

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

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FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 108030	(X2) MULTIPLE CONSTRUCTION A. DULOID B. WING	(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(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 502	<p>Continued From page 90</p> <p>performed as ordered, on 01/28/10. Review of the lab reports revealed no documented evidence of a lab report for a PT/INR or a CBC on 01/28/10.</p> <p>Interview on 02/21/10, at 8:37 PM with Licensed Practical Nurse (LPN) #4 revealed the PT/INR and CBC were performed on 01/28/10 by a lab tech. LPN #4 stated the lab tech left the vials of blood for a lab courier to pick up, but was not picked up. However this was not discovered until another lab tech found the vials of blood on the morning of 01/29/10. Further interview with LPN #4 revealed on the morning of 01/29/10, a lab tech obtained another blood specimen which was transported to the laboratory (lab). The LPN stated the CBC was run "and something was wrong with the PT/INR, so they (lab) had to come and draw it again".</p> <p>Interview on 02/19/10, at 1:20 PM with the Regulatory Manager at the lab revealed there was no evidence in the lab computer system of blood being obtained by a lab tech on 01/28/10. In an additional interview on 02/25/10, at 10:15 AM the Regulatory Manager stated the lab was not contacted by the facility related to the 01/28/10 blood draw. She stated the facility did not call to inquire why no results were received on 01/28/10. Further interview on 02/19/10, at 1:20 PM with the Regulatory Manager of the lab revealed there was a specimen obtained on 01/28/10, for a PT/INR and CBC. The Regulatory Manager stated the specimen was "questionable" for the PT/INR, so the facility was contacted regarding obtaining another blood draw for the PT/INR. According to the Regulatory Manager, a specimen was obtained and results were called to the facility that afternoon.</p>	F 502		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 189038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED G 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
(X4) ID PREFIX TAG F 502	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 502	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Continued From page 01</p> <p>Review of a lab report dated 01/28/10, revealed results were received at 3:44 PM, and indicated Resident #13 had critical values. The PT was noted to be greater than 100 seconds (normal range 9.0-11.4 seconds) and the INR greater than 11 (normal for standard anticoagulant use is 2.0-3.0). A Physician Orders order dated 01/28/10 and timed 4:00 PM, revealed and order for 10 mg/ml (milligram/milliliter) Vitamin K (for blood coagulation) subcutaneously times one (1) dose. Review of the Interdisciplinary Progress Note dated 01/29/10, timed 8:55 PM revealed a new order was received for Vitamin K. The nurse noted the Vitamin K was administered as ordered at 4:00 PM on 01/29/10.</p> <p>Review of the Interdisciplinary Progress Note dated 01/30/10, timed 4:00 AM revealed the night shift nurse noted Resident #13's was found without a blood pressure, respirations or pulse and was cool to touch. The resident was pronounced dead.</p> <p>Interview on 02/21/10, at 8:37 PM with LPN #4 revealed there was a problem with labs. She indicated there was really no system to ensure Physicians were notified of lab results. According to LPN #4, labs were frequently not followed up on to ensure faxed results were received by the Physicians. Additionally, she stated the labs would be left by the 3:00 PM to 11:00 PM nurse for the day shift nurse to follow up on the next day. LPN #4 stated she had reported this to the Director of Nursing (DON), Registered Nurse #1. However, nothing was ever done.</p> <p>Interview on 02/19/10, at 4:30 PM with Registered Nurse (RN) #1, the former DON revealed there</p>				

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F-502	<p>Continued From page 02</p> <p>was no system in place to ensure labs were completed as ordered and the results reported to the Physician. She stated she was aware labs were not followed up to ensure the results were reported to the Physician.</p> <p>Interview on 02/22/10, at 2:15 PM with Registered Nurse #2, the current Director of Nursing (DON), revealed licensed nursing staff should have followed up on the 01/28/10 PT/INR lab and inquired as to why no results were received. The DON indicated there was no system in place to ensure labs were followed up on and the results reported to the Physician.</p> <p>Interview on 02/19/10, at 3:00 PM with the Physician revealed he should have been notified the PT/INR on 01/28/10, had not been received. He stated he was not notified of this information until 01/29/10.</p> <p>2. Record review revealed Resident #15 was admitted to the facility on 01/30/10 with diagnoses which included Atrial Fibrillation, Congestive Heart Failure, and History of Cardiovascular Accident. The resident was receiving Coumadin Therapy upon admission. Record review revealed Resident #15 missed multiple doses of the ordered Coumadin from 02/01/10 through 02/19/10. (Refer to F328)</p> <p>Review of the PT/INR results from 02/15/10 revealed Resident #15's PT was 86.8 (normal range 10.-13.8) and the INR was 6.8 (normal range .85-1.22). The Physician was notified and ordered to hold the Coumadin and repeat PT/INR on 02/18/10. Record review revealed no documented evidence the PT/INR was drawn on</p>	F 502		

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F 502	<p>Continued From page 03</p> <p>02/10/10. Interview with the Administrator and the DON on 02/10/10 at 2:30 PM revealed the lab did not come to the facility that day due to inclement weather.</p> <p>Record review revealed on 02/10/10 at 9:30 AM, Resident #15 was sent to the hospital with complaints of Chest Pain and Shortness of Breath. Review of the PT/INR from the hospital emergency record revealed PT-131.9 and INR-10.3. Resident #15 was sent back to the facility and given Vitamin K 20 milligrams at 6:30 PM. The Physician ordered to repeat the PT/INR on 02/17/10. Record review revealed no evidence the PT/INR was drawn on 02/17/10. Interview with the DON on 02/19/10 at 2:30 PM revealed she felt there was a serious system breakdown with getting the ordered labs. Further record review revealed the Physician ordered another Vitamin K injection of 10 mg on 02/17/10.</p> <p>Interview with the Physician on 02/10/10 at 3:15 PM revealed he was not notified that Resident #15 had missed multiple doses of the ordered Coumadin. He stated he should have been notified. He further stated that Coumadin Therapy needed to be monitored closely and it was a definite concern to him that the facility staff were not administering the medication as ordered because he was increasing the Coumadin dosage based on the PT/INR lab results.</p> <p>3. Record review revealed Resident #7 was admitted to the facility on 12/23/08 with diagnoses which included Diabetes Mellitus, Hypertension and Depression. Review of the Minimum Data Set (MDS) dated 01/08/10 revealed the facility assessed the resident as being continent of bowel and bladder.</p>	F 802			

