RECEIVED SEP 2012 OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185046	A. BUILDING _____ B. WING _____	08/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER	609 NORTH HAYDEN AVE. SALEM, KY 42078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification/abbreviated survey (KY #18917) was conducted on 08/21/12 through 08/24/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of an "E". KY #18917 was substantiated with deficiencies cited.	F 000	The statements contained in this plan of corrections are not and admission and do not constitute agreement with the alleged deficiencies herein. To remain compliant with all federal and state regulations the facility has taken or will take the following actions set forth within the following corrections. The following corrections constitute the facility's compliance such that all deficiencies cited will be corrected by 9/21/12.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	1. This resident no longer resides in the facility. 2. All residents have the potential to be affected. 3. Nursing staff will be educated by in-service on policy regarding notification of change. Review of past thirty days of documentation will be done to ensure to identify any other concerns. 4. Nursing documentation will be reviewed by DON or designee daily and any issues will discussed in the daily interdisciplinary meeting. All findings will be reported to the Quarterly Patient Care Committee meeting. 5. Date corrective action will be corrected for F 157	09/21/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tammy Workman — TITLE: Administrator — (X6) DATE: 9/20/12

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

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview, closed record review, review of the facility's policy/procedure, and the hospital's discharge summary, it was determined the facility failed to consult/notify the physician related to a significant change of condition for one resident (#14), in the selected sample of fourteen (14) residents. The facility failed to follow the "Notification of Physicians" policy/procedure. On 05/13/12, the facility failed to notify Resident #14's physician when he/she presented with a decline in appetite, decreased responsiveness and a blood pressure of 80/48 mm/hg (normal for this resident was 130/70 mm/hg range). Resident #14's family member notified the physician, and the physician notified the nurse who was instructed to transfer Resident #14 to the hospital. Findings include: A review of the facility's policy/procedure, "Notification of Change," revised 01/11, revealed "the resident's physician must be notified when the resident experiences a change in condition." The physician should be immediately notified when a resident's systolic blood pressure (top number of blood pressure) is less than 90 mm/hg unless the values are consistently this level and the physician is aware. A closed record review revealed the facility	F 157		

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F 157	Continued From page 2 admitted Resident #14 on 04/23/11 with diagnoses to include Hypertension, Dementia, Urinary Tract Infection, and Dementia. A review of the resident's vital signs form revealed blood pressures taken from 04/26/11 through 07/03/12 ranged from 120-140 mm/hg (systolic)/60-80 mm/hg (diastolic). Additionally, a review of Resident #14's intake records, dated 05/2012 revealed the resident usually ate 100 % of breakfast and 75-100 % of lunch and supper. A review of a nurse's note, dated 05/09/12 at 9:00 AM, revealed Resident #14 was up in his/her wheelchair. The resident was on Levaquin and Macrodantin related to UTIs, and the facility was awaiting the results of a urine culture and sensitivity. Further review of a nurse's note, dated 05/09/12 at 12:45 PM, revealed the resident's white blood count was increased, the physician was notified, and an order was received for Rocephin (antibiotic) one gram (gm) intramuscular (IM) times one. On 05/10/12 at 8:30 AM, Resident #14 complained of abdominal cramping, nausea, and loose stools. The physician was notified with an order received for Imodium. On 05/11/12 at 1:00 PM, the nurse practitioner was at the facility and ordered a stool culture and to check stools for occult blood. At 6:00 PM, Resident #14 was propelling self around the facility in his/her wheelchair. Review of a nurse's note, dated 05/12/12 (Saturday) at 5:00 AM, revealed the resident was alert, resting quietly, and continued to have loose stools. The resident's blood pressure was 130/82 mm/hg. Review of the nurse's notes, dated 05/12/12 at 2:15 PM and 2:30 PM, revealed Resident #14 had two episodes of loose stool, was very sluggish, ate no breakfast or lunch, and was	F 157		

