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

PRINTED: 12/16/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185159		12/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - FRANKFORT	117 OLD SOLDIERS LANE FRANKFORT, KY 40601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey Survey was conducted 11/30/10-12/02/10; and, a Life Safety Code Survey was conducted 12/02/10. Deficiencies were cited, with the highest Scope and Severity of a "F".	F 000	**Preparation and submission of this plan of correction does not constitute an admission of agreement of any kind by the facility or the correctness of any conclusions set forth in this 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 time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. The plan of correction is submitted as the facility's credible allegation of compliance.**	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to develop a Comprehensive Plan of Care for one (1) of nineteen (19) sampled residents (Resident #1) for urinary incontinence.	F 279	**F279 D** **Corrective Action:** **A urinary incontinence care plan was developed on December 1, 2010 for Resident #1 and was immediately placed in the resident's clinical record.** **Identification of other residents with potential for similar concern:** **An audit was conducted on December 3, 2010 of all resident's clinical records by the MDS Coordinators to ensure that all resident's requiring a urinary incontinence care plan had one in place.**	

RECEIVED
JAN 13 2011
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert Turkan	Executive Director	1/12/11

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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F 279	Continued From page 1 The findings include: Review of the clinical record for Resident #1 revealed the resident was admitted to the facility with diagnoses which included Dementia and Altered Mental Status. Review of the Quarterly Minimum Data Set (MDS) dated 08/31/10 revealed Resident #1 had occasional urinary incontinence and was to be on a scheduled toileting plan. Further review of the clinical record for Resident #1 revealed the resident wore adult briefs based on the admission MDS dated 04/27/10. Review of the Comprehensive Plan of Care with an original date of 05/04/10 revealed no documented evidence for a urinary incontinence plan of care. Interview with the MDS Coordinator on 12/01/10 at 2:30 PM revealed, Resident #1 did not have a developed plan of care for urinary incontinence. The MDS Coordinator stated, "urinary incontinence should have been addressed". The MDS Coordinator was unable to provide any documented evidence for a urinary incontinence plan of care.	F 279	**Two resident's were identified to have needed urinary incontinence care plans and those care plans were immediately developed and placed in the resident's clinical record.** **Current resident records were audited by the MDS Coordinators and completed by January 13, 2010 to ensure resident's specific care needs had a current and active care plan to address each individual resident needs.** **Systemic Changes:** **With each assessment completed, the MDS Coordinators will compare the current MDS with the prior completed MDS to identify any changes in incontinence status and will ensure that changes are reflected on the resident's care plan. Residents will be reassessed at least quarterly using the clinical assessment for Bowel/Bladder to ensure resident's current status of bowel/bladder is care planned. During this review, MDS Coordinators will conduct a complete review of the current MDS with the prior MDS to identify any changes in status and ensure that changes identified are reflected on the resident's care plan.**	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318	**Monitoring:** **An audit will be conducted monthly by the MDS Coordinators for three months of the assessment to validate incontinence status on the MDS concurs with what is reflected on the resident's care plan. The audit will be submitted to the DNS for further review. This audit will also**	

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F 318	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure the resident had reached and maintained his or her highest level of range of motion (ROM) and to prevent an avoidable decline of ROM for one (1) of nineteen (19) sampled residents (Resident #4).	F 318	**validate any other changes in the MDS have been reflected on the resident's care plan. Daily reviews will be conducted by the MDS Coordinators during the enhanced start-up meeting of new orders or changes in resident status. A care plan will be initiated and/or updated for any changes or new issues that are identified at that time.** **Results of the audits will be reviewed monthly by the QA & A committee. Action plans will be implemented for an issues identified.**	
	The findings include: Record review revealed Resident #4 was admitted with diagnoses which included Persistent Vegetative State and Acute Cerebrovascular Disease. The Annual Minimum Data Set (MDS) assessment dated 09/23/10, revealed the facility assessed Resident #4 as having a partial loss of range of motion in the neck with full range of motion loss for all extremities. Review of Physician's Orders dated 11/01/10 revealed an order for application of bilateral wrist splints, which were to remain in place for eight (8) hours daily following range of motion exercises. Observation on 11/30/10 at 10:45 AM revealed Resident #4 was lying in a left lateral position. The head of the bed was elevated thirty (30) degrees, with tube feeding infusing at the prescribed rate of fifty milliliters per hour (50 ml/hour). Further observation revealed Oxygen was administered at two (2) liters per nasal cannula. The resident's hands were contracted, laying across the abdomen and the bilateral hand		**Compliance Date of January 14, 2011** **F318 D** **Corrective Action:** **Resident #4 will continue to have splints applied per physician orders for 8 hours/day from 7a-7p. The splints will be removed following the time frame for use. There have been no decline in this resident's Range of Motion status for past several months.** **Identification of other residents with potential for similar concern:** **Current residents with physician orders for splint use were audited for correct application of use. These residents had no issues during this audit and splints were applied as per physician orders.**	01/14/11

