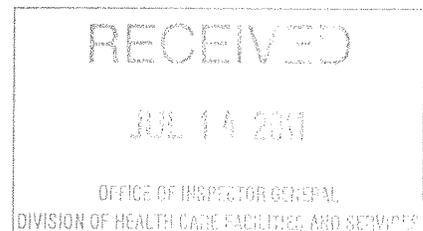
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/16/2011 |
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| NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF FRANKLIN | STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEEY ST. FRANKLIN, KY 42135 |
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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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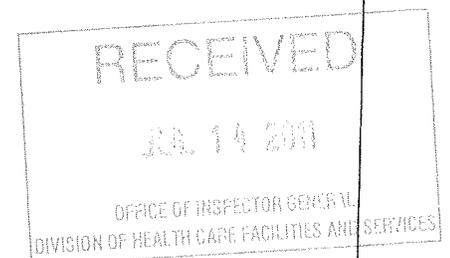
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| F 371 | <p>Continued From page 8</p> <p>Review of the Dining Procedures Policy revealed all staff were to avoid touching food with bare hands.</p> <p>Observation of the lunch tray pass, on 06/14/11 at 11:25am, revealed CNA #3 assisted a resident up out bed, from a lying position to a sitting position without gloves on and without washing her hands before assisting the resident with a meal tray. CNA #3 cut a biscuit on the resident's tray with a knife and fork touching the biscuit with bare hands. CNA #3 then picked up the biscuit halves with her bare hands, scooped up pureed chicken onto the biscuit halves, and placed the biscuit sandwich into the resident's hands.</p> <p>Observation of lunch in the Restorative Dining area, on 06/15/11 at 12:30pm, revealed a Restorative Aid, CNA #1, breaking up bread for a resident with bare hands and then feeding the bread to the resident.</p> <p>Interview with the Restorative Aide, CNA #1, on 06/15/11 at 12:50pm, revealed she was instructed on infection control and she was aware that she picked up the bread with her bare hands. CNA #1 further stated she should have cut the bread with a knife and fork and not touched the bread with her bare hands.</p> <p>Interview with CNA #3, on 06/16/11 at 9:20am, revealed she was taught to not touch food with bare hands and she recognized that she had touched the residents food after she passed the biscuit to the resident. CNA #3 further stated if you touch a resident's food you can spread germs and bacteria onto the food.</p> | F 371 | | |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| F 371 | Continued From page 9 Interview with the Unit Manager, on 06/16/11 at 1:20pm, revealed that if staff are going to actually put their hands on food they need to be wearing gloves. Interview with the Assistant Director of Nursing (ADON), on 06/16/11 at 1:55pm, revealed staff are not to touch resident food with their bare hands. The ADON further stated if staff are touching a resident's food, an infection control issue can occur, for example, the spread of Clostridium Difficile (a bacteria found on surfaces such as bedpans, toilet seats, linens and telephones which causes diarrhea, nausea, and cramping). | F 371 | | | |



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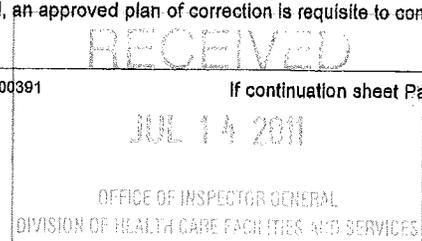
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| K 000 | INITIAL COMMENTS A Life Safety Code Survey was initiated and concluded on 06/14/2011. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F". | K 000 | Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare requirements. | |
| K 018 SS=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 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, according to NFPA | K 018 | <p>K018</p> <ol style="list-style-type: none"> Room 212 door will be repaired or replaced by 7-27-2011 to ensure that the door resists the passage of smoke. Room 113 door will have the latch adjusted to make sure it latches properly by 7-27-2011. Room 134 door was observed by the Administrator to not be propped open on 07-08-11, and Room 132 door has had the privacy curtain corrected so that it will close properly by 07-27-2011. The facility's Maintenance Director will audit all other facility doors to insure they resist the passage of smoke, latch properly, and have no impediments to closure. Any identified concerns will be corrected by 7-27-2011. The Administrator will re-educate the Maintenance Director related to assuring facility doors meet the standards to resist the passage of smoke, latch properly and have no impediments to closure. This education will be provided by 7-27-2011. The Maintenance Director will audit all facility doors monthly for three (3) months to assure all doors meet the standards to resist the passage of smoke, latch properly and have no impediments to closure. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. <p>Completion Date: July 27, 2011</p> | 7/27/11 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *07/09/11*

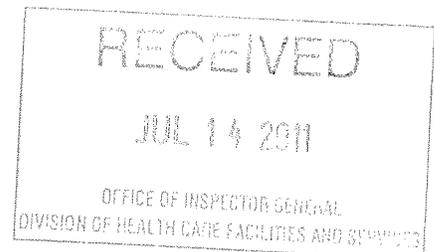
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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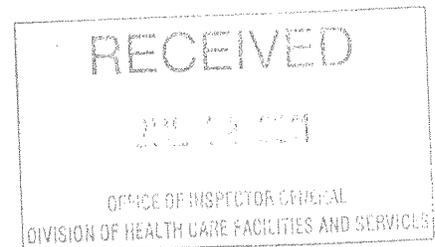
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 06/14/2011 |
| NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF FRANKLIN | | | STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135 | |
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| K 018 | <p>Continued From page 1</p> <p>standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, visitors, and staff. The facility is licensed for ninety eight (98) beds with a census of ninety-one (91) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/14/11 between 10:05 and 3:55 PM, with the Maintenance Director revealed the corridor door to resident room 212 had a gap at the top too large to resist the passage of smoke. The corridor door to resident room 113 did not latch. The corridor door to resident room 134 was held open with a trash can. The corridor door to resident room 132 was blocked from closing by the privacy curtain.</p> <p>Interview, on 06/14/11 between 10:05 AM and 3:55 PM, with the Maintenance Director confirmed all the observations.</p> <p>Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall</p> | K 018 | | |



