

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

PRINTED: 10/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185294	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/13/2011
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NAME OF PROVIDER OR SUPPLIER MAPLE MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 515 GREENE DRIVE GREENVILLE, KY 42345
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>An annual survey and abbreviated survey (KY #17020) were conducted on 10/11/11 through 10/13/11 and a Life Safety Code survey was conducted on 10/13/11 to determine the facility's compliance with Federal requirements. KY #17020 was substantiated with no deficiencies cited. Deficiencies were cited with the highest S/S being an "F" and the facility having the opportunity to correct deficiencies before remedies would be recommended for imposition.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: Unknown</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (000) Unprotected</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (Wet SYSTEM)</p> <p>EMERGENCY POWER: Type II Propane Generator.</p> <p>A life safety code survey was initiated and concluded on 10/13/11. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for ninety-seven (97) beds and the census was ninety-four (94) the day of the survey.</p> <p>Deficiencies were cited with the highest</p>	K 000		



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

TITLE

(X6) DATE

Cherie Henry

Administrator / E.D.

11/3/11

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K 000	Continued From page 1	K 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
K 027 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-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, the facility failed to maintain smoke doors that would close and resist the passage of smoke. The deficient practice affected five (5) of five (5) smoke compartments, staff and all residents. The facility has the capacity for ninety-seven (97) beds with a census of ninety-four (94) on the day of survey.</p> <p>Findings include:</p> <p>Observation, on 10/13/11 between 9:30 AM and 12:30 PM, revealed that the doors in the smoke barriers had astragals installed on doors and no door coordinators so doors could completely close to resist the passage of smoke as required by NFPA Code. Doors in smoke barriers are required to be self closing to resist the passage of smoke. The doors identified were located A Hall Nurses Station, B Hall, B Hall Nurses Station, C Hall.</p>	K 027	<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>K027 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door coordinators were obtained and have been installed on all 5 of the facility smoke doors. There are no other affected smoke doors in the facility. The smoke doors will be inspected monthly by the facility Maintenance Supervisor to ensure the new door coordinators are in good working condition and functioning properly. The Administrator, or her designee, will check a sample of smoke doors monthly to ensure the door coordinators are functioning properly during Maintenance quality assurance audits.</p>	11/03/11

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K 038	<p>Continued From page 3</p> <p>determined the facility failed to ensure delayed egress doors were maintained according to National Fire Protection Association (NFPA) standards. Doors with delayed egress must be maintained to ensure residents, staff, and visitors can exit during an emergency. The deficiency had the potential to affect one (1) of five (5) smoke barriers, four (4) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation, on 10/13/11 at 11:15 AM, revealed the two (2) delayed egress doors located at the physical therapy end of C Hall did not have the required signage. The observation was confirmed with the Maintenance Supervisor.</p> <p>Interview, on 10/13/11 at 11:15 AM, with the Maintenance Supervisor revealed he was unsure of why the delayed egress signage was not located on the doors.</p> <p>Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p>	K 038	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>K038 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Delayed egress door signage was placed on the two physical therapy doors at the end of C Hall. All egress doors were inspected to ensure proper delayed egress door signage was in place. The egress doors will be inspected monthly by the Maintenance Supervisor to ensure the delayed egress door signage is in place. The Administrator, or her designee, will check a sample of egress doors monthly for delayed egress signage during Maintenance quality assurance audits.</p>	11/03/11

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K 038	Continued From page 4 (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters	K 038			

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K 038	Continued From page 5 not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 038	<i>This Plan of Correction is the center's credible allegation of compliance.</i>		
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 egress were maintained free and clear of obstructions according to NFPA standards. The deficiency has the potential to affect five (5) of five (5) smoke compartments, all residents, staff, and visitors. The facility is licensed for ninety-seven (97) beds; the census on the day of the survey was ninety-four (94). The findings include: Observation during the Life Safety Code survey tour, on 10/13/11, between 9:30 AM and 12:30 PM, with the Maintenance Supervisor revealed medication carts were stored and not in use near nurses stations in A Hall, B Hall, and C Hall. The items observed in the corridors were stored and not in use for a period of more than 30 minutes. Means of egress must be kept clear at all times in	K 072	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> K072 NFPA 101 LIFE SAFETY CODE STANDARD Storage areas for the Medication carts on A Hall, B Hall and C Hall areas will be created by 11/26/11. All other corridors were inspected to identify any other obstacles which may prevent the corridor from remaining free and clear for egress. The Maintenance Supervisor will observe on his daily rounds for any possible obstacles which may need to be removed or relocated if they prevent clear egress within corridors. The Administrator, or her designee, will check a sample of corridors monthly for possible obstacles which prevent free and clear egress within corridors during Maintenance quality assurance audits.	11/26/11	

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K 072	Continued From page 6 case of fire or other emergency. Interview with the Maintenance Supervisor confirmed the items located in the corridors and indicated that they did not have enough room. 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	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
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 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 deficient practice has the potential to affect all residents, staff, and visitors. The facility has the capacity for ninety-seven (97) beds and the census on the day of the survey was ninety-four (94) residents. The findings include: Observation, on 10/13/11, between 9:30 AM and 12:30 PM, with the Maintenance Supervisor revealed hanging decorations on resident room doors 43, 27, 36, 37, 8, 4, 14 and the activities door. Interview with the Maintenance Supervisor, on	K 073	K073 NFPA 101 LIFE SAFETY CODE STANDARD The door decorations were removed from rooms 43, 27, 36, 37, 8, 4, 14 and the Activities Office door. All other facility doors were inspected for decorations which were not constructed with fire retardant material. Upon admission, the Admissions Coordinator will review with new resident families the requirement to only place decorations which have been treated with fire retardant on resident room doors; affected existing resident families were contacted to educate them regarding the regulation; all residents, responsible parties and facility employees will receive a letter by November 10 th regarding this requirement. Maintenance Supervisor will inspect facility doors for any possible combustible decorations when he makes his daily rounds. The Administrator, or her designee, will inspect a sampling of resident doors monthly for any combustible decorations during Maintenance quality assurance audits.	11/10/11

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K 073	Continued From page 7 10/13/11, at 9:30 AM, revealed the facility did not have a policy or system in place to ensure the decorations were treated 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.	K 073			