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F 318	Continued From page 3 splints were lying on the bedside table. Observation on 11/30/10 at 10:45 AM revealed Resident #4 was awake and on the left side. Bilateral hand splints remained on bedside table. Observation on 11/30/10 at 12:55 PM revealed Resident #4 was awake in right lateral position with arms to the side and across the abdomen. No bilateral hand splints were observed to be in place. The splints continued to remain on the resident's bedside table. Observation on 11/30/10 at 3:30 PM revealed Resident #4 was in bed, with the head of bed elevated thirty (30) degrees. Bilateral hand splints remained on the bedside table. Observation on 11/30/10 at 6:00 PM revealed Resident #4 was awake with eyes open. Ordered bilateral hand splints were located on the bedside table. Observation and interview with Licensed Practical Nurse (LPN) #1 on 12/01/10 at 9:45 AM revealed Resident #4 lying in bed. Bilateral hand splints were on the bedside table. Interview with LPN #1 revealed contractures to the hands were not a new issue for the resident. Resident #4 had the contractures for quite some time. Observation on 12/01/10 at 12:15 PM revealed Resident #4 lying in the left lateral position with eyes open. Hand splints remained on the bedside table. Interview with the Restorative Nurse on 12/01/10 at 12:15 PM revealed the "bilateral splints were ordered to be applied in the morning and	F 318	**Current residents were reassessed for Range Of Motion changes utilizing the Joint Mobility Assessment Tool. Audits were completed by 1/13//11. No significant changes were noted as a result of this audit.** **<u>Systemic Changes :</u>** **The restorative nurse/aide will continue to apply splints for residents according to the physician orders. The restorative nurse/aide will continue to document application of splints and remove according to physician orders. Residents with physician orders for splint use will have splints removed during care and reapplied as per physician orders. Current Residents will be reassessed at least quarterly using the Joint Mobility Assessment Tool for changes in range of motion status.** **Alterations in splint wearing pattern will be documented by the restorative nurse or charge nurse on date of occurrence on the restorative documentation nursing record.** **<u>Monitoring:</u>** **The restorative nurse will continue to observe splint use daily for residents with current orders for splints. Documentation for residents with splints will continue to reflect the application of splints according to physician orders. Monthly documentation will include tolerance to**	

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F 318	Continued From page 4 removed at the end of the shift. The nurse revealed a certified nursing assistant had removed the splints after they had been applied that morning during Resident # 4's bath. Further interview revealed the splints had not been replaced following the resident's bath. Observation on 12/02/10 at 1:00 PM revealed Resident #4 awake and the bilateral hand splints were on the bedside table.	F 318	**splint usage and correct application of splints according to physician orders.** **Compliance Date of January 14, 2011** Addendum 1/27/10 Range of motion status for each resident will be monitored quarterly and PRN through joint mobility assessments conducted by the RNAC and through therapy screens. Caregivers will notify the charge nurse immediately of any changes in range of motion noted for further evaluation and treatment.	01/14/11
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to serve food that was at the proper temperature. Temperatures taken from a test tray revealed hot foods were cool and cold liquids were warm. The findings include: Interview on 11/30/10 at 12:55 PM with Resident #9 and a Group interview on 11/30/10 at 3:15 PM, revealed residents stated the food was served cold. Observation of the tray line on 11/30/10 from 4:42 PM until 6:44 PM, revealed foods were served cold and iced tea and milk were greater than forty (40) degrees Farenheit (F), at Point of Service	F 364	**F364** **Corrective Action:** **The facility recognizes that all residents of the facility have the potential to be affected by the alleged deficient practice.** **The Director of Dietary Services has interviewed Resident #9 to identify specific food temperature issues and has immediately addressed any concerns that were identified.** **The Director of Dining Services will meet with the Resident Council monthly to determine if any further issues related exist related to food temperatures at point of service.** **Identification of other residents with potential for similar concern:** **The facility recognizes that all residents of the facility have the potential to be affected by the alleged deficient practice.**	