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F 502	<p>Continued From page 94</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 01/05/10, and the Comprehensive Care Plan dated 01/11/10 revealed the facility assessed the resident as having an urinary tract infection and was receiving antibiotics. Interventions included obtain laboratory tests as ordered.</p> <p>Review of the Physician's Orders dated 01/06/10, revealed an order to obtain an urinalysis to include a culture and sensitivity, on that date. Review of the laboratory report revealed the urinalysis was not obtained until two (2) days later on 01/08/10. Continued review revealed Resident #7 had antibiotics ordered for a urinary tract infection as a result of the urinalysis.</p> <p>Interview on 02/25/10 at 3:45 PM with the Director of Nursing revealed Resident #7's urinalysis should have been obtained on 01/08/10 as ordered.</p> <p>An acceptable Allegation of Compliance, related to the Immediate Jeopardy, was received on 02/26/10, prior to exit. Facility actions taken and verified by the survey team through interviews and record review revealed the following:</p> <p>Record reviews revealed PT/INR tracking was being monitored daily by the Administrator and DON. Record review revealed all nurses were involved on the lab tracking process and the newly adopted procedure for laboratory tests. Interviews with five (5) nursing staff revealed they had been educated and were aware on the lab tracking system and procedure.</p>	F 502		

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F 502	Continued From page 95 Immediate Jeopardy was determined to be removed on 02/27/10. Noncompliance continued with the Scope and Severity lowered to an "D" based on the facility's need to evaluate the effectiveness of quality assurance activities related to residents on Coumadin therapy who required laboratory monitoring to ensure therapeutic levels and appropriate doses of Coumadin were maintained through audits and review of the 24 hour report.	F 502		
F 520 SS=K	485.75(c)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520	F 520 Residents identified in F 157, F 281, F 282, F 309, F 329, and F 333 have been reviewed and corrected as stated in the plan of correction for each corresponding citation. The Facility implemented an effective system to address physician notification for change of condition. Refer to plan of correction (F 157). The facility implemented an effective system to ensure physicians' orders were transcribed onto the MAR and implemented. Refer to plan of correction (F 201). The facility implemented an effective system to ensure services were provided in accordance with each resident's written plan of care. Refer to plan of correction (F 282) The facility implemented an effective	4/13/10

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F 520	<p>Continued From page 08</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, and record review it was determined the facility failed to have an effective Quality Assurance (QA) Committee which was structured to identify quality issues with the potential for negatively affecting residents. In addition, the facility failed to ensure the Medical Director was involved in the Quality Assurance Committee meetings and/or promptly informed of quality of care concerns.</p> <p>Resident #13 had a physician's order to hold Coumadin on 01/27/10, however, facility records indicate the Coumadin was administered; the physician was not notified. In addition, Resident #13 had a physician's order to obtain a Prothrombin/International Normalized Ratio (PT/INR) on 01/28/10, this order was not followed through on timely. The laboratory testing was obtained on 01/29/10 which revealed abnormal results. Resident #13 received Vitamin K therapy on 01/29/10. The resident expired on 01/30/10.</p> <p>Resident #1 was assessed to have an elevated blood pressure (220/100) with no evidence the physician was notified or the facility provided interventions and/or continued to monitor the resident's blood pressure. The resident was hospitalized with a Cardiovascular Accident (CVA/stroke).</p> <p>The facility's failure to have an effective QA Committee which identified quality issues and implemented corrective action plans placed residents at risk for serious injury, harm, impairment or death.</p> <p>The findings include:</p>	F 520	<p>system to ensure residents were appropriately assessed and monitored and staff was appropriately trained on change of condition with physician notification. Refer to plan of correction (F 309)</p> <p>The facility implemented an effective system to ensure residents receiving Coumadin therapy receive adequate laboratory monitoring. Refer to plan of correction (F 328)</p> <p>The facility implemented an effective system to ensure staff was trained on medication administration. Refer to plan of correction (F 333).</p> <p>The facility implemented an effective system to ensure residents received laboratory services in a timely manner in accordance with physician orders. Refer to plan of correction (F 602)</p> <p>Quality assurance issues will be identified through reviewing the (24) hour nursing report, management team meeting notes, quality indicator reports, and departmental audits. Any identified issues will be sent to the quality assurance committee for further evaluation and appropriate plan of action.</p> <p>The Quality Assurance Committee met 2/23/10, 3/2/10, 3/9/10, and 3/17/10 to review deficient practices</p>	