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F 157	Continued From page 3 sitting at the nurse's station asleep with a blood pressure of 128/78 mm/hg. On 05/12/12 at 10:00 PM, Resident #14 was lethargic, speech was clear but very soft, required constant cueing to take fluids, color was pale and blood pressure was 128/74 mm/hg. The resident also had two more loose stools. On 05/13/12 (Sunday-Mother's Day) at 11:30 AM, the resident would not open his/her eyes, but responded with a very low voice. The resident only ate a few bites of breakfast, and had two more loose stools. At that time, the resident's blood pressure was 80/48 mm/hg. An interview with Resident #14's family member, on 08/24/12 at 1:30 PM, revealed he arrived at the facility on 05/13/12 around lunch time. He stated the resident was in his/her room in bed and was unresponsive. The nurse came into the room and stated the resident's blood pressure was "eighty-something over forty-something." He asked the nurse if she had contacted the physician and was told the resident's physician was not on call. He stated he was informed that the resident was in a deep rest and they would contact the physician on Monday. He left the facility and the more he thought about what the nurse said, the more concerned he became, so he decided to contact the physician himself. He revealed that he contacted the physician about the resident's condition and the physician contacted the facility. The resident was then sent out to the hospital. Interview with Certified Nurse Aide (CNA) #1, on 08/23/12 at 10:00 AM, revealed the resident's condition had declined and the resident was not the same. The resident was having diarrhea.	F 157		

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F 157	Continued From page 4 The CNA revealed the family had visited Resident #14 and was concerned about the resident's condition. Interview with Registered Nurse (RN) #2, on 08/23/12 at 8:45 AM, revealed she did not see any reason to send the resident out to the hospital or to notify the physician. She revealed she notified the family member and let him know that the resident was having loose stools. She recalled the family did not request to have the resident sent out to the hospital. Interview with the Director of Nursing (DON), on 08/24/12 at 2:00 PM, revealed she relied on her nurses' decisions; however, she probably would have contacted the physician. A review of the hospital's discharge summary, dated 05/16/12, revealed final diagnoses to include Urinary Tract Infection, Clostridium Difficile Colitis, Sepsis, and Acute Renal Failure.	F 157		
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, closed record review, review of the facility's policy/procedure, and the facility's	F 224	1. This resident no longer resides in the facility. 2. All residents have the potential to be affected. 3. Staff education will be completed by 9/20/12 on the policy of abuse and neglect and reporting. Review of past thirty days of documentation will be done to ensure to identify any other concerns. 4. On going daily review of documentation will be completed and discussed at the daily interdisciplinary meeting. Any reportable event will be reported as defined in the CMS operations manual.	

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F 224	Continued From page 5 final Investigation Report, it was determined the facility failed to ensure written policies and procedures were implemented that prohibit neglect of residents for one resident (#14), in the selected sample of fourteen (14) residents. The facility failed to implement the Abuse and Neglect policy/procedure as evidenced by the failure to identify an allegation made by Resident #14's family as neglect, according to the policy's definition of neglect. This failure prevented the facility from notifying the State Agencies about the allegation. Furthermore, the facility failed to conduct a thorough investigation, having only interviewed one staff member regarding the incident. Additionally, due to the failure of identifying the allegation as neglect, this prevented the facility from reporting the investigation results within five (5) days. On 05/30/12, Resident #14's family reported an allegation of neglect to the Director of Nursing (DON), alleging that the facility failed to provide timely care and services to Resident #14 related to notifying the physician when there was a significant change in condition. On 05/13/12, the family member alleged he contacted the physician in order to get Resident #14 transferred to the hospital when the resident was identified as unresponsive, and the resident's blood pressure dropped to 80/48 mm/hg (normal range for this resident was in the 130/70 mm/hg range). The facility failed to identify the allegation as neglect and the investigation failed to determine that neglect occurred. Findings include: A review of the facility's "Abuse and Neglect" policy/procedure, last revised 01/08, revealed the	F 224	All findings will be reported at the Quality Patient Care Committee meetings. 5. Date corrective action will be completed for F 224.	9/21/12

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F 224	Continued From page 6 facility's definition of neglect was "the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness". The Administrator and DON should coordinate completion of a full investigation to include summary of the incident and witness statements. The State Agency should be notified about allegations of neglect within 24 hours of the allegation and in accordance with state law, and within five days of initiating the investigation, the Administrator will fax the results of the investigation and investigation data to the State Agency. A closed record review revealed the facility admitted Resident #14 on 04/23/11 with diagnoses to include Hypertension, Dementia, Urinary Tract Infection, and Dementia. A record review revealed no evidence the physician was notified about Resident #14's change in condition. An interview with Resident #14's family member, on 08/24/12 at 1:30 PM, revealed he arrived at the facility on 05/13/12 (Sunday-Mother's Day) around lunch time. He stated the resident was in his/her room in bed and was unresponsive. The nurse came into the room and stated the resident's blood pressure was "eighty-something over forty-something." He asked the nurse if she had contacted the physician and was told the resident's physician was not on call. He stated he was informed that the resident was in a deep rest and they would contact the physician on Monday. He left the facility and the more he thought about what the nurse said, the more concerned he became, so he decided to contact the physician himself. He revealed that he contacted the physician about the resident's condition and the	F 224		