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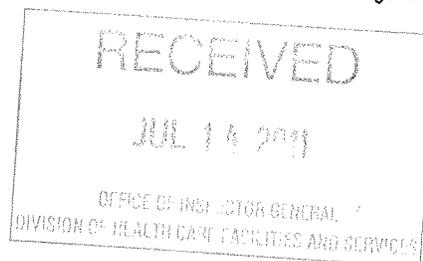
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| K 018 | Continued From page 2 not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service. | K 018 | | | |



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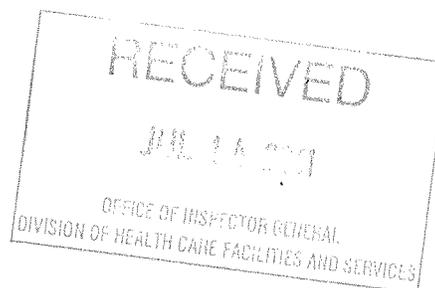
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| K 018 | Continued From page 3 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. | K 018 | | |
| K 025 SS=F | A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches. 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 observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments per NFPA standards. The facility is licensed for ninety eight (98) beds with a census of ninety-one (91) on the day of the survey. The deficiency has the potential to affect all smoke compartments, | K 025 | K025 1. The identified smoke wall penetrations will be repaired by 7-27-2011. 2. The Maintenance Director will audit all smoke barriers to ensure the all smoke barriers have no penetrations and any penetrations are filled with a material equal to the partition. All identified concerns will be repaired by 7-27-2011. 3. The Administrator will re-educate the Maintenance Director related to requirement that all smoke barriers resist the passage of smoke and that any penetrations are filled with a material equal to the partition. This education will be completed by 7-27-2011. 4. The Maintenance Director will audit the smoke wall barriers monthly for three (3) months to ensure that smoke wall barriers remain free from penetrations and that any penetrations are filled with a material equal to the partition. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. Completion Date: July 27, 2011 | 7/27/11 |



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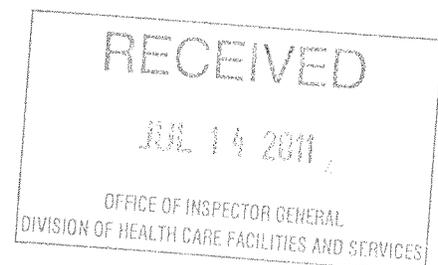
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| K 025 | Continued From page 4 residents, staff and visitors. The findings include: Observation, on 06/14/11 at 3:40 PM, with the Maintenance Director revealed the smoke partitions extended above the ceiling and located throughout the facility were noted to have penetrations by wires and water pipes. The space around the penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. Interview, on 06/14/11 at 3:40 PM, with the Maintenance Director revealed he was unaware of the penetrations in the smoke partitions. Reference: NFPA 101 Life Safety Code (2000 Edition) 8-2.4.4 Penetrations and Miscellaneous Openings in Smoke Partitions. 8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows: (1) The space between the penetrating item and the smoke partition shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. NFPA 101 LIFE SAFETY CODE STANDARD | K 025 | | |
| K 027 SS=F | Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least | K 027 | | |



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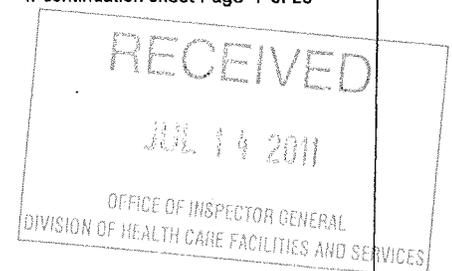
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| K 027 | <p>Continued From page 5</p> <p>1¼-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure access doors in smoke barriers were installed to meet NFPA Standard. The deficiency had the potential to affect all smoke compartments, residents, staff, and visitors. The facility is licensed for ninety eight (98) beds with a census of ninety-one (91) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/14/11 at 3:45 PM, with the Maintenance Director revealed unrated homemade smoke barrier access doors located in the attic.</p> <p>Interview, on 06/14/11 at 3:45 PM, with the Maintenance Director confirmed the observation and indicated he was unaware that the doors in the attic must be rated for use.</p> <p>Reference: NFPA 101 (2000 Edition)</p> | K 027 | <p>K027</p> <ol style="list-style-type: none"> The identified smoke barrier access doors will be replaced by 7-27-2011 with access doors that meet NFPA standards. The Maintenance Director will audit all attic access doors to ensure all access doors meet NFPA standards for smoke barriers. Any identified concerns will be corrected by 7-27-2011. The Administrator will re-educate the Maintenance Director on the requirement that all access doors in smoke barriers be rated to meet NFPA standards. This education will be completed by 7-27-2011. The Maintenance Director will check the smoke barrier access doors monthly for three (3) months to ensure that they are the appropriate smoke barrier doors per NFPA standards. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. <p>Completion Date: July 27, 2011</p> | 7/27/11 |