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F 520	<p>Continued From page 97</p> <p>Crosswalk to F157: The facility failed to notify the Physician and/or Responsible Party related to change in condition and/or need to alter treatment. Resident #13 had a physician's order to hold Coumadin on 01/27/10, however, facility records indicate the Coumadin was administered. The facility failed to notify the physician after the Coumadin was administered. In addition, Resident #13 had a physician's order to obtain a Prothrombin/International Normalized Ratio (PT/INR) on 01/28/10. Even though the blood was obtained for the laboratory testing, there was no evidence the facility followed up to obtain the results of the testing, and did not notify the physician regarding the lack of results. The laboratory testing was obtained on 01/29/10 and revealed the PT results were greater than 100 (normal range 9.0-11.4 seconds), and an INR greater than 11 (normal for standard anticoagulant use is 2.0-3.0), and the resident received Vitamin K on 01/29/10. On 01/30/10 Resident #13 was found without pulse, blood pressure, or respirations. The resident was pronounced dead.</p> <p>Resident #1 experienced an elevated blood pressure on 01/20/10 of 228/108. The facility failed to notify the Physician of the elevated blood pressure. The resident was transferred to the hospital on 01/21/10, and diagnosed with a Cerebrovascular Accident (CVA).</p> <p>Crosswalk to F281: The facility failed to ensure Physicians' orders were implemented therefore, failed to provide services to meet professional standards of quality. Resident #13 had an order to hold his/her</p>	F 520	<p>identified, education, and monitoring processes.</p> <p>Quality assurance minutes were reviewed with the Medical Director on 2/24/10 and 3/17/10.</p> <p>The quality assurance committee will meet weekly for (4) weeks to review citations, plan of correction, monitoring, and any other identified concerns. After (4) weeks, the quality assurance committee will meet every (2) weeks for (4) weeks. Once scheduled meetings are completed, the quality assurance committee will determine frequency of future meetings, but not less than quarterly.</p>		

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
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F 520	<p>Continued From page 08</p> <p>Coumadin on 01/27/10. There was no documented evidence the order was transcribed to the Medication Administration Record (MAR) and the resident subsequently received the Coumadin. Laboratory (lab) testing, performed on 01/29/10, revealed Resident #13's lab values measuring the thickness of the blood were at a critical level (indicating the resident's blood was too thin), and Vitamin K (for blood coagulation) was administered.</p> <p>Resident #15's Physician ordered daily Coumadin therapy however, the facility failed to to administer the Coumadin as ordered on 02/01/10 through 02/05/10, on 02/09/10 and again on 02/16/10. The Physician was not made aware of the missed dosages and increased the Coumadin based on laboratory values. The resident's lab values were at a critical level and the resident required Vitamin K.</p> <p>Resident #7 had physician orders for antibiotics on two (2) separate occasions. The facility failed to ensure the antibiotics were administered as ordered and the resident missed the first three (3) doses of antibiotics on both occasions. Resident #4 had a physician's order for a pelvic restraint which the facility failed to ensure was applied as ordered. The facility failed to follow Physician's orders for Residents #3 and #5 related to completing weekly skin assessments.</p> <p>In addition, the facility failed to develop initial care plans to meet the needs of newly admitted residents for two residents (Resident #15 and #13).</p> <p>Crosswalk to F282: The facility failed to ensure the Comprehensive</p>	F 520		

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F 620	<p>Continued From page 00</p> <p>Plans of Care were implemented. Resident #1 had a diagnosis of Hypertension with care plan interventions to monitor blood pressure and alert the Physician of adverse reactions. The facility failed to implement the Plan of Care by failing to notify the resident's Physician, and continuing to monitor the resident's blood pressure, after the resident complained of dizziness and the facility assessed a blood pressure of 228/108 on 01/20/10. Resident #1 was sent to the hospital on 01/21/10 and diagnosed with a Cerebrovascular Accident (CVA).</p> <p>Crosswalk to F309: The facility failed to ensure care and services were provided to attain and maintain the resident's highest practicable physical well-being. The facility failed to ensure care and services were provided for Resident #1, who the facility assessed to have a blood pressure of 228/108 on 01/20/10. There was no documented evidence the physician was notified and/or evidence the resident was provided intervention(s) or continued monitoring Resident #1's blood pressure. The resident was hospitalized on 01/21/10 with a Cerebrovascular Accident (CVA/stroke). In addition the facility failed to have a system in place related to monitoring the residents' bowels.</p> <p>Crosswalk to F329: The facility failed to have an effective system in place to ensure residents who required Coumadin therapy received adequate laboratory monitoring, in order to ensure monitoring of therapeutic levels and appropriate dosage of Coumadin were maintained. This failure resulted in significantly increased PT/INR results to levels associated with life-threatening bleeding.</p>	F 620		