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F 224	Continued From page 7 physician contacted the facility. The resident was then sent out to the hospital. Interview with Certified Nurse Aide (CNA) #1, on 08/23/12 at 10:00 AM, revealed the resident's condition had declined and the resident was not the same. The resident was having diarrhea. The CNA revealed the family had visited Resident #14 and was concerned about the resident's condition. Interview with Registered Nurse (RN) #2, on 08/23/12 at 8:45 AM, revealed she did not see any reason to send the resident out to the hospital or to notify the physician. She revealed she notified the family member and let him know that the resident was having loose stools. She recalled the family did not request to have the resident sent out to the hospital. A review of the DON's note, dated 05/30/12, revealed Resident #14's family member came to her with a concern that he had to contact the physician in order to get Resident #14 transferred to the hospital. The note revealed the DON assured Resident #14's family member that she would "look into things." Further review of the note revealed the DON discussed the situation with RN #2, who told her the resident was assessed and that the family member contacted the physician before she had the chance to do so. A review of the facility's Investigation Report, completed 08/14/12, after a State Agency reported the allegation of neglect to the facility on 08/09/12, revealed the DON reviewed the medical record and determined that "care and services were rendered accurately, appropriately	F 224		

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F 224	Continued From page 8 and in a timely manner." Further review of the Investigation Report revealed the DON interviewed RN #2; however, she did not interview the other staff who provided care for Resident #14 that weekend. Additionally, the DON did not identify that the resident's appetite decreased and the resident's systolic blood pressure dropped below 90 mm/hg, which required notification of the physician according to the facility's policy and procedure. Interview with the DON, on 08/24/12 at 2:00 PM, revealed she did not complete a thorough investigation of the incident back in May 2012 because she did not feel that this was an allegation of neglect. The DON stated her definition of neglect was when staff did not take care of the resident or meet their basic needs. She revealed the physician should have been notified.	F 224		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, closed record review, review of the facility's policy/procedure, and the facility's final Investigation Report, it was determined the facility failed to ensure written policies and procedures were implemented that prohibit	F 226	1. This resident no longer resides in the facility. 2. All residents have the potential to be affected. 3. Staff education on the policy of abuse and neglect and reporting will be completed by 9/20/12. Review of past thirty days of documentation will be done to ensure to identify any other concerns. 4. All documentation will be reviewed daily and discussed in the daily interdisciplinary meeting to ensure compliance to the facility policy and to CMS operations manual. All findings will be reported to the Quality	

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F 226	Continued From page 9 neglect of residents for one resident (#14), in the selected sample of fourteen (14) residents. The facility failed to implement the Abuse and Neglect policy/procedure as evidenced by failure to identify an allegation of neglect according to their policy's definition of neglect. This failure prevented the facility from notifying the State Agencies about the allegation. Furthermore, the facility failed to conduct a thorough investigation, having only interviewed one staff member regarding the incident. Additionally, the facility failed to identify the allegation as neglect, which prevented the facility from reporting the investigation results within five (5) days. On 05/30/12, Resident #14's family reported an allegation of neglect to the Director of Nursing (DON), alleging that the facility failed to provide timely care and services for Resident #14 related to the failure to notify the physician when the resident had a significant change in condition. On 05/13/12, the family member alleged he contacted the physician in order to get Resident #14 transferred to the emergency room when the resident had a significant change in condition. The facility failed to identify the allegation as neglect and their investigation failed to determine neglect occurred. Refer to F224 Findings include: A review of the facility's "Abuse and Neglect" policy/procedure, last revised 01/08, revealed the facility's definition of neglect was "the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness". The Administrator and DON will coordinate	F 226	Patient Care committee quarterly. 5. Date corrective action will be completed for F 226	9/21/12