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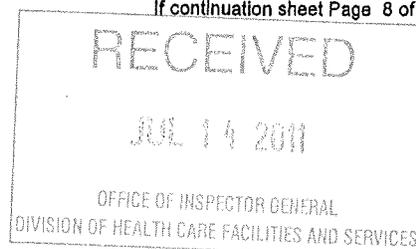
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| K 027 | Continued From page 6 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Continuity 8.3.2 Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. | K 027 | | |
| K 038 SS=F | 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 exit access was maintained, according to NFPA standards. The deficiency had the potential to affect four (4) smoke compartment, residents, staff, and visitors. The facility is licensed for ninety eight (98) beds with a census of ninety-one (91) on the day of the survey. | K 038 | K038 1. The doors with the magnetic locks will have the signs for the 15 minute delay removed from all exit doors by 07-27-11. The exit doors were free of obstructions, as witnessed by the Administrator on 07-07-11. 2. The exit doors were free of obstructions as witnessed by the Administrator on 07-08-11, and the signage of the 15 minute delay on all exit doors will be removed by 07-27-11. 3. The Administrator will re-train all staff on the requirement for keeping the doors free of obstructions in an education training by 07-27-11. The Maintenance Director will be re-educated on the requirements for delayed egress and the posting of the signage per NFPA standards by the Administrator by 7-27-11. 4. The Maintenance Director will audit the facility's exits on a weekly basis for three (3) months to ensure the doors are free of obstructions. The Maintenance Director will also audit the removal of the signage from all exit doors in the facility once a quarter. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. Completion Date: July 27, 2011 | 7/27/11 |



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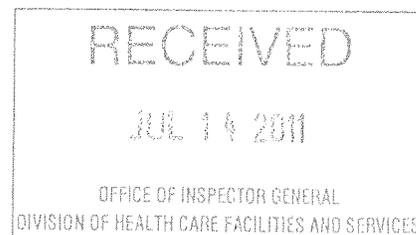
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 06/14/2011 |
| NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF FRANKLIN | | | STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBESY ST. FRANKLIN, KY 42135 | |
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| K 038 | <p>Continued From page 7</p> <p>The findings include:</p> <p>Observation, on 06/14/2011 at 11:24 AM, revealed the exit doors located at the end of each corridor were secured with magnetic locks using a keypad combination. The combination was not posted, and the doors were not equipped with a delayed egress device. The doors had signage stating " Push Door Will Open in 15 Seconds ". The doors will not open in 15 seconds by pushing. They will only open with the key pad combination, or by activation of the fire alarm.</p> <p>Interview on 06/14/2011 at 11:24 AM, with the Maintenance Director revealed the door would release with the combination lock or when the fire alarm was activated. The Maintenance Director confirmed the door was not equipped with a delayed egress device.</p> <p>Observation, on 06/14/11 at 1:47 PM, with the Maintenance Director revealed the Exit door in the rear of the Kitchen to be blocked with a bread rack.</p> <p>Interview, on 06/14/11 at 1:47 PM, with the Maintenance Director confirmed the observation and the rack was moved.</p> <p>NFPA reference: NFPA 101 (2000 edition) 19.2.2.2.4 Doors within a required means of</p> | K 038 | | |



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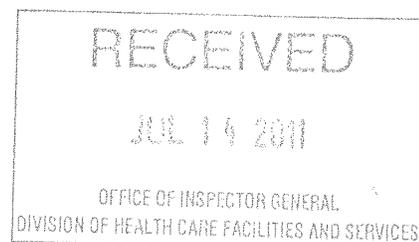
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| K 038 | Continued From page 8 egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2:* Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. Reference: NFPA 101 (2000 edition) 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency | K 038 | | |
| K 062 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the | K 062 | | |



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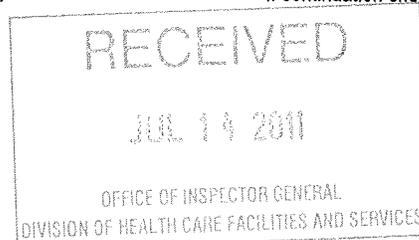
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| K 062 | <p>Continued From page 9 sprinkler system according to NFPA standards. The deficiency had the potential to affect all smoke compartments, residents, staff and visitors. The facility is licensed for ninety eight (98) beds with a census of ninety-one (91) on the day of the survey.</p> <p>The Findings Include:</p> <p>Observation, on 06/14/11 at 12:05 PM, with the Maintenance Director revealed the facility failed to provide a sprinkler head wrench per NFPA requirements.</p> <p>Interview, on 06/14/11 at 12:05 PM, with the Maintenance Director confirmed the observation.</p> <p>Observation, on 06/14/11 at 2:22 PM, with the Maintenance Director revealed blankets being stored within 18 inches of a sprinkler head located in the Hall C Housekeeping closet.</p> <p>Interview, on 06/14/11 at 2:22 PM, with the Maintenance Director revealed he was aware items could not be stored within 18 inches of a sprinkler head, and removed the items.</p> <p>Observation, on 06/14/11 at 2:39 PM, with the Maintenance Director revealed a sprinkler head installed too close to the wall.</p> <p>Interview, on 06/14/11 at 2:39 PM, with the</p> | K 062 | <p>K062</p> <ol style="list-style-type: none"> The facility placed a sprinkler head wrench on 07-01-11, and has removed the items above the 18 inch clearance from the housekeeping closet on 06-17-11. The sprinkler heads will be moved to four inches away from the wall by 07-27-11. The wiring will be removed from the sprinkler piping, and the sprinkler heads in the attic will be cleaned by 07-27-11. The facility's Maintenance Director will audit all sprinkler heads to ensure all sprinkler heads are clean, installed with the proper clearance and have no objects hanging from any sprinkler head as well as all closet/storage areas will be inspected to ensure nothing is stored within eighteen (18) inches of the ceiling. Any identified concerns will be corrected by 7-27-2011. The Administrator will re-educate the Maintenance Director regarding the NFPA requirements for sprinkler heads including, installation clearance, maintenance of sprinkler heads to be free from debris or obstacles as well as the required storage limits of eighteen inch clearance from the ceiling for storage areas. This education will be provided by 7-27-2011. The Maintenance Director will audit all sprinkler heads and storage areas monthly for three (3) months to ensure compliance with clearance, cleanliness and keeping sprinkler heads free of obstacles including clearance from the ceiling. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. <p>Completion Date: July 27, 2011</p> | 7/27/11 |



