PRINTED: 06/09/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185436	A. BUILDING B. WING	05/24/2011

RECEIVED JUN 2011 OFFICE OF INSPECTOR GENERAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARC OF OWENSBORO	2885 NEW HARTFORD RD OWENSBORO, KY 42303

(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 An annual survey and abbreviated survey (KY #16459) was conducted on 05/22/11 through 05/24/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S of "E". KY #16459 was unsubstantiated with unrelated deficiencies cited.	F 000	**Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.**	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, it was determined the facility failed to provide care in a manner and in an environment that enhanced each resident's dignity for one resident (#11), not in the selected sample. On 05/23/11, Resident #11 was observed in the dining room with peers during the breakfast meal. He/she requested assistance to the bathroom multiple times during the mealtime and the staff did not respond or provide assistance for the resident in a timely manner. Findings include: A record review revealed Resident #11 was admitted to the facility 01/21/10 with diagnoses to include Cerebral Ischemia, Senile Dementia, Spinal Stenosis and Generalized Weakness.	F 241	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality: **Criteria #1** – Resident #1 is toileted prior to meals; if he/she requests to be toileted during meal time, staff is assisting him/her in a timely manner. . **Criteria #2** – All residents capable of using the toilet are assisted to toilet prior to meals; and upon request, are assisted during meals in a timely manner. **Criteria #3** – Direct care staff members received in-service education on 5/23/11 and 6/20/11 by the Director of Nursing (DON) and/or Staff Development Coordinator (SDC) on assisting residents to the toilet during meal service. Direct care staff members received in-service education on 6/20/11 by the Social Services Director and/or Assistant on providing care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. **Criteria #4** – The QA tool for the monitoring of resident dignity shall be utilized monthly X 2,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admr — (X6) DATE: 6/16/11

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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	185436		05/24/2011

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F 241	Continued From page 1 A review of a quarterly Minimum Data Set (MDS) assessment, dated 03/23/11, revealed the facility assessed the resident to be cognitively impaired and required extensive assistance with activities of daily living. He/she was occasionally incontinent of bowel. A review of Resident #11's care plan, dated 01/29/10, revealed the staff determined times when the resident required toileting and they observed for cues which indicated the need for toileting. Additionally, a review of the Medication Administration Record (MAR) revealed the resident received Lactulose 15 ccs by mouth (po) every day to prevent constipation. An observation of the breakfast meal, on 05/23/11 at 7:50 AM, revealed Resident #11 was eating breakfast in the dining room with his/her peers. He/she told the staff (five staff in the dining room) that he/she needed to go to the bathroom. Resident #11 stated "I want to go the the potty" two times. He/she said "You know you do not wait on stuff like this, you have to go when nature strikes."/The resident continued to tell the staff, "You are fixing to get in a mess, oh me, you are fixing to get into a mess, I cannot wait." He/she also stated, "It will ruin everybody's breakfast, they say to speak up, I did and nobody responded, I really, really need to go, I cannot hold it." An observation, on 05/23/11 at 8:10 AM, revealed Certified Nurse Aide (CNA) #5 and CNA #6 stopped what they were doing and assisted Resident #11 to the bathroom. Resident #11 was incontinent of a moderate amount of light brown	F 241	then quarterly as per established QA calendar under the supervision of the Administrator. Criteria #5 – Target date:	6/24/11