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F 520	<p>Continued From page 100</p> <p>Resident #13 had a physician's order to hold Coumadin on 01/27/10; however, there was no documented evidence the order to hold the Coumadin was transcribed to the MAR. The facility's records indicated the Coumadin was administered. Resident #13 had a physician's order to obtain a Prothrombin/International Normalized Ratio (PT/INR) on 01/28/10. The facility failed to follow up to obtain the results of the testing. The laboratory testing was obtained on 01/29/10 and revealed the PT/INR results were abnormal. The resident was administered Vitamin K on 01/29/10. At 4:00 AM on 01/30/10, the resident was found without a blood pressure, respirations or pulse and was cool to touch. The resident was pronounced dead.</p> <p>The facility failed to ensure Resident #15 received Coumadin as ordered and failed to ensure the Physician was notified of missed doses. The Physician continued to increase the resident's Coumadin. Further the resident required Vitamin K injections, related to PT/INR lab results.</p> <p>Crosswalk to F333: The facility failed to ensure residents were free from significant medication errors. Resident #13 had a Physician's order to hold Coumadin on 01/27/10, however, the Coumadin was administered on that date. On 01/28/10 Resident #13's PT/INR was at a critical level and required a Vitamin K injection. Resident #15 failed to receive six (6) doses of Coumadin, the Physician was not made aware and subsequently continued to increase the Coumadin dosage until the resident's PT/INR was at a critical level, and the resident required Vitamin K injections. Resident #7 failed to receive the first three doses of an antibiotic on two separate occasions for a total of</p>	F 520			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(X5) PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F-520	<p>Continued From page 101</p> <p>six (6) missed doses. Resident #3 failed to receive the first two doses of Proscar (used to improve symptoms of an enlarged prostate).</p> <p>Interview on 02/24/10, at 3:20 PM with the Director of Nursing (DON) revealed quality of care was ensured through report and morning meetings. However, interview revealed the facility had not identified quality concerns related to physician's orders not being transcribed to the Medication Administration Record (MAR) and medication administration. The DON stated the facility had identified a concern with the lab tracking process and implemented a lab tracking book. However, no formal inservice training was provided to licensed nursing staff in regards to the lab tracking book. The DON stated she had not performed monitoring to ensure the tracking system was effective.</p> <p>Interview on 02/23/10, at approximately 7:00 PM with the Administrator revealed quality of care was ensured through Quality Assurance (QA) meetings and quality indicators. He stated that quality indicators were identified through review of the 24 hour report, Resident Council, and care conferences. The Administrator stated issues involving problems with physician notification, medication administration, staff competencies, and resident monitoring related to change of condition had not been discussed in the QA Committee meetings. Further interview revealed the problem with lab tracking was identified during the investigation of the death of Resident #13. However, the QA Committee had not monitored the effectiveness of the new lab tracking book.</p> <p>Interview on 02/24/10, at 8:30 AM with the Medical Director revealed the facility had not kept</p>	F 520		

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
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F 520	<p>Continued From page 102</p> <p>him informed of identified problems. He stated things were left to the nurses discretion that should not have been. The Medical Director stated he was aware there had been a problem with Coumadin dosing and the lab reporting and issues with the Physician not being notified of lab results. According to the Medical Director, he was not always kept "abroad" of pertinent information related to residents care. In addition, he stated he had not been involved in the development of facility policies and procedures. He stated he had not been informed of any Quality Assurance (QA) Committee meetings "at this point", therefore had not attended a QA Committee meeting since becoming Medical Director. Record review revealed the last quarterly QA Committee meeting was held on 11/19/09, prior to the current Medical Director's appointment.</p> <p>An acceptable allegation of compliance related to the Immediate Jeopardy was received on 02/20/10, prior to exit. Facility actions taken and verified by the survey team through interview and record review revealed all nurses and CNAs were educated on change of condition, Physician notification, and monitoring. The 24 Hour Report was revised and implemented to track changes in condition, physician notification and appropriate monitoring.</p> <p>Interview with the DON and Administrator revealed the 24 hour report would be reviewed in the Interdisciplinary Team (IDT) Meeting each morning to review changes in condition, Physician notification, new Physician's orders, and lab tracking. Interview further revealed the information from the morning IDT meetings would be reviewed in the weekly QA meetings.</p>	F 520			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185038	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
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F 520	Continued From page 103 Interview with the Administrator and DON revealed the QA team would be meeting every Tuesday to evaluate identified plan of correction audits for four (4) consecutive weeks. Immediate Jeopardy was determined to be removed on 02/27/10. Noncompliance continued with the Scope and Severity lowered to an "E" based on the facility's need to evaluate the effectiveness of quality assurance activities related to professional standards of quality, use of the 24 Hour Report book to ensure changes of condition are reported and monitored.	F 520			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185038	(X2) MULTIPLE CONSTRUCTION A. BUILDING PP - 4TH FLOOR SKILLED UN B. WING _____	(X3) DATE SURVEY COMPLETED 02/25/2010
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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K 000	INITIAL COMMENTS Amended Statement of Deficiencies. A state Life Safety Code survey was conducted on 02/25/10 for compliance with Title 42, Code of Federal Regulations, 483.70 (a) (Life Safety from fire, requirements for Long Term Care Facilities)NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest deficiency identified at an " F".	K 000	<p><i>This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Providence Pavilion agrees with the allegations and citations listed on this statement of deficiencies. Providence Pavillion maintains that the alleged deficiencies do not, individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as proscribed by the regulations. This plan of correction shall operate as Providence Pavilion's written credible allegation of compliance.</i></p> <p><i>By submitting this plan of correction, Providence Pavilion does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Providence Pavilion reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action, or proceeding.</i></p>	
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 1 1/4 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 10.3.6.3.6 are permitted. 10.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		K 018
	This STANDARD is not met as evidenced by:		No residents were identified to be affected by the deficient practice. Door wedges were removed from	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Director	(X6) DATE 3/29/10
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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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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION		STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
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K 018	<p>Continued From page 1</p> <p>Based on observation and interview, it was determined the facility failed to ensure that corridor doors were being held open by approved devices.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 02/25/10 between 9:30 AM and 5:00 PM, multiple observations on the fourth floor construction wing of the facility revealed door wedges were used to hold open the stairway door. An interview with the Maintenance Director and the Construction Foreman on 02/25/10 between 9:30 AM and 5:00 PM revealed the Maintenance Director and the Construction Foreman were aware that stairway doors should not be held open in this manner. Observations of doors inappropriately held open continued during the course of the survey.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted</p> <p>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</p> <p>19.3.6.3.4 Door-closing devices shall not be required on doors in corridor wall openings other than those serving required exits, smoke barriers, or</p>	K 018	<p>the construction site at time of discovery. Construction staff was educated on doors not being blocked open by alternative devices on 2/25/10 by the Construction Foreman.</p> <p>Property Manager and/or designee will audit doors on construction wing (4) times per week for (4) weeks.</p> <p>Results will be reviewed at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring.</p>