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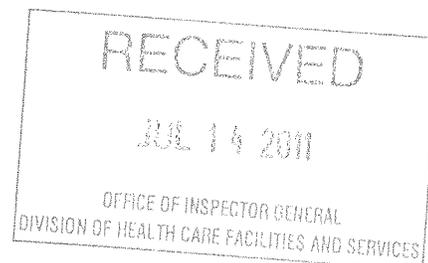
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| K 062 | <p>Continued From page 10 Maintenance Director confirmed the observation.</p> <p>Observation, on 06/14/11 at 3:40 PM, with the Maintenance Director revealed electrical and data wiring hanging from attic sprinkler piping located in the attic above Hall A.</p> <p>Interview, on 06/14/11 at 3:40 PM, with the Maintenance Director confirmed the observation.</p> <p>Observation, on 06/14/11 at 3:55 PM, with the Maintenance Director revealed insulation and dust on sprinkler heads located in the attic above Hall C.</p> <p>Interview, on 06/14/11 at 3:55 PM, with the Maintenance Director confirmed the observation.</p> <p>Reference: NFPA 13 (1999 edition)</p> <p>6.2.9.6 A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. One sprinkler wrench shall be provided for each type of sprinkler installed.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous</p> | K 062 | | |



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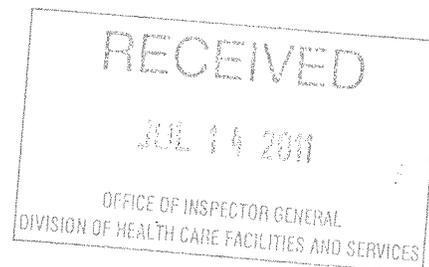
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| K 062 | Continued From page 11 obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2. Reference: NFPA 13 (1999 edition) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall. Reference: NFPA 13(1999 edition) 6-1.1.5 Sprinkler piping or hangers shall not be used to support nonsystem components. Reference: NFPA 25 (1999 Edition). 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. | K 062 | | | |
| K 064 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 | K 064 | | | |



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| K 064 | <p>Continued From page 12</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the installed fire extinguishers. The deficiency had the potential to affect two (2) of four (4) smoke compartments, staff and all residents. The facility is licensed for ninety eight (98) beds with a census of ninety-one (91) the day of survey.</p> <p>Findings include:</p> <p>Observation, on 06/14/11 at 10:22 AM, with the Maintenance Director revealed three extinguishers, identified as new in the year 1999 or 2000. The fire extinguishers did not have any markings of a six year maintenance inspection or test. The extinguishers did not have a "verification of service" collar indicating that the extinguishers had ever been emptied, internally examined, and recharged.</p> <p>Interview, on 06/14/11 at 10:22 AM, with the Maintenance Director revealed the facility was not aware the portable fire extinguishers had not been serviced properly, by their extinguisher service company. The facility called the extinguisher service provider to the facility and he stated he did not know why the service collars were missing, and replaced the extinguishers.</p> <p>Actual NFPA Standard: NFPA 10, 4-4.3*. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. The removal of agent from halon agent fire extinguishers shall only be</p> | K 064 | <p>K064</p> <ol style="list-style-type: none"> The identified fire extinguishers have been serviced and a service collar placed on 06-14-11. All fire extinguishers in the facility were audited on 06-14-11 by a representative of Booth Fire & Safety and verified that those extinguishers which require service collars, have service collars on them within the appropriate time frame. No concerns were identified. The Maintenance Director will be re-educated on the requirement for servicing of fire extinguishers per NFPA standards by the Administrator by 7-27-2011. The Maintenance Director will audit all fire extinguishers quarterly to assure all have been serviced and collars replaced if applicable per NFPA standards for one year. The results of the audits will be reviewed with the Quality Assurance Committee quarterly for one year. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. <p>Completion Date: July 27, 2011</p> | 7/27/11 |