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F 364	Continued From page 5 (POS). Observation, on 11/30/10 at 4:42 PM, revealed staff had begun placing food into the steam table. temperatures for the food was greater than 140 degrees F, except the ground and regular consistency entree (sweet and sour pork). The entrees were placed back into the steamer and temperatures taken at 4:54 PM revealed the entrees were below 140 degrees F. The entrees were placed in longer and shallower pans and again placed into the steamer for heating. Observation at 5:06 PM revealed the broth for the regular consistency entree was 142 degrees F. Staff did not test the temperature of the meat and vegetables in the broth. Approximately half of the entree was placed on the steam table and the remainder was placed back into the steamer. The temperature of the ground entree was 152 degrees F. Observations at 5:25 PM and 5:47 PM, revealed the dietary aide served two (2) plates which had been setting prepared on the steam table for ten (10) to twelve (12) minutes prior to being served. At 5:50 PM, observation revealed the regular consistency entree was replenished with the entree which had been placed in the steamer at 5:06 PM. No temperature was taken of the added regular consistency entree. Observation, on 11/30/10 at 4:54 PM, revealed the temperature for the milk was obtained and documented as 39 degree F. There was no observation of or documentation of a temperature taken for the iced tea. Observation, at 6:37 PM, revealed a test tray was prepared and taken to the North Nursing Unit. After the last resident tray was delivered at 6:44 PM, temperatures were taken for the test tray. Three (3) items were found to be out of	F 364	**The Director of Dining Services will meet with the Resident Council monthly to determine if any further issues exist related to food temperatures at point of service, palatability of food and appearance.** **Heat platelets are beings used to assist in controlling temperatures for all residents. An additional cart has also been added to South Hall which will prove to assist with temperatures holding at an acceptable and palatable level.** **<u>Systemic Changes :</u>** **Dietary Service Staff were educated by December 27, 2010 by the Director of Dietary Services on temperature documentation and holding of temperatures of hot and cold foods and beverages on the tray line.** **Dietary Service Staff were educated by January 11, 2011 by he Director of Dining Services on common issues related to food palatability and appearance and tactics to use to ensure food is pleasant in appearance, served at the appropriate temperature and preference of the resident.** **<u>Monitoring:</u>** **Test tray temperatures will be taken a minimum of weekly and randomly at all three meals by the Director of Dining Services or designee.**	

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F 364	Continued From page 6 temperature range for POS, the milk, iced tea, and regular consistency entree. The temperature of the regular consistency entree (meat chunk) was 106 degree F. The temperature for the milk was 42 degrees F and the temperature for the iced tea was 58 degrees F. Interview, on 11/30/10 at 6:44 PM, with the Dietary Manager revealed the POS temperatures for hot items should be 125 to 130 degrees F. In addition, he stated the POS temperatures for cold drinks should be 40 degrees F.	F 364	**The review of the test tray will also include an inspection of food appearance. The Director of Dining Services will conduct resident interviews a minimum of weekly and randomly with residents to determine if there are any issues with food palatability.** **Any issues identified with test tray temperatures, food appearance or resident interviews will be immediately addressed by the Director of Dining Services. Results of test tray temperature checks will be reviewed monthly in the QA & A committee meeting.**	
F 371 SS=F	The facility had no policy or procedures related to the POS food temperatures. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to prepare and serve food under sanitary conditions, as evidenced by staff handling food with gloved hands and staff's failure to wash and sanitize hands. The facility's failure had the potential to effect eighty-eight (88) of ninety-three (93) residents living in the facility.	F 371	**Compliance Date of January 14, 2010** **F371** **Corrective Action:** **No residents were noted to have been affected.** **The facility recognizes that all residents of the facility have the potential to be affected by the alleged deficient practice.** **Director of Dining Services was educated by the Registered Dietician by December 27, 2010 on the facility's Hand Washing policy and Food Preparation policies.** **Dietary staff were educated by December 27, 2010 by the Registered Dietician and the Director of Dining Services on the facility's Hand Washing policy and Food Preparation policies.**	01/14/11