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F 241	Continued From page 2 stool and told CNAs #5 and #6, "You all think I do not know anything and you all just will not listen to me." At 8:22 AM, Resident #11 was assisted back to the dining room where he/she sat and looked at his/her food. He/she stated, " I just do not want to eat now." An interview with Resident #11, on 05/23/11 at 9:40 AM, revealed he/she was confused about what happened earlier this morning, but revealed he/she waited a long time when he/she needed assistance to the bathroom. An interview with Nurse Aide (NA) #3, on 05/23/11 at 3:45 PM, revealed staff were supposed to stop and assist residents who requested to go to the bathroom. An interview with NA #1, on 05/24/11 at 10:30 AM, revealed he took another resident to the bathroom during the breakfast meal on 05/23/11. He provided no explanation as to why Resident #11 was not taken to the bathroom when he/she requested. Interviews with CNAs #5 and #6, on 05/24/11 at 10:45 AM and 10:50 AM, revealed they thought they were supposed to finish with the residents who required assistance with eating before they assisted with residents who required assistance with toileting. An interview with Registered Nurse (RN) #1, (Staff Development), on 5/24/11 at 10:55 AM, revealed staff were supposed to get someone to cover for them and assist any resident who requested to go to the bathroom.	F 241	/ /	

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F 241	Continued From page 3 An interview with the Director of Nursing (DON), on 05/23/11 at 10:00 AM, revealed the staff were not clear about what they needed to do during the times residents were being fed by the staff and required assistance to the bathroom. She stated she expected the staff to take Resident #11 to the bathroom when he/she requested. Additionally, the DON stated there was no facility policy and procedure to address this particular situation.	F 241		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, it was determined the facility failed to provide the necessary care and services to maintain the highest practicable physical, mental, and psychosocial well being for one resident (#1), in the selected sample of 10, related to complaints of pain during wound care on 05/23/11. Findings include: A review of the "Pain Management" policy and procedure, undated, revealed residents were to be assessed for his/her level of pain.	F 309	483.25 PROVIDE CARE/SERVICE FOR HIGHEST WELL BEING Each resident shall receive and the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care: **Criteria #1** – Resident # 1 is observed for pain/discomfort during pressure ulcer treatments and pre-medicated as indicated to ensure that his/her current medication regime is effective. **Criteria #2** - All residents with pressure ulcers have been assessed for pain/discomfort during dressing changes by the scheduled charge nurse and the DON or SDC to determine if an analgesic prior to treatment would be beneficial to each resident. Attending MD's shall be consulted as indicated for medication orders. **Criteria #3** - Licensed nurses received in-service education on 6/22/11 by the DON and/or SDC on monitoring for signs/symptoms of pain or discomfort during treatments, and pre-medicating as indicated based on individual resident needs. Effectiveness of pain control is monitored and documented daily on the	

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F 309	Continued From page 4 A record review revealed Resident #1 was admitted to the facility on 03/01/11 with diagnoses to include Arthritis. A review of the admission Minimum Data Set (MDS), dated 03/08/11, revealed the facility assessed the resident to be severely cognitively impaired. The resident was admitted to the facility with four stage two pressure ulcers. A review of the "Pain Management Flow Sheet," dated 05/11, revealed there was no documented evidence of pain on 05/23/11. A review of the Medication Administration Record (MAR), dated 05/11, revealed no pain medication was administered to the resident on 05/23/11. A review of the "Potential for Pain" care plan, dated 03/09/11, revealed to monitor for nonverbal signs of pain such as grimacing and moaning. There were no specific interventions related to the resident's pressure ulcers. An observation of wound care provided by Licensed Practical Nurse (LPN) #1, on 05/23/11 at 10:45 AM, revealed Resident #1 winced and moaned "oh" when the nurse touched the resident's left second toe. LPN #1 stated "I am sorry" and continued with the wound care. An interview with LPN #1, on 05/24/11 at 9:00 AM, revealed the resident usually complained of pain during wound care; however, she revealed pre-medication was not needed because the only time the resident complained was when the left second toe was touched. An interview with LPN #3, on 05/24/11 at 10:15	F 309	pressure ulcer monitoring log. **Criteria #4** – The QA tool for the monitoring of pain/discomfort during treatments shall be utilized weekly X 4, then monthly X 2, and then annually under the supervision of the DON as per established QA calendar. **Criteria #5** – Target Date	6/24/11