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
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K 018	Continued From page 2 enclosures of vertical openings and hazardous areas. 7.6.4.11.2 Smoke Barriers. Smoke barriers are partitions extending across the entire width of the building or so arranged as to combine a partition in the corridor with existing building elements and subdividing partitions and walls to partition the building into two completely separate units. The smoke barrier must be equipped with doors in the corridor that are self-closing, closed upon detection by smoke detectors located at the door arches, or closed by smoke detector systems that have been credited with a 0-point parameter value in 7.6.4.4. Smoke barriers also shall conform to the requirements of Section 8.3 (NFPA 101). A horizontal exit acts as a smoke barrier and is credited as both a smoke barrier in 7.6.4.11 and a horizontal exit in 7.6.4.7.	K 018			
K 021 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2	K 021	No residents were identified to be affected by the deficient practice. The facility stairway door on the 4 th floor near room (# 415) was repaired on 2/25/10. In order to ensure compliance, the Maintenance Director and/or designee will audit the door release system (1) time per week for (4) weeks. Results will be reviewed at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring.	3/29/10	

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K 021	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the building's fire alarm system as required by the National Fire Protection Association (NFPA) Standard 72.</p> <p>The findings include:</p> <p>1. During the Life Safety Code tour with the Maintenance Director on 02/25/10 at 10:50 AM, a test of the Fire Alarm System was conducted. When the fire alarm pull station was activated, and the system placed in silent mode, the facility stairway door on the fourth floor near room (#415) failed to release. The stairway door prevented anyone from exiting the building in the event of a fire.</p> <p>Interview with the Maintenance Director and Building Manager on 02/25/10 at 10:30 AM revealed the Maintenance Director and the Building Manager were not aware the stairway door would not open when the fire alarm pull station was activated. The Maintenance Director and Building Manager agreed that this was a serious issue.</p> <p>NFPA: 72 1999</p> <p>3-9.6 Door Release Service. 3-9.6.1 The provisions of 3-9.6 shall apply to the methods of connection of door hold-open release devices and to integral door hold-open release, closer,</p>	K 021		

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K 021	Continued From page 4 and smoke detection devices. 3-9.0.2 All detection devices used for door hold-open release service shall be monitored for integrity in accordance with 1-5.8. Exception: Smoke detectors used only for door release and not for open area protection. 3-9.0.3 All door hold-open release and integral door release and closure devices used for release service shall be monitored for integrity in accordance with 3-9.2. 3-9.0.4 Magnetic door holders that allow doors to close upon loss of operating power shall not be required to have a secondary power source. NFPA 101 LIFE SAFETY CODE STANDARD	K 021		
K 048 SS*E	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 10 7 1 1 This STANDARD is not met as evidenced by: Based on an interview and record review, it was determined the facility failed to provide training for staff regarding the evacuation of smoke compartments directly affected by fire. Based on observation, the facility failed to maintain the building's fire alarm system, training, and zone notification as required by the National Fire Protection Association (NFPA) Standard 72. This deficient practice affects all residents in the facility. The findings include:	K 048	No residents were identified to be affected by the deficient practice. The facility educated staff on the fire and evacuation plan on 3/5/10. A copy of the fire and evacuation plan was placed at the nurse's station on 2/25/10. The facility implemented a system to have a designated employee monitor the fire alarm control unit 24 hours per day, effective 2/25/10. The Maintenance Director and/or designee will randomly question (3) staff members, (4) times per week on fire and evacuation procedures for (4) weeks.	3/29/10

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K 048	<p>Continued From page 5</p> <p>1. Record review and interview on 02/23/10 and 02/25/10, between 9:30 AM and 3:00 PM revealed the health survey team asked for the fire and evacuation plan. No fire and evacuation plan was provided. On 02/25/10, the Life Safety Code surveyor requested a copy of the fire and evacuation plan. A copy of the fire and evacuation plan was provided by the Director of Maintenance. Interview with the Director of Maintenance and the Building Manager, revealed that the current staff had only been working at this facility for about two to three months and everyone was still learning the building and the fourth floor. Interview with two Nursing staff, one (CNA) and one (LPN) on 02/25/10 revealed, when asked about the Fire Alarm system plan and Fire Evacuation plan the (CNA) and the (LPN), both said they were not on the floor very long and would have to ask someone else. NFPA 101, 2000 Edition requires that a written health care occupancy fire safety plan must provide for the evacuation of smoke compartments. An interview on 02/25/10, between 9:30 AM and 4:00 PM with the Maintenance Director and the Building Manager revealed there was sufficient training on the fire alarm system and fire evacuation plan.</p> <p>2. Observation on 02/23/10 at 7:00 PM by the health survey team revealed the Fire Alarm System was activated and it took the staff over twenty (20) minutes to locate the area of trouble.</p> <p>Interview with the Maintenance Director and the Building Manager on 02/25/10 at 10:00 AM revealed that building personnel were not familiar with the fire alarm system.</p>	K 048	Results will be reviewed at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring.	