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F 226	Continued From page 10 completion of a full investigation to include a summary of the incident and witness statements. The State Agency will be notified about allegations of neglect within 24 hours of the allegation and in accordance with state law, and within five days of initiating the investigation, the Administrator will fax to the State Agency the results of the investigation and investigation data. A closed record review revealed the facility admitted Resident #14 on 04/23/11 with diagnoses to include Hypertension, Dementia, Urinary Tract Infection, and Dementia. Further review revealed no evidence the physician was notified regarding Resident #14's change in condition. An interview with Resident #14's family member, on 08/24/12 at 1:30 PM, revealed he arrived at the facility on 05/13/12 (Sunday-Mother's Day) around lunch time. He stated the resident was in his/her room in bed and was unresponsive. The nurse came into the room and stated the resident's blood pressure was "eighty-something over forty-something." He asked the nurse if she had contacted the physician and was told the resident's physician was not on call. He stated he was informed that the resident was in a deep rest and they would contact the physician on Monday. He left the facility and the more he thought about what the nurse said, the more concerned he became, so he decided to contact the physician himself. He revealed that he contacted the physician about the resident's condition and the physician contacted the facility. The resident was then sent out to the hospital. A review of the DON's note, dated 05/30/12,	F 226		

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F 226	Continued From page 11 revealed Resident #14's family member came to her with a concern that he had to contact the physician in order to get Resident #14 transferred to the hospital. The note revealed the DON assured Resident #14's family member that she would "look into things." Further review of the note revealed the DON discussed the situation with RN #2, who told her the resident was assessed and that the family member contacted the physician before she had the chance to do so. No further investigation or action was taken at that time. A review of the facility's Investigation Report, completed 08/14/12, after a State Agency reported the allegation of neglect to the facility on 08/09/12, revealed the DON reviewed the medical record and determined that "care and services were rendered accurately, appropriately and in a timely manner." Further review of the Investigation Report revealed the DON interviewed RN #2; however, she did not interview the other staff who provided care for Resident #14 that weekend. Additionally, the DON did not identify that the resident's appetite decreased and the resident's systolic blood pressure dropped below 90 mm/hg, which required notification of the physician according to the facility's policy and procedure. Interview with the DON, on 08/24/12 at 2:00 PM, revealed she did not complete a thorough investigation of the incident back in May 2012 because she did not feel that this was an allegation of neglect. The DON stated her definition of neglect was when staff did not take care of the resident or meet their basic needs. She revealed the physician should have been	F 226		

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F 226	Continued From page 12 notified. She was unable to give an explanation as to why she did not identify the resident's systolic blood pressure was below 90 mm/hg, which required physician notification per the facility's policy and procedures.	F 226		
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to ensure food preferences were honored for three residents (#4, #5 and #7), in the selected sample of fourteen (14) residents, and for one resident (#16), not in the selected sample. Findings include: 1. A record review revealed the facility admitted Resident #5 on 07/23/09 and was re-admitted on 05/20/10 with diagnoses to include Intracranial Hemorrhage, Hypertension, Closed Fracture Lumbar Vertebra, Psychosis, Anemia, Pain, and Dysphagia. Observation during the lunch meal, on 08/21/12 at 12:45 PM, revealed documentation on Resident #5's dietary slip that the resident disliked carrots. Further observation revealed he/she was served mixed vegetables containing carrots. The resident refused to eat the mixed vegetables after two small bites.	F 366	1. Residents #4, #5, #7 and #16 were interviewed for likes and dislikes by the dietary manager and their tray card was updated to reflect likes/dislikes. All dislikes entered into the tray card system. 2. All residents have the potential to be affected. 3. Dietary staff educated on tray card system and on not serving residents what is on their dislike section of their tray card. All residents will be interviewed and their tray card system updated 4. The dietary manager or designee will interview all residents and update all likes/ dislikes in the tray card system. The dietary manager will monitor for compliance 5 days a week for 2 weeks then 3 days a week for 2 weeks then monthly for 3 months to ensure compliance. All findings will be reported quarterly to the Quality Patient Care committee meetings. 5. Date corrective action will be corrected for F 366.	9/21/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	186046	A. BUILDING _____ B. WING _____	08/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER	609 NORTH HAYDEN AVE. SALEM, KY 42078

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F 366	Continued From page 13 2. A record review revealed the facility admitted Resident #16 on 08/04/09 with diagnoses to include Anemia, Esophageal Stricture, Malnutrition, Dementia, Diabetes Type II, and Alzheimer's Disease. Observation during the lunch meal, on 08/21/12 at 12:47 PM, revealed documentation on Resident #16's dietary slip that the resident disliked corn and beans. Further observation revealed he/she was served mixed vegetables which contained corn and lima beans. Resident #16 refused to eat the mixed vegetables. 3. A record review revealed the facility admitted Resident #7 on 03/17/08 and was re-admitted on 06/25/10 with diagnoses to include Diabetes, Dementia, Heart Failure, and Epilepsy. Observation during the lunch meal, on 08/21/12 at 12:49 PM, revealed documentation on Resident #7's dietary slip that the resident disliked carrots. Further observation revealed the resident was served mixed vegetables which contained carrots. Resident #7 refused to eat the carrots on his/her plate. 4. A record review revealed the facility admitted Resident #4 on 07/13/11 and was re-admitted on 02/09/12 with diagnoses to include Diverticulitis and Intestinal Obstruction. Further review revealed Resident #4 was assessed by the facility's Registered Dietician, on 07/13/11, for a "regular diet, no nuts, seeds, corn or peas," and noted the resident had a diagnosis of Diverticulitis.	F 366		