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F 309	Continued From page 5 AM, revealed the resident "jerked" his/her foot when the soiled dressing was taken off, but not all the time. She revealed the resident does not request medication for pain. An interview with the Director of Nursing (DON), on 05/24/11 at 10:30 AM, revealed she expected the nurse to medicate a resident prior to wound care if he/she was aware of a pain issue.	F 309		
F 371 SS=E	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 observations and interviews, it was determined the facility failed to ensure food was distributed and served under sanitary conditions. Observations of the facility dishwasher on 05/22/11 revealed the temperatures were not appropriate for the wash and rinse cycle. Observation on 05/23/11 revealed the sanitizer solution in the three compartment sink was not at an appropriate level. Findings include: An observation of the kitchen, on 05/22/11 at	F 371	483.35(i) FOOD PROCURE, STORE/ PREPARE/SERVE - SANITARY The facility shall procure food from sources approved or considered satisfactory by Federal, State or local authorities; store, prepare, distribute, and serve food under sanitary conditions. **Criteria #1** – The dish washing machine was repaired on 5/23/11. It is running at the proper temperature. The dish machine is monitored for proper water temp three times per day and findings are documented as per facility protocol. When used, the pH/sanitizer level in the 3 compartment sink is being maintained at the proper level. Dietary staff members utilize a test strip to ensure the proper pH level prior to use. **Criteria #2** – All residents have to potential to be affected by this alleged deficient practice. **Criteria #3** – Dietary staff received in-service education on 6/1/11 by the Certified Dietary Manager on proper water temps during dish machine use, that machine is not to be used when proper temp cannot be maintained and proper pH/sanitizer level for 3 compartment sink. **Criteria #4** – The CQI indicator tool for the monitoring of dietary sanitary conditions shall	

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F 371	Continued From page 6 12:45 PM, revealed dietary staff member #1 was operating the facility dishwasher. The temperature gauge read 133 degrees Farenheit (F) for the wash cycle. The rinse cycle temperature was 128 degrees F. Dietary staff member #1 stated the temperatures of the wash and rinse cycles were "messed up all morning and kept changing." She told the cook about the problem and then cleaned some parts on the dishwasher, but it did not help. An observation, on 05/23/11 at 7:55 AM, revealed the sanitizer solution in the three compartment sink tested at 100 parts per million (ppm). An interview with the Dietary Manager, on 05/23/11 at 7:55 AM, revealed the solution should test at least 200 ppm, as directed, on the sanitizer solution container. An interview with Kitchen staff member #2, on 05/23/11 at 7:58 AM, revealed she did not test the solution when she mixed it. Further interview with the Dietary Manager, on 05/23/11 at 8:00 AM, revealed the kitchen staff notified her at home about the dishwasher temperatures on 05/22/11 (Sunday) approximately 12:00 PM. She stated the wash cycle temperature should be 150 degrees F and the rinse cycle should be 180 degrees F. The Dietary Manager told the kitchen staff, at that time, to hand wash the dishes using a sanitizing rinse. She did not notify the dishwasher repair service until 05/23/11 (Monday), because she did not think repair service was available on Sunday. Additionally, the Dietary Manager stated staff should know what to do in an emergency event.	F 371	be utilized weekly X 4 weeks and then monthly under the supervision of the Administrator. **Criteria #5** – Target Date	6/24/11

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F 371	Continued From page 7 An interview with the Service Repair technician, on 05/23/11 at 9:00 AM, revealed repair service was available on weekends and the facility just needed to call.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility shall establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection: **Criteria #1** – The jar of Silvadene used for Resident #1's pressure ulcer treatment has been replaced with a new one. All licensed nurses are following proper infection control technique when performing prescribed treatments to Resident #1's pressure ulcer(s). **Criteria #2** – Residents with Stage 2 or greater pressure ulcers who's multi-use cream/ointment used during pressure ulcer treatment have the potential to be affected by this alleged deficient practice and have had their cream/ointment replaced with new ones. **Criteria #3** – Licensed nurses (LN's) have received in-service education proper infection control techniques during wound care on 6/22/11 by the DON and/or SDC. A skills check for wound care has been completed on all LN's by the DON and/or SDC. **Criteria #4** – The CQI indicator tool for monitoring of Infection Control practices during wound care shall be utilized weekly X 4, then monthly X 2, and then annually under the supervision of the DON. **Criteria #5** – Target Date	6/24/11