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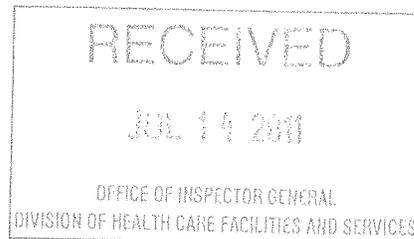
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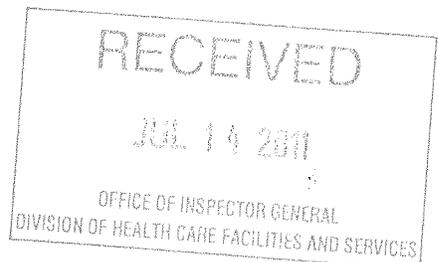
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| K 064 | Continued From page 13 done using a listed halon closed recovery system. When the applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall begin from that date. Exception: Non-rechargeable fire extinguishers shall not be hydrostatically tested but shall be removed from service at a maximum interval of 12 years from the date of manufacture. Non-rechargeable halon agent fire extinguishers shall be disposed of in accordance with 4-3.3.3. Actual NFPA Standard: NFPA 10, 4-4.4*. Each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed and that identifies the person performing the service. Actual NFPA Standard: NFPA 10, 4-4.4.1*. Fire extinguishers that pass the applicable 6-year requirement of 4-4.3 shall have the maintenance information recorded on a suitable metallic label or equally durable material having a minimum size of 2 in. by 3 1/2 in. (5.1 cm 8.9 cm). The new label shall be affixed to the shell by a heatless process, and any old maintenance labels shall be removed. These labels shall be of the self-destructive type when removal from a fire extinguisher is attempted. The label shall include the following information: (a) Month and year the maintenance was performed, indicated by a perforation such as is done by a hand punch (b) Name or initials of person performing the maintenance and name of agency performing the maintenance Actual NFPA Standard: NFPA 10, 4-4.4.2*. Each extinguisher that has undergone maintenance that includes internal examination or that has been recharged (see 4-5.5) shall have a | K 064 | | |
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| K 064 | Continued From page 14 "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch. Exception No. 1: Fire extinguishers undergoing maintenance before January 1, 1999. Exception No. 2: Cartridge/cylinder-operated fire extinguishers do not require a "Verification of Service" collar. | K 064 | | |
| K 070 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure portable space heaters used in the facility were according to NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for ninety eight (98) beds with a census of ninety-one (91) on the day of the survey. | K 070 | K070 1. The portable space heater identified was removed from the Housekeeping Supervisor's office on 06-14-11. 2. A facility audit was conducted to identify any portable space heaters by the Maintenance Director on 06-14-11. No other portable space heaters were found. 3. The Maintenance Director will be re-educated by the Administrator on the requirements related use of portable space heaters in non-sleeping staff areas to not exceed 212 degrees F. This education will be completed by 7-27-2011 4. The Maintenance director will audit the facility on a monthly basis for three (3) months to insure that there are no portable space heaters in the building. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. Completion Date: July 27, 2011 | 7/27/11 |



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| K 070 | Continued From page 15 Observation, on 06/14/11 at 2:17 PM, with the Maintenance Director revealed a portable space heater located in the Housekeeping Supervisors Office. Interview, on 06/14/11 at 2:17 PM, with the Maintenance Director revealed he was unaware that portable heaters could not exceed 212 degrees. The space heater was immediately removed from the office. Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). | K 070 | | | |
| K 072 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure means of | K 072 | | | |

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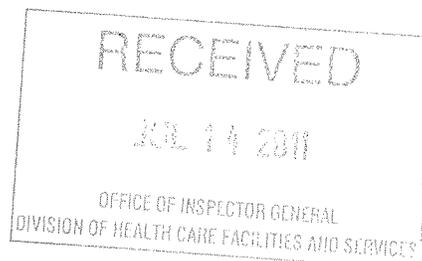
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| K 072 | Continued From page 16 egress were maintained free and clear of obstructions according to NFPA standards. The deficiency had the potential to affect all four (4) smoke compartments, residents, staff and visitors. The facility is licensed for ninety eight (98) beds, with a census of ninety-one (91) the day of the survey. The Findings include: Observation, on 06/14/11 between 10:05 AM and 3:55 PM, with the Maintenance Director revealed med carts, linen carts, a patient lift, trash carts, wheel chair, chairs, and refreshment carts located within the resident area corridors. The items were observed in the corridors to be stationary for a period of more than thirty (30) minutes. Interview, on 06/14/11 between 10:05 and 3:55 PM with the Maintenance Director confirmed the items located in the corridors and indicated the facility lacked the needed storage space. Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. | K 072 | K072 1. An observation by the Administrator on 07-07-11 noted the means of egress to be free and clear. 2. An observation by the Administrator on 07-08-11 noted the means of egress to be free and clear. 3. The facility has developed a revised plan for the storing of items away from the resident corridors, including utilizing the clean and soiled linen rooms, the bathrooms, and the areas behind the nurses stations. All staff will be re-educated by the Education and Training Director, the Administrator, the Director of Nursing or the Assistant Director of Nursing related to maintaining a free and clear means of egress. This education will be completed by 7-27-2011. 4. The Administrator, Maintenance Director, Director of Nursing or the Assistant Director of Nursing will observe hallways five (5) times per week for four (4) weeks followed by three (3) times per week for four (4) weeks then weekly for four (4) weeks, to assure that all means of egress remain free and clear of clutter. The results of the observations will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. Completion Date: July 27, 2011 | 7/27/11 |
| K 130 SS=F | NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 | K 130 | | |