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F 371	Continued From page 7 The findings include: Observation of the tray line, on 11/30/10 from 4:42 PM until 6:37 PM, revealed the Dietary Manager removed one glove and placed it into a trash can. The Dietary Manager then put on a new glove and began placing slices of bread into plastic bags without washing and/or sanitizing his hands. Observations, on 11/30/10 at 6:02 PM revealed Dietary Aide #5 removed her hands from the soapy dishwater in the three (3) compartment sink and replenished the regular and mechanical soft entrees (sweet and sour pork) without washing/sanitizing her hands. Additionally, Dietary Aide #5 removed her hands from the soapy dishwater in the three compartment sink and obtained a sandwich from the reach in refrigerator, donned gloves, and proceeded to cut the crust from the sandwich before placing it on a resident's tray. Observation revealed Dietary Aide #5 also prepared green beans after she removed her hands from the soapy dishwater in the three compartment sink. The dietary aide did not wash and/or sanitize her hands prior to putting on gloves or completing the tasks detailed above. Additional observation revealed Dietary Aide #5 picked up paper a towel from the floor and proceeded to obtain hamburger buns and prepared a hamburger with one glove and one ungloved hand with out washing and or sanitizing her hands. Additionally, Dietary Aide #5 was observed to pick up a napkin from the floor rewrite the information from the napkin onto a new napkin and place the new napkin on the steam table without washing	F 371	**Weekly sanitation audits are being completed by the Director of Dining Services and/or Executive Director to ensure food is stored, prepared, distributed and served under sanitary conditions.** **<u>Identification of other residents with potential for similar concern:</u>** **The facility recognizes that all residents of the facility have the potential to be affected by the alleged deficient practice.** **Dietary staff were educated by December 27, 2010 by the Registered Dietician and the Director of Dining Services on the facility's Hand Washing policy and Food Preparation policies.** **A sanitation audit was conducted by the Director of Dining Services and the Executive Director by January 13, 2011 to identify an other issues. Any issues identified were immediately addressed.** **<u>Systemic Changes :</u>** **Dietary staff were educated by December 27, 2010 by the Registered Dietician and the Director of Dining Services on the facility's Hand Washing policy and Food Preparation policies.** **Weekly sanitation audits are being completed by the Director of Dining Services and/or Executive Director to ensure food is stored, prepared,**	

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F 371	Continued From page 8 her hands. Interviews, on 11/30/10 at 6:50 PM, with Dietary Aides #5 and #6 revealed they were to wash their hands anytime they changed tasks and before leaving and after returning to the kitchen area. Both aides stated they were not to use their bare hands when handling food. Interview, on 12/01/10 at 1:50 PM, withe the Dietary Manager revealed hands were to be washed after removing gloves and before putting on new gloves. Additionally, he stated staff should use utensils to handle food when ever possible. Review of the facility's policy "Hand Washing" Dietary associates were to wash hands, before handing food, before putting on disposable gloves, after removing disposable gloves, after handling any soiled or contaminated equipment or trash can lids, after disposing of trash or food, and after picking up anything from the floor. Review of the facility's policy "Preparation" in order to prevent cross-contamination, do not use bare hands for mixing, portioning, preparing (sandwiches) or serving. Use tongs, scoops, gloves, or other utensils for serving, mixing, portioning and handling.	F 371	**distributed and served under sanitary conditions.** **<u>Monitoring:</u>** **Compliance with Hand Washing and Food Preparation policies will be monitored through daily rounds by the Director of Dining Services and Weekly Rounds by the Executive Director or designee for three months and then monthly thereafter.** **Results of the rounds will be reviewed monthly in the QA & A committee with action plans developed as needed.** **Weekly sanitation audits are being completed by the Director of Dining Services and/or Executive Director to ensure food is stored, prepared, distributed and served under sanitary conditions.** **<u>Compliance Date of January 14, 2011</u>**	01/14/11

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on December 2, 2010. The facility was found to not meet the minimum requirements with 42 Code of the Federal Regulations, Part 483.70. Deficiencies were cited with the highest Scope and Severity of an "F".	K 000	**Preparation and submission of this plan of correction does not constitute an admission of agreement of any kind by the facility or the correctness of any conclusions set forth in this 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 time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. The plan of correction is submitted as the facility's credible allegation of compliance.**	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the facility's doors were functioning properly to resist the passage of smoke. The deficient practice has the potential to effect all residents and staff.	K 018	**K018 E** **<u>Corrective Action:</u>** **No residents were noted to have been affected.** **<u>Identification of other residents with potential for similar concern:</u>** **There were no residents noted to have been affected.** **The two sets of doors at the entrance to the lobby and the corridor doors in the lobby have been repaired by January 16, 2011 to ensure that they function properly to resist the passage of smoke.**	

RECEIVED
DEC 27 2010
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Robert Turham — Executive Director — 12/22/10