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F 441	Continued From page 8 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide a sanitary environment during wound care for one resident (#1) in the selected sample of ten (10). Findings include: A record review revealed Resident #1 was admitted to the facility on 03/01/11 with diagnoses to include Arthritis. A review of the admission Minimum Data Set (MDS), dated 03/08/11, revealed the facility assessed the resident to be severely cognitively impaired with a risk of developing pressure ulcers. Further review of the MDS revealed the resident was admitted to the facility with four stage two pressure ulcers. An observation of wound care provided by Licensed Practical Nurse (LPN) #1, on 05/23/11 at 10:45 AM, revealed she cleansed the resident's right heel with wound cleanser. She then put her soiled right index finger in a jar of Silvadene and applied the cream to the resident's right heel. LPN #1 removed those gloves and donned a new pair of gloves. She then removed	F 441		

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F 441	Continued From page 9 the soiled dressing from the resident's left second toe toe and cleansed the toe with wound cleanser. LPN #1 placed her soiled right index finger back in the same jar of Silvadene and applied the cream to the resident's left second toe. An interview with LPN #1, on 05/23/11 at 11:00 AM, revealed she should have used a cotton tipped applicator to apply the Silvadene to the resident's wounds. An interview with the Director of Nursing (DON), on 05/24/11 at 10:30 AM, revealed a cotton tipped applicator should be used whenever cream was applied to a wound. The gloved finger, if soiled, contaminated the jar of Silvadene.	F 441		

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NAME OF PROVIDER OR SUPPLIER WELLINGTON PARC OF OWENSBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD RD OWENSBORO, KY 42303	

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 03/08/1991 K7 SURVEY UNDER: 2000 Existing K8 SNF Type of Structure: A 1991 single story, Type III (200) unprotected construction. The facility has a complete (dry) automatic sprinkler system. The skilled nursing care units have a total of four smoke compartments. The facility is licensed for 38 beds and the census was 37 the day of the survey. A Life Safety Code Survey was initiated and concluded on 05/23/2011 for compliance with Title 42 Code of Federal Regulations, Part 483.70, and found the facility not in compliance with NFPA 101 Life Safety Code, 2000 Edition. The highest scope and severity was an " F ".	K 000	Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
K 029 SS=D	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	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: **Criteria #1** – A self closer device was installed on the door leading onto the food storage on	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Admr | (X6) DATE: 6/21/11

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185436	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARC OF OWENSBORO	2885 NEW HARTFORD RD OWENSBORO, KY 42303

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K 029	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were protected according to National Fire Protection Association (NFPA) standards. The findings include: Observation on 05/23/2011 at 1:06 PM, with the Maintenance Director, revealed the door leading into the food storage did not have a self closer. The area was used to store large quantities of food. Interview on 05/23/2011 at 1:06 PM, with the Maintenance Director, and Dietary Manager revealed they were unaware of this requirement. This was also confirmed with the Administrator upon exit interview. Reference: NFPA 101 (2000 edition) 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing.	K 029	6/15/11 by the maintenance director. **Criteria # 2** – The food storage room is located within the kitchen. The doors leading into the kitchen are kept locked and are fire rated; therefore there are no residents at risk of being affected by this alleged deficient practice. There were no other doors identified as needing a self closer on 05/23/11. **Criteria # 3** - The Administrator and Maintenance Director received in-service education on Regulation K 029 by the corporate Vice President of Operations on 6/16/11. **Criteria # 4** – The QA tool for monitoring of doors that protect hazardous areas shall be utilized monthly X 2, and then quarterly thereafter as per established QA calendar under the supervision of the Administrator. **Criteria # 5** – Target date	6/24/11