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

REPRINTED: 06/20/2011
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 06/14/2011 |
| NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF FRANKLIN | | | STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| K 130 | Continued From page 17 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress. This deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for ninety eight (98) beds, with a census of ninety-one (91) on the day of the survey. The findings include: Observation, on 06/14/11 between 10:05 AM and 3:55 PM, with the Maintenance Director revealed an unapproved lock (slide bolt type) was installed on the egress side of the bathroom door in resident rooms 115, 117, 120, 205, 206, and 208. Also noted, was a slide bolt type lock on the clean utility room door located in Hall C. Interview, on 06/14/11 between 10:05 AM and 3:55 PM, with the Maintenance Director revealed he was aware of the locks, but not aware they could not be used and removed them upon discovery. NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. | K 130 | K130 1. The slide bolt locks in Rooms 115, 117, 120, 205, 206, and 208 as well as the clean utility room door on hall C were removed on 06-14-11. 2. The Maintenance Director will audit all facility doors to assure no slide bolt locks are used. any identified will be removed by 7-27-2011. 3. The Maintenance Director will be re-educated by the Administrator prior to 7-27-2011 regarding the life safety code regulation related to locks and means of egress. 4. The Maintenance director will audit the facility doors on a monthly basis for three (3) months to ensure that they are all free of slide bolt locks. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. Completion Date: July 27, 2011 | |
| K 143 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: | K 143 | | 7/27/11 |



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

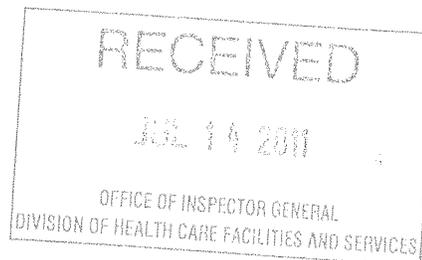
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OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 06/14/2011 |
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| NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF FRANKLIN | STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135 |
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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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| K 143 | Continued From page 18 (a) separated from any portion of a facility 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 assure the room being used to transfer liquid oxygen had ventilation per NFPA requirements. The deficiency had the potential to affect all smoke compartments, residents, staff and visitors. The facility is licensed for ninety eight (98) beds with a census of ninety-one (91) on the day of the survey. The findings include: Observation, on 06/14/11 at 2:26 PM, with the Maintenance Director revealed the room which oxygen was being transferred did not have ventilation. | K 143 | K143 1.The identified oxygen storage room had ventilation installed by 07-01-11. 2. The Maintenance Director conducted an environmental audit by 07-01-11 to identify any other areas used for oxygen transfer to assure ventilation was present. No other areas were identified. 3. The Administrator will re-educate the Maintenance Director on the requirements for oxygen storage and transfer by 7-27-2011. 4.The Maintenance Director will audit all areas used for oxygen transfer to assure proper ventilation on a monthly basis for three (3) months. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. Completion Date: July 27, 2011 | 7/27/11 |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