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K 048	<p>Continued From page 6</p> <p>3. Observation on 02/25/10 at 10:00 AM during the test of the Fire Alarm System revealed that the main fire alarm system panel was located in the basement in an area that was not occupied continuously by building personnel. Only one of the two fire alarm control units on the fourth floor was addressable. The residents occupy the fourth floor of this building.</p> <p>Interview with the Building Owner on 02/25/10 at 5:00 PM revealed the Building Owner was aware that the Fire Alarm Control Unit at the nurse's station needed to be addressable. He said he would replace the Fire Alarm Control Unit at the nurses station to meet NFPA 72.</p> <p>19.1.1.3 Total Concept. All health care facilities shall be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. Because the safety of health care occupants cannot be ensured adequately by dependence on evacuation of the building, their protection from fire shall be provided by appropriate arrangement of facilities, adequate staffing, and development of operating and maintenance procedures composed of the following: (1) Design, construction, and compartmentation (2) Provision for detection, alarm, and extinguishment (3) Fire prevention and the planning, training, and drilling programs for the isolation of fire, transfer of occupants to areas of refuge, or evacuation of the building</p> <p>19.7.2.2</p>	K 048			

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K 048	<p>Continued From page 7</p> <p>A written health care occupancy fire safety plan shall provide for the following: (6) Evacuation of smoke compartment</p> <p>NFPA: 99 1009</p> <p>3-8.4.1 Occupant Notification. Fire alarm systems provided for evacuation or relocation of occupants shall have one or more notification appliances listed for the purpose on each floor of the building and so located such that they have the characteristics described in Chapter 4 for public mode or private mode, as required. Notification zones shall be consistent with the emergency response or evacuation plan for the protected premises. The boundaries of notification zones shall be coincident with building outer walls, building fire or smoke compartment boundaries, floor separations, or other fire safety subdivisions.</p> <p>3-8.4.1.1 Survivability. 3-8.4.1.1.1 Paragraph 3-8.4.1.1 applies only to systems used for partial evacuation or relocation of occupants. 3-8.4.1.1.2 A single notification appliance circuit shall not serve more than one notification zone. 3-8.4.1.1.3* The system shall be designed so that failure of equipment or a fault on one or more installation wiring conductors of one notification appliance circuit shall not result in functional loss of any other notification appliance circuit. 3-8.4.1.1.4* Notification appliance circuits and any other circuits necessary for the operation of the</p>	K 048			

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K 048	Continued From page 8 notification appliance circuits shall be protected from the point at which they exit the control unit until the point that they enter the notification zone that they serve using one or more of the following methods: (1) A 2-hour rated cable assembly (2) A 2-hour rated shaft or enclosure (3) A 2-hour rated stairwell in a building fully sprinklered in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems NFPA 101 LIFE SAFETY CODE STANDARD	K 048			
K 052 SS=F	A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.8.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the building's fire alarm system as required by the National Fire Protection Association (NFPA) Standard 72. This deficient practice affects all residents in the facility. The findings include:	K 052	K 052 No residents were identified to be affected by the deficient practice. The facility implemented a system to have a designated employee monitor the fire alarm control unit 24 hours per day, effective 2/25/10. Smoke detector was ordered for the security office on the ground floor on 3/11/10. In order to ensure compliance, the Maintenance Director and/or designee will monitor the current system (4) times per week for (4) weeks. Results will be reviewed at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring.	3/29/10	

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

PRINTED: 03/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185038	(X2) MULTIPLE CONSTRUCTION A. BUILDING PP - 4TH FLOOR SKILLED UNI B. WING _____	(X3) DATE SURVEY COMPLETED 02/25/2010	
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION		STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
(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)	(X4) COMPLETION DATE
K 052	<p>Continued From page 9</p> <p>1. Observation during the Life Safety Code survey on 02/25/10 at 10:00 AM revealed during the inspection and testing of the fire alarm system, the fire alarm system consisted of multiple components, including an automatic dialer. Observation of the main fire alarm control panel (FACP), located in the security office on the ground floor, revealed the fire alarm system failed to provide addressable zones in the facility's fourth floor nurse's station. The Fire Alarm Control Unit did not communicate as a stand alone system. NFPA 72.</p> <p>Interview with the building owner on 02/25/10 revealed he would make the necessary changes to the nurse's station fire alarm system unit on the fourth floor. The building owner was not aware the fire alarm system was not operating according to NFPA standards.</p> <p>2. Observation on 02/25/10 at 10:00 AM revealed there was no smoke detection device provided for the Main Fire Alarm Panel located in the old security office on the ground floor.</p> <p>Interview on 02/25/10 with the Maintenance Director and the Building Manager revealed they were not aware a smoke detector was needed for the Main Fire Alarm Panel.</p> <p>Reference: NFPA 72 1999 edition</p> <p>1-5.6* Protection of Fire Alarm Control Unit(s). In areas that are not continuously occupied,</p>	K 052		

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION		STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
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K 052	<p>Continued From page 10</p> <p>automatic smoke detection shall be provided at the location of each fire alarm control unit(s) to provide notification of fire at that location. Exception: Where ambient conditions prohibit installation of automatic smoke detection, automatic heat detection shall be permitted.</p> <p>A-1-5.6 The intent of 1-5.6 is to have the fire alarm system respond before it is incapacitated by fire. There have been several fatal fires where the origin and path of the fire resulted in destruction of the control unit before a detector responded. CAUTION: The exception to 1-5.6 permits use of a heat detector if ambient conditions are not suitable for smoke detection. It is important to also evaluate whether the area is suitable for the control unit. The code intends that only one smoke detector is required at the control unit even when the area of the room would require more than one detector if installed according to the spacing rules in Chapter 2</p> <p>6-2.1* If implemented at the option of the authority having jurisdiction, a public fire alarm reporting system shall be designed, installed, operated, and maintained to provide the maximum practicable reliability for transmission and receipt of fire alarms.</p> <p>NFPA 72 1999 Actual NFPA standard: Fire alarm system components shall be permitted to share control equipment or shall be able to operate as stand alone subsystems, but, in any case, they shall be arranged to function as a single system. NFPA 72</p>	K 052		