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F 366	Continued From page 14 A review of Resident #4's nutritional care plan, dated 07/13/11, and last reviewed 08/07/12, revealed an intervention of "no seeds, corn, peas or nuts." Observation during the lunch meal, on 08/21/12 at 12:47 PM, revealed documentation on Resident #4's dietary slip that the resident disliked corn. Further observation revealed the resident was served mixed vegetables which contained corn and peas. Resident #4 refused to eat the mixed vegetables. Interview with the facility's Dietary Manager, on 08/24/12 at 2:20 PM, revealed the tray card showed the food likes and dislikes, and any food allergy was indicated by an "A" circled beside the food listed. The kitchen staff were responsible for reviewing the tray card on the tray line to ensure the resident was served the appropriate foods. If a resident expressed a dislike for certain food, then information was to be documented on the dietary card at that time. Interview with the Dietician, on 08/23/12 at 2:30 PM, revealed the staff were suppose to go by the tray cards related to likes/dislikes. She stated the staff should not serve mixed vegetables to residents if the mixed vegetables contained a resident's dislike.	F 366		
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	F 371	1. Dietary Manager discarded all identified items. Can opener was washed.. 2. All residents have the potential to be affected. 3. Education on how to properly store/prepare/ and serve food provided for all dietary staff by 9/20/12.	

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F 371	Continued From page 15 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies and procedures, it was determined the facility failed to store and prepare food under sanitary conditions related to the lack of labeling of opened food items, boxes of vegetables in the freezer open to air, the use of a soiled can opener, and putting away dishes which were not dry. A review of the facility's Census and Condition, dated 08/21/12, revealed there were 53 residents in the building and two residents received tube feedings. Findings include: A review of the facility's "Storage" policy/procedure, last revised 12/09, revealed food in the refrigerator should be covered, dated and stored loosely. All foods in the freezer should be wrapped in moisture proof wrapping or placed in suitable containers to prevent freezer burn. They are to be labeled and dated. A review of the facility's policy/procedure for sanitizing the bench can opener, no date, revealed the bench can opener will be cleaned and sanitized after each use. 1. Observations during the initial tour, on	F 371	4. The dietary manager or designee will monitor for compliance 5 days a week for 1 month then 3 days a week for 3 months. All findings will be reported to the Quality Patient Care committee quarterly. 5. Date corrective action will be corrected for F 371.	9/21/12

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F 371	Continued From page 16 08/21/12 at 11:00 AM, revealed: A. A package of sliced cheese stored in the walk-in refrigerator that was opened and in a sealed plastic bag that was not dated or labeled. B. Two (2) boxes of frozen green peas and two (2) boxes of frozen carrots in opened plastic bags in the walk-in freezer that were not sealed and were open to air. C. A box with a plastic bag containing liquid thickener powder that was open to air in the dry storage area. D. A can opener with a black sticky substance noted on the blade and small pieces of plastic paper noted below the blade. An interview with the Dietician and Dietary Manager, on 08/23/12 at 2:45 PM and on 08/24/12 at 2:30 PM, respectively, revealed the open items of food should be stored in the original container, freezer bag or plastic container. The items should be dated when opened and should have the expiration date on them. They revealed all food should be sealed and not open to air, and the can opener should be cleaned every day. 2. Observation of the dishwasher area, on 08/24/12 at 9:05 AM, revealed the dishwasher removed coffee cups and plate holders from the dish rack and stacked them without letting them completely dry. Further observation of the stacks of plate holders and coffee cups revealed the inverted coffee cups stacked on the shelf unit, and a stack of plate holders next to the steam	F 371		