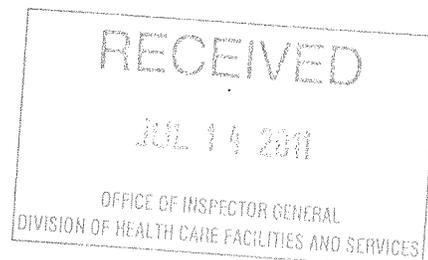
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| NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF FRANKLIN | STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135 |
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| K 143 | Continued From page 19 Interview, on 06/14/11 at 2:26 PM, with the Maintenance Director confirmed the observation. 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. 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, sw and re shall be installed in fixed locations not f 152 cm4 the floor | K 143 | | |
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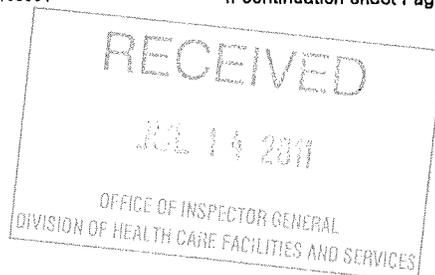
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| K 143 | Continued From page 20 as a precaution against their physical damage. 5. Storage locations for oxygen and nitrous oxide shall be kept free of flammable materials [also 4-3.1.1.2(a) 7]. 6. Cylinders containing compressed gases and containers 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 [Copyright NFPA 99 8-2.1.2.3(c)]. 10. Location of Supply Systems. 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. 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. | K 143 | | |
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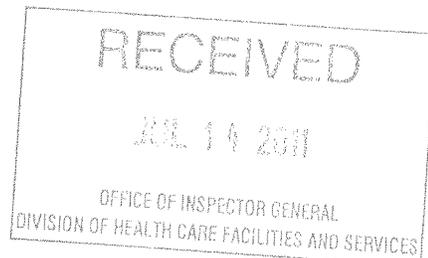
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| K 143 | Continued From page 21 c. Locations for supply systems shall not be used for storage purposes other than for containers of nonflammable gases. Storage of full or empty containers shall be permitted. Other nonflammable medical gas supply systems 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. 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. 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. 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, | K 143 | | |
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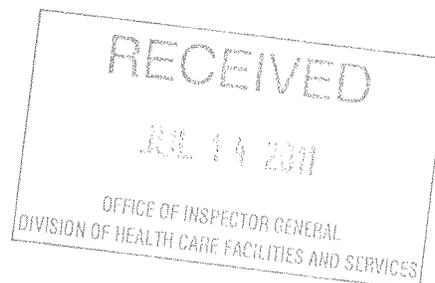
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| K 143 | Continued From page 22 such as furnaces, incinerators, or boiler rooms, they shall be of construction that protects cylinders from reaching temperatures exceeding 130°F (54°C). Open electrical conductors and transformers shall not be located 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. Copyright NFPA g. Heating shall be by steam, hot water, or other indirect means. Cylinder temperatures shall not exceed 130°F (54°C). (b) Additional Storage Requirements for Nonflammable Gases Greater Than 3000 ft (85 m). 1. Oxygen supply systems or storage locations having a total capacity of more than 20,000 ft (566 m (NTP), including unconnected reserves on hand at the site, shall comply with NFPA 50, Standard for Bulk Oxygen Systems at Consumer Sites. 2. Nitrous oxide supply systems or storage locations having a total capacity of 3200 lb (1452 kg) [ft (793 m (NTP)] or more, including unconnected reserves on hand at the site, shall comply with CGA Pamphlet G-8.1, Standard for the Installation of Nitrous Oxide Systems at Consumer Sites. 3. The walls, floors, and ceilings of locations for supply systems of more than 3000 ft (85 m total capacity (connected and in storage) separating the supply system location from other occupancies in a building shall have a fire resistance rating of at least 1 hour. This shall also apply to a common wall or walls of a supply system location attached to a building having | K 143 | | |
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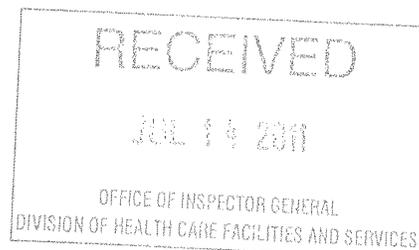
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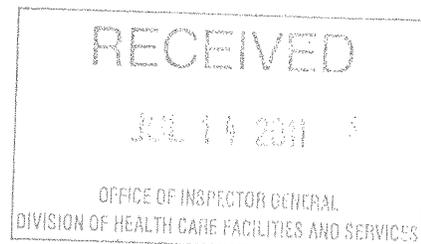
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| K 143 | Continued From page 23 other occupancy. 4. Locations for supply systems of more than 3000 ft (85 m total capacity (connected and in storage) shall be vented to the outside by a dedicated mechanical ventilation system or by natural venting. If natural venting is used, the vent opening or openings shall be a minimum of 72 in. (0.05 m in total free area. (c) Storage Requirements for Nonflammable Gases Less Than 3000 ft (85 m- Doors to such locations shall be provided with louvered openings having a minimum of 72 in. (0.05 m in total free area. Where the location of the supply system door opens onto an exit access corridor, louvered openings shall not be used, and the requirements of 4-3.1.1 .2(b)3 and 4 and the dedicated mechanical ventilation system required in 4-3.1.1 .2(b)4 shall be complied with. | K 143 | | |
| K 147 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. The deficiency had the potential to affect all smoke compartments, including residents, staff, and visitors. The facility is licensed for ninety eight (98) beds with a census of ninety-one (91) the day of the survey. | K 147 | | |



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| K 147 | <p>Continued From page 24 The findings include:</p> <p>Observation on 06/14/11 between 10:05 AM and 3:55 PM, with the Maintenance Director revealed extension cords located in the Television Room /Old Rehab Department (Main Hall), Social Services Admissions Office (Main Hall), FRC Office (Main Hall), Mechanical Room (Main Hall), Physical Therapy (Main Hall), Business Office (Hall C), Resident Room 201 (Hall C), Life Enrichment Office (Hall C), Resident Room 207 (Hall C), Residents Rooms 210,211,212,215,223 (Hall B) and Resident Room 117 (Hall C),</p> <p>Interview, on 06/14/11 between 10:05 AM and 3:55 PM, with the Maintenance Director revealed he was aware extension cords could not be used, and was unaware so many were in use.</p> <p>Observation, on 06/14/11 between 10:05 AM and 3:55 PM, with the Maintenance Director revealed the misuse of power strips and multi plug adaptors. The misuse and location are as follows: a refrigerator and microwave plugged into a power strip in the Clinical Reimbursement Services Office; a refrigerator plugged into a power strip in resident room 208 (Hall C); an extension cord plugged into a power strip in the Life Enrichment Office (Hall C); resident room 211 bed was plugged into a power strip that was plugged into an extension cord (Hall B); a refrigerator was plugged into a power strip in resident room 216 (Hall B); a lift chair was plugged into a power strip in resident room 112 (Hall C); two (2) refrigerators were plugged into a</p> | K 147 | <p>K147</p> <ol style="list-style-type: none"> The extension cords identified in the television room/old rehab room, social services office, FRC office, mechanical room, physical therapy, business office, resident room 201, life enrichment office, resident rooms 210, 211, 212, 215, 223 and 117 were removed on 6-14-2011. The identified power strips in the clinical reimbursement office, life enrichment office, resident rooms 208,211,216,112,125, and room 142, as well as the nurse's station office were removed on 6-14-2011. The items stored in front of the electrical panels in the sprinkler room were removed on 6-14-2011. The electrical junction boxes identified as open in the laundry room were repaired on 6-15-11. The Maintenance Director will conduct an audit of the center to identify any extension cords, power strips used inappropriately, items stored in front of electrical panels or open electrical junction boxes by 7-27-2011. Any identified concerns will be corrected by 7-27-2011. The Administrator will re-educate the Maintenance Director on monitoring for inappropriate use of extension cords, power strips, improper storage of items in front of electrical panels and open electrical junction boxes in accordance with NFPA codes by 7-27-2011. All facility staff will be re-educated on the appropriate use of power strips and extension cords by the Education and Training Director, Director of Nursing, Administrator or Assistant Director of Nursing by 7-27-2011. The Maintenance Director will conduct weekly rounds in the facility for twelve (12) weeks to ensure that extension cords are not in use and that power strips are used appropriately, that electrical panels are free of storage items, as well as that there are no open electrical junction boxes. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. <p>Completion Date: July 27, 2011</p> | | 7/27/11 |