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
(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 052	<p>Continued From page 11 section 3-8.1. Actual NFPA standard: The trouble signal(s) shall be located in an area where it is likely to be heard. NFPA 72, section 1-5.4.6. Actual NFPA standard: A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70. NFPA 101 section 9.6.1.4 Actual NFPA standard: Distinctive Signals. Fire alarms, supervisory signals, and trouble signals shall be distinctively and descriptively annunciated. NFPA 72 section 1-5.4.4.</p> <p>NFPA: 99 1099</p> <p>3-8.4.1 Occupant Notification. Fire alarm systems provided for evacuation or relocation of occupants shall have one or more notification appliances listed for the purpose on each floor of the building and so located such that they have the characteristics described in Chapter 4 for public mode or private mode, as required. Notification zones shall be consistent with the emergency response or evacuation plan for the protected premises. The boundaries of notification zones shall be coincident with building outer walls, building fire or smoke compartment boundaries, floor separations, or other fire safety subdivisions. 3-8.4.1.1 Survivability. 3-8.4.1.1.1 Paragraph 3-8.4.1.1 applies only to systems used for partial evacuation or relocation of occupants. 3-8.4.1.1.2 A single notification appliance circuit shall not serve more than one notification zone.</p>	K 052			

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K 052	Continued From page 12 3-8.4.1.1.3* The system shall be designed so that failure of equipment or a fault on one or more installation wiring conductors of one notification appliance circuit shall not result in functional loss of any other notification appliance circuit. 3-8.4.1.1.4* Notification appliance circuits and any other circuits necessary for the operation of the notification appliance circuits shall be protected from the point at which they exit the control unit until the point that they enter the notification zone that they serve using one or more of the following methods: (1) A 2-hour rated cable assembly (2) A 2-hour rated shaft or enclosure (3) A 2-hour rated stairwell in a building fully sprinklered in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems NFPA 101 LIFE SAFETY CODE STANDARD	K 052			
K 109 SS=F	This requirement applies only to existing limited care facilities. An automatic smoke detection system is installed in all corridors. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridors.) Such detectors are electrically interconnected to the fire alarm system. 19.3.4.5.1	K 109	K 109 No residents were identified to be affected by the deficient practice. The facility has hired a contractor on 3/11/09 and work is currently in progress for installation of the smoke detectors to meet code requirements. The work is anticipated to be complete by 3/29/10. The facility implemented a system to have a designated employee monitor the fire alarm control unit 24 hours per day, effective 2/25/10. In order to ensure compliance, the Maintenance Director and/or	3/29/10	

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
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K 109	<p>Continued From page 13</p> <p>This STANDARD Is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the building's fire alarm system as required by the National Fire Protection Association (NFPA) Standard 72. This deficient practice affects all residents of the facility.</p> <p>The findings include:</p> <p>Observation during the Life Safety Code tour on 02/25/10 between 9:30 AM and 5:00 PM with the Maintenance Director and the Sprinkler contractor revealed the ground floor, first, second, third, and fifth floor, were partially sprinklered. The fourth floor was fully sprinklered. Also on these floors, smoke detection in the corridors, rooms, and bath were not in compliance with NFPA 72 Regulation. Smoke detectors in the corridors are not on thirty foot (#30") on center. In addition, this building was formerly known as St. Elizabeth in Covington, KY.</p> <p>Interview with the Maintenance Director, Building Manager and Building Owner on 02/25/10 at 9:00 PM revealed they were not aware the building's smoke detectors were not in concordance with NFPA 72 1999.</p> <p>NFPA 72 1999 2-3.4.9 Raised Floors and Suspended Ceilings. Spaces beneath raised floors and above suspended ceilings shall be treated as separate rooms for smoke detector spacing purposes. Detectors installed beneath raised floors or above suspended ceilings, or both, including raised floors and suspended ceilings used for</p>	K 109	<p>designee will monitor the current system (4) times per week for (4) weeks.</p> <p>Results will be reviewed at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring.</p>		

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
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K 109	Continued From page 14 environmental air, shall not be used in lieu of providing detection within the room. 2-3.4.9.2 Suspended Ceilings. Detector spacing above suspended ceilings shall conform to the requirements of 2-3.4 for the ceiling configuration. If detectors are installed in ceilings used for environmental air, detector spacing shall also conform to 2-3.5.1 and 2-3.5.2. 2-3.1 General. 2-3.1.1* The purpose of Section 2-3 shall be to provide information to assist in design and installation of reliable early warning smoke detection systems for protection of life and property. 2-3.1.2 Section 2-3 shall cover general area application of smoke detectors in ordinary indoor locations. 2-3.1.3 For information on use of smoke detectors for control of smoke spread, the requirements of Section 2-10 shall apply. 2-3.1.4 For additional guidance in the application of smoke detectors for flaming fires of various sizes and growth rates in areas of various ceiling heights, refer to Appendix B. 2-3.2* Smoke detectors shall be installed in all areas where required by applicable laws, codes, or standards.	K 109			
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130	K 130 No residents were identified to be affected by the deficient practice. Construction material that was identified to be blocking means of	3/29/10	

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K 130	<p>Continued From page 15</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide a safe environment for the residents of the facility while construction was in progress.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 02/23/10 and 02/25/10 between 9:30 AM and 5:00 PM revealed the health team surveyors observed on 02/23/10 contractors cutting the brick in the construction area with a brick cutting saw, and smoke from the cutting filling a large part of the fourth floor wing. No residents were harmed. When the construction workers saw the smoke going into the residents' area, the contractors tried to use a fan to pull the smoke to the outside window in the construction work area.</p> <p>Observation on 02/25/10 between 9:00 AM and 5:00 PM revealed the means of egress was blocked by all types of construction material, tools, drywall, plumbing equipment, was blocking the path of egress. The stairway door was open by using a wedge or some foreign material. Smoke detectors were covered with plastic to avoid activation of the fire alarm system. However, interview with the contractor and the Maintenance Director on 02/25/10 revealed around 4:00 PM the contractors left for the day. No one uncovered the smoke detectors in the construction area to provide smoke and fire protection for the residents and staff.</p> <p>Interview with the Maintenance Director, Building</p>	K 130	<p>egress was removed at time of discovery.</p> <p>Smoke detectors were uncovered at time of discovery.</p> <p>Construction staff was educated on blocking of egress and uncovering smoke detectors on 2/25/10 by Construction Foreman.</p> <p>Maintenance Director and/or designee will audit means of egress and smoke detectors on construction wing daily during hours of construction to ensure compliance</p> <p>Results will be reviewed at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring.</p> <p>All construction work on the new unit is anticipated to be completed by 3/26/10.</p>		