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K 029	Continued From page 2 Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
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	K 038	NFPA 101 LIFE SAFETY CODE STANDARD See page 4 of 7	

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

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K 038	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 exit access was maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) smoke compartment, twenty (20) residents, and visitors. The findings include: Observation on 05/23/2011 at 12:30 PM, revealed the exit doors (2) for the 400 Hall north and south and Service Hall Exit was secured with a magnetic locks using a keypad combination. The combination was not posted, and the doors were not equipped with a delayed egress device. The doors were not near a nurse's station. The observation was confirmed with the Maintenance Director. Interview on 05/23/2011 at 12:30 PM, with the Maintenance Director, revealed the door would release with the combination lock or when the fire alarm activated. The Maintenance Director confirmed the door was not equipped with a delayed egress device. Further interview, with the Maintenance Director, revealed the combination to the keypad was not posted due to wandering residents using the area and residents may be able to access the code and exit the building. This was also confirmed with the Administrator upon exit interview on 05/23/2011 at 2:45 PM. NFPA reference: NFPA 101 (2000 edition)	K 038	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.: The facility is requesting an Exception/Waiver to this requirement that the doors be equipped with delayed egress under Exception No. 1 of Section 19.2.2.2.4 of the NFPA 101 Life Safety Code Standard. The facility is requesting the exception/waiver due to the clinical needs of the residents that require specialized security measures for their safety. Residents of this facility all have admitting diagnosis of dementia or Alzheimer's disease. There are 20 residents that resident on the 400 hall. Of the ambulatory and/or mobile non-ambulatory residents on this unit, all but 1 exhibit exit seeking behavior and are at risk for wandering. Allowing the door to open unobserved after a 15-30 second period would put this population further at risk due to the location of the exit doors. Both the North and South exits are out of view of the nurses' station and are on the ends of the unit, not always within sight of the nursing staff. This exception will only involve the above stated two doors. Door locking devices on this unit can be readily unlocked by staff at all times and staffing will be maintained to ensure patient staffing.	

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K 038	Continued From page 4 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. 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.	K 038		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076	**NFPA 101 LIFE SAFETY CODE STANDARD** Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4: **Criteria # 1** – Oxygen tank storage area has been clearly marked and combustible items	

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

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K 076	Continued From page 5	K 076	moved to ensure at least 5 feet of space is between the O2 tanks and combustibles. **Criteria # 2** – Residents in the direct area of the O2 storage have the potential to be affected by this alleged deficient practice. **Criteria # 3** – The Administrator and Maintenance Director received in-service education on Regulation K 076 by the corporate Vice President of Operations on 6/16/11. **Criteria # 4** – The QA tool for the monitoring of medical gas storage shall be utilized monthly X 2 and then quarterly as per established QA calendar under the supervision of the Administrator. **Criteria # 5** – Target Date	6/24/11

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were maintained according to National Fire Protection Association (NFPA) standards. Oxygen storage areas must be maintained to prevent the risk of fire. The deficiency had the potential to affect one (1) smoke compartment, thirty eight (38) residents, staff and visitor.

The findings include:
Observation on 05/23/2011 at 1:20 PM revealed four (4) oxygen E cylinders located within five (5) feet of combustibles (boxes of supplies). The observation was confirmed with the Maintenance Director.

Interview on 05/23/2011 at 1:20 PM, with the Maintenance Director revealed he was unaware of the requirement to limit oxygen storage from being within five (5) feet of combustibles. This was also confirmed with the Administrator upon exit interview.

Reference: NFPA 99 (1999 edition)
8-3.1.11.2
Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3)
(A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry.
(B) Oxidizing gases, such as oxygen and nitrous

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K 076	Continued From page 6 oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.	K 076		