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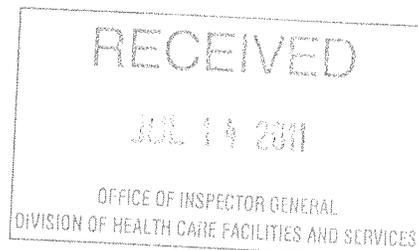
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 06/14/2011 |
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| NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF FRANKLIN | STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135 |
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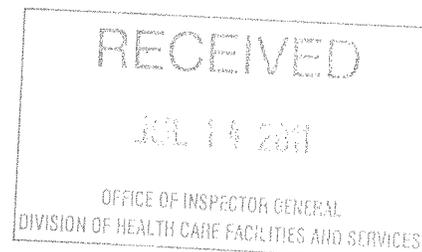
| | | | | |
|-------|--|-------|--|--|
| K 147 | <p>Continued From page 25</p> <p>power strip and the power strip was plugged into a multi plug adaptor in the Nurses Station Office (Hall A); a refrigerator was plugged into a power strip, and a CPAP machine was plugged into a multi plug adaptor in resident room 125 (Hall A); and an oxygen concentrator was plugged into a power strip in resident room 142 (Hall A).</p> <p>Interview, on 06/14/11 between 10:05 AM and 3:55 PM, with the Maintenance Director revealed he was aware of the use of power strips, but did not realize they were being misused. Corrections by the Maintenance Director were performed upon discovery.</p> <p>Observation, on 06/14/11 at 12:00 PM, with the Maintenance Director revealed storage in front of electrical panels located in the Sprinkler Room.</p> <p>Interview, on 06/14/11 at 12:00 PM, with the Maintenance Director revealed he was aware items could not be stored in front of electrical panels.</p> <p>Observation, on 06/14/11 between 10:05 AM and 3:55 PM with the Maintenance Director revealed open electrical junction boxes located behind the clothes dryers (Hall C) and in the attic near Hall A.</p> <p>Interview, on 06/14/11 between 10:05 AM and 3:55 PM with the Maintenance Director revealed he was unaware of the open electrical junction boxes.</p> | K 147 | | |
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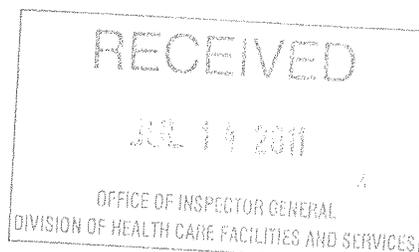
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/29/2011
FORM APPROVED
OMB NO. 0938-0391

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| K 147 | Continued From page 26 Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. Reference: NFPA 70 (1999 edition) 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. 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 | K 147 | | |



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| K 147 | Continued From page 27 from the cover of an exposed box shall comply with Section 370-22, Exception. | K 147 | | |
| K 211 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation and interview conducted on 06/14/11 it was determined the facility failed to ensure that Alcohol Based Hand Rub dispensers were not installed over or adjacent to an ignition source, per NFPA standards. The deficiency had the potential to affect one (1) smoke compartment, residents, staff and visitors. The facility is licensed for ninety eight (98) beds with a census of ninety-one (91) on the day of the survey. | K 211 | K211 1. The alcohol based hand sanitizer dispensers were removed from Rooms 202 and 204 on 06-14-11. 2. An audit of all hand sanitizer dispensers will be completed by the Maintenance Director by 7-27-2011 to identify any dispensers located in an inappropriate areas; any identified will be moved by 7-27-2011. 3. The Administrator will re-educate the Maintenance Director by 7-27-2011 regarding appropriate placement of alcohol based hand sanitizer dispensers in accordance with NFPA codes. 4. The Maintenance Director will audit the alcohol based hand sanitizer dispensers monthly for three (3) months to assure they are mounted in an appropriate location per NFPA codes. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly. Completion Date: July 27, 2011 | 7/27/11 |



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| K 211 | Continued From page 28 The findings include: Observation, on 06/14/11 at 10:26 AM, with the Maintenance Director revealed Alcohol Based Hand Rub dispensers were installed over or adjacent to the light switches in resident rooms 202, and 204. Interview, on 06/14/11, at 10:22 AM, with the Maintenance Director revealed he was unaware Alcohol Based Hand Rub dispensers were prohibited to be mounted over or adjacent to an electrical ignition source. Reference: Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 | K 211 | | |