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K 130	<p>Continued From page 16</p> <p>Owner and the Administrator on 02/25/10 at 6:00 PM revealed, they were not aware of the problem. They further stated while construction was performed the area affected should be continuously maintained and occupied. Alternative life safety measures acceptable to the authority having jurisdiction were in place.</p> <p>NFPA: 101 2000</p> <p>4.6.10 Construction, Repair, and Improvement Operations.</p> <p>4.6.10.1* Buildings or portions of buildings shall be permitted to be occupied during construction, repair, alterations, or additions only where required means of egress and required fire protection features are in place and continuously maintained for the portion occupied or where alternative life safety measures acceptable to the authority having jurisdiction are in place.</p> <p>4.6.10.2* In buildings under construction, adequate escape facilities shall be maintained at all times for the use of construction workers. Escape facilities shall consist of doors, walkways, stairs, ramps, fire escapes, ladders, or other approved means or devices arranged in accordance with the general principles of the Code insofar as they can reasonably be applied to buildings under construction.</p> <p>4.6.10.3 Flammable or explosive substances or equipment for repairs or alterations shall be permitted in a building while the building is occupied if the condition of use and safeguards provided do not create any additional danger or impediment to egress beyond the normally permissible</p>	K 130			

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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K 130	<p>Continued From page 17</p> <p>conditions in the building.</p> <p>4.6.11* Changes of Occupancy. In any building or structure, whether or not a physical alteration is needed, a change from one occupancy classification to another shall be permitted only where such a structure, building, or portion thereof conforms with the requirements of this Code that apply to new construction for the proposed new use or, where specifically permitted elsewhere in the Code, existing construction features shall be permitted to be continued in use in conversions.</p> <p>4.6.12 Maintenance and Testing.</p> <p>4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction.</p> <p>4.6.12.2* Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed.</p> <p>4.6.12.3 Equipment requiring periodic testing or operation to ensure its maintenance shall be tested or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction.</p> <p>4.6.12.4 Maintenance and testing shall be under the supervision of a responsible person who shall ensure that testing and maintenance are made at specified intervals in accordance with applicable NFPA standards or as directed by the authority having jurisdiction.</p>	K 130		
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K 130	<p>Continued From page 18</p> <p>NFPA: 101 2000 8.2 CONSTRUCTION AND COMPARTMENTATION 8.2.1* Construction. Buildings or structures occupied or used in accordance with the individual occupancy chapters (Chapters 12 through 42) shall meet the minimum construction requirements of those chapters. NFPA 220, Standard on Types of Building Construction, shall be used to determine the requirements for the construction classification. Where the building or facility includes additions or connected structures of different construction types, the rating and classification of the structure shall be based on either of the following: (1) Separate buildings if a 2-hour or greater vertically-aligned fire barrier wall in accordance with NFPA 221, Standard for Fire Walls and Fire Barrier Walls, exists between the portions of the building Exception: The requirement of 8.2.1(1) shall not apply to previously approved separations between buildings. (2) The least fire-resistive type of construction of the connected portions, if no such separation is provided 8.2.2 Compartmentation. 8.2.2.1 Where required by Chapters 12 through 42, every building shall be divided into compartments to limit the spread of fire and restrict the movement of smoke. 8.2.2.2* Fire compartments shall be formed with fire barriers that are continuous from outside wall to outside wall, from one fire barrier to another, or a</p>	K 130		

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K 130	Continued From page 10 combination thereof, including continuity through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Walls used as fire barriers shall comply with Chapter 3 of NFPA 221, Standard for Fire Walls and Fire Barrier Walls. The NFPA 221 limitation on percentage width of openings shall not apply. Exception: A fire barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space has a fire resistance rating not less than that of the fire barrier.	K 130		
K 155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide, in writing, a procedure to be implemented in case the fire alarm system was out of service for more than four (4) hours in a 24-hour period of time. NFPA 9.6.1.8 The findings include: Observations during the Life Safety Code Inspection on 02/25/10 at 9:30 AM revealed	K 155	K 155 No residents were identified to be affected by the deficient practice. The facility implemented a written procedure to address the fire alarm system when out of service for more than (4) hours in a 24 hour period. In order to ensure compliance, the Property Manager and/or designee will monitor via fire watch log on a daily basis. Results will be reviewed at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring.	3/29/10

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K 155	<p>Continued From page 20</p> <p>contractors were working on the fourth floor wing of the facility.</p> <p>At 10:30 AM, on 02/25/10 the Life Safety Code surveyor, Maintenance Director and the Building Manager were about to conduct a test of the Fire Alarm System when the Director stated the system was in test mode, and off-line with the monitoring provider. The Maintenance Director said the contractors had been working in the facility for some time and the facility could not provide in writing when the fire alarm system was out of service for more than four (4) hours in a 24-hour period for 01/25/10, 02/25/10, and the last off line period.</p> <p>Review of the facility's policy on fire watch revealed that if the system was out of service for more than four (4) hours in a 24-hour period, staff would conduct a fire watch and would make rounds every thirty (30) minutes.</p>	K 155		