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185159		12/02/2010

NAME OF PROVIDER OR SUPPLIER
GOLDEN LIVINGCENTER - FRANKFORT

STREET ADDRESS, CITY, STATE, ZIP CODE
117 OLD SOLDIERS LANE
FRANKFORT, KY 40601

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K 018	Continued From page 1 The findings include: Observation on 12/02/10 at 10:30 AM with the Maintenance Director, revealed the fire doors at the front entrance to the lobby would not close properly when tested. The two (2) sets of doors at the entrance and the corridor doors in the lobby all had a gap of more than one eight (1/8) inch when closed. Interview with the Maintenance Director on 12/02/10 at 10:30 AM, indicated that he was not aware the doors were not closing properly.	K 018	**Systemic Changes :** **An inspection was completed by the Maintenance Director on December 21, 2010 to identify an other doors that did not function properly. No problems with doors were identified to exist other than those noted on the Life Safety Code survey.** **The two sets of doors at the entrance to the lobby and the corridor doors in the lobby have been repaired by January 16, 2011 to ensure that they function properly to resist the passage of smoke.**	
K 029 SS=D	Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors. NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	**Monitoring:** **The Maintenance Director will conduct monthly inspections of all fire doors and exit doors to ensure proper function. Any identified problems will be immediately addressed. Monthly inspections will also be reviewed in the Safety Committee meeting.** **Monthly inspection results will also be discussed quarterly in the QA & A committee meeting.** **Compliance Date of January 16, 2011** **K029 D** **Corrective Action:** **No residents were noted to have been affected.**	01/16/11

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K 029	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure NFPA standards, for protection from hazards. The findings include: Observation on 12/2/10 at 9:50 AM with the Maintenance Director, revealed the door to the bio-hazard/soiled linen room did not have a self-closing device installed, as required by NFPA standards.	K 029	**<u>Identification of other residents with potential for similar concern:</u>** **There were no residents noted to have been affected.** **A self-closing device will be installed on the door to the bio-hazard/soiled line room by January 16, 2011 that was noted to not have a self-closing device during the Life Safety Code survey.** **<u>Systemic Changes :</u>** **An inspection was conducted by the Maintenance Director on December 21, 2010 of doors in the facility to identify doors that needed a self-closing device. A similar door to the one noted on the Life Safety Code survey was identified. A self-closing device will be installed on this door by January 16, 2011.** **A self-closing device will be installed on the door to the bio-hazard/soiled linen room by January 16, 2011 that was noted to not have a self-closing device during the Life Safety Code survey.** **<u>Monitoring:</u>** **The Maintenance Director will conduct monthly inspections of self-closing devices in the facility to ensure proper function. Any identified problems will be immediately addressed. Monthly inspection will also be reviewed in the monthly Safety Committee meeting.**	
K 056 SS=F	Interview with the Maintenance Director on 12/2/10 at 9:50 AM, indicated that he was not aware of the NFPA code for the door. Reference: NFPA 101 (2000 Edition) 19.3.2 Protection from Hazards The doors shall be self-closing or automatic-closing in hazardous areas. NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056		

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K 056	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, according to NFPA standards. The deficiency could effect all ninety-three (93) residents and staff. The facility is licensed for one-hundred beds (100) and the census on the day of the survey was ninety-three (93). The findings include:	K 056	**Results of monthly inspections will also be reviewed during the quarterly QA & A committee meeting. Action plans will be developed for any issues noted.** **Compliance Date of January 16, 2011** **K056 F** **Corrective Action:** **No residents were noted to have been affected.** **Identification of other residents with potential for similar concern:** **There were no residents noted to have been affected.**	01/16/11
	Observation on 12/02/10 at 10:30 AM with the Maintenance Director, revealed the canopy over the main entrance to the facility was not sprinkled and was constructed with combustible material. Further observation also revealed the overhangs on the North and South exits were over four (4) feet with no sprinklers. Interview with the Maintenance Director on 12/2/10 at 10:30 AM, indicated that he was not aware that the canopy and overhangs needed to be sprinkled. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.		**Sprinklers have been installed at the canopy over the main entrance to the facility and the overhangs on the North and South exits by January 16, 2011 that were noted not to be sprinkled during the Life Safety Code survey.** **Systemic Changes :** **An inspection was completed by the Maintenance Director on December 21, 2010 to identify any other areas that were not sprinkled that were required to be sprinkled. No further areas were noted to exist other than those noted during the Life Safety Code survey.**	
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.	K 072	**Sprinklers have been installed at the canopy over the main entrance to the facility and the overhangs on the North and South exits by January 16, 2011 that were noted not to be sprinkled during the Life Safety Code survey.**	

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K 072	Continued From page 4 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the corridors were free from obstructions in the case of fire or other emergency. This deficiency has the potential to affect all staff and residents. The findings include:	K 072	**Monitoring:** **The Maintenance Director will conduct monthly inspections of the newly installed sprinklers identify any problems with proper functioning. Any identified problems will be addressed immediately. Results of monthly inspections will be reviewed monthly in the Safety committee meeting and quarterly in the QA & A committee meeting.** **Compliance Date of January 16, 2011**	01/16/11
	Observation on 12/2/10 at 10:30 AM, revealed medication carts stored and not in use in front of the North Nurses Station and the South Nurses Station. Also noted were Hoyer lifts next to rooms 122 and 125. Further observation revealed a Hoyer lift and chair next to the exit at the end of the corridor on the short hall on the North Wing. A linen cart was observed outside room #124 and a chair next to room #109. The observations were confirmed with the Maintenance Director. Interview with the Maintenance Director on 12/02/10 at 10:30 AM, revealed the corridors would be cleared of all impediments. Reference: NFPA 101 (2000 Edition) 7.1.10 Means of Egress Reliability Means of degrees shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.		**K072 F** **Corrective Action:** **No residents were noted to have been affected.** **Identification of other residents with potential for similar concern:** **There were not residents noted to have been affected.** **Systemic Changes :** **The facility has identified specific areas on the North and South units to be used for the storage of equipment when not in use. South unit will utilize the area marked "not and exit" located outside the laundry. The North unit whirlpool room will be utilized for storage of equipment when not in use.**	
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4	K 073		

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K 073	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency could effect all ninety-three (93) residents and staff. The facility is licensed for one-hundred (100) beds and the census on the day of the survey was ninety-three (93).	K 073	**Monitoring:** **The Executive Director or designee will conduct rounds daily to ensure the corridors are free from obstructions in the case of fire or other emergency. Issues identified during rounds will be addressed immediately.** **Results of daily rounds will be discussed monthly in the Safety Committee meeting and quarterly in the QA & A committee.** **Compliance Date of January 16, 2011**	01/16/11
	The findings include: Observation on 12/02/10 at 9:30 AM, revealed five (5) resident rooms with hanging decorations on the doors that were not flame retardant. The resident rooms were numbers 103, 117, 124, 125, and 203. This observation was confirmed with the Maintenance Director. Interview with the Maintenance Director on 12/2/10 at 9:30 AM, indicated that they would treat the decorations with a flame retardant material. Reference: NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.		**K073 E** **Corrective Action:** **No residents were noted to have been affected.** **Identification of other residents with potential for similar concern:** **There were not residents noted to have been affected.** **The hanging decorations on the doors to rooms 103, 117, 124, 125 and 203 identified on the Life Safety Code survey have been treated by the Maintenance Director with a flame retardant material or have been removed by January 16, 2011.**	

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K 073	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency could effect all ninety-three (93) residents and staff. The facility is licensed for one-hundred (100) beds and the census on the day of the survey was ninety-three (93).	K 073	**Systemic Changes :** **An inspection was conducted by the Maintenance Director on December 21, 2010 to identify any other combustible decorations that had not been treated with a flame retardant material. Items identified were immediately treated with a flame retardant material or were removed from the facility.**	
	The findings include: Observation on 12/02/10 at 9:30 AM, revealed five (5) resident rooms with hanging decorations on the doors that were not flame retardant. The resident rooms were numbers 103, 117, 124, 125, and 203. This observation was confirmed with the Maintenance Director. Interview with the Maintenance Director on 12/2/10 at 9:30 AM, indicated that they would treat the decorations with a flame retardant material. Reference: NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.		**The hanging decorations on the doors to rooms 103, 117, 124, 125 and 203 identified on the Life Safety Code survey have been treated by the Maintenance Director with a flame retardant material or have been removed by January 16, 2011.** **Monitoring:** **The Maintenance Director will conduct weekly rounds to identify combustible decorations that have not been treated with a flame retardant material. Issue identified will be immediately addressed.** **Results of weekly inspections will be reviewed monthly in the Safety committee meeting and quarterly in the QA & A committee meeting.** **Compliance Date of January 16, 2011**	01/16/11