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F 371	Continued From page 17 table had water on the inside of them. An interview with the Dietician and Dietary Manager, on 08/23/12 at 2:45 PM and on 08/24/12 at 2:30 PM, respectively, revealed the dishes should be allowed to air dry completely before stacking them and putting them away.	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	F 441	1. Residents #5, and # 11 were not negatively affected by the deficient practice. 2. All residents have the potential to be affected. 3. Education on Infection Control policy, Standard Precautions, and proper handling of linens will be completed by 9/20/12. 4. A random audit will be completed by DON or designee for 5 days a week for 2 weeks then 3 days a week for a month to ensure compliance. 5. All findings will be reported to the Quality Patient Care committee quarterly. Date corrective action will be corrected for F 441.	9/21/12

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F 441	Continued From page 18 professional practice. (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, record review, and facility policy and procedure review, it was determined the facility failed to ensure staff changed gloves and/or washed hands to ensure a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for two residents (#5 and #11), in the selected sample of fourteen (14) residents. Findings include: A review of the facility's policy and procedure for "Standard Precautions", undated, revealed gloves were to be worn "when touching body fluids... and contaminated items." Gloves were to be changed "between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms." Additionally, staff was to "wash hands immediately after gloves were removed... to avoid transfer of microorganisms to other residents or environments." Staff was also to "wash hands between tasks and procedures on the same resident to prevent cross contamination of different body sites."	F 441		

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F 441	Continued From page 19 1. A record review revealed the facility admitted Resident #5 on 09/07/10 and was re-admitted on 06/08/12 with diagnoses to include Muscle Weakness, Dysphagia, Neuropathy, Congestive Heart Failure, Depressive Disorder, and Chronic Airway Obstruction. An observation of a skin assessment, on 08/22/12 at 2:55 PM, revealed Resident #5 was assessed to have a three inch by four inch area of red skin around the coccyx. Registered Nurse (RN) #4 used her gloved hand to determine blanchability of the skin and proceeded with the skin assessment without changing gloves. After blanching the perimeter of the reddened skin, RN #4 used the same glove to reset the tag alarm when it sounded, reposition the resident with the resident's personal body pillow, and remove and re-attach the tag alarm clip to the resident's clothing. With gloves still on, RN #4 covered and smoothed the resident's sheet and blanket at the conclusion of the skin assessment. Interview with RN #4, on 08/24/12 at 11:10 AM, revealed precautions should be used that were appropriate for the task being completed. The precautions included gloves, gowns, and masks. Interview with Licensed Practical Nurse (LPN) #1, on 08/24/12 at 11:25 AM, revealed gloves should be changed after touching any area of the body with fluids, such as the sacral area. Interview with the Director of Nursing (DON), on 08/24/12 at 5:30 PM, revealed she expected her staff to change gloves during a skin assessment if they touched any body fluids.	F 441		

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F 441	Continued From page 20 2. A record review revealed the facility admitted Resident #11 on 07/03/08 and was re-admitted on 12/11/11 with diagnoses to include Depression, Anemia, Kidney Disease, Diabetes Type II, and Parkinson's disease. A review of the facility's policy and procedure for "Laundry/ Linen", undated, revealed "all soiled linen should be considered potentially infectious" and "must be placed directly into a covered laundry hamper which is adequate to contain moisture." An observation, on 08/24/12 at 9:00 AM, revealed a strong odor of urine prior to entering the room of Resident #11. An open plastic bag was on the floor in the room approximately three feet from the doorway. The open bag contained white bed linens and a blue and white bed pad. Interview with Certified Nurse Aide (CNA) #5, on 08/24/12 at 9:05 AM, revealed the bags were not suppose to be stored on the floor after the bed was changed. She stated the dirty linen bags should have been placed in the dirty linen cart that was kept in the hallway. Interview with LPN #1, on 08/24/12 at 11:25 AM, revealed dirty linen bags should not be left on the floor in a resident's room. She stated the linens should have be placed in the dirty linen cart immediately. Interview with other facility staff #10, on 08/24/12 at 3:25 PM, revealed she removed the soiled linens from Resident #11's bed, placed the soiled linens in the clear plastic bag, and placed the bag on the floor next to the trash can in the room. She	F 441		

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F 441	Continued From page 21 stated an unknown CNA entered the room while she assisted Resident #11 with ambulation. She stated she asked the CNA to take care of the dirty linens and the CNA did so.	F 441		

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1996 Survey under: NFPA 101 (2000 edition) Chapter 19 Facility type: SNF/NF Type of structure: Type II (000) Smoke Compartment: 4 Fire Alarm: Complete fire alarm installed 1996. Smoke detectors located in corridors and heat detectors located in Kitchen and Main Mechanical Room. Sprinkler System: Complete automatic sprinkler system (wet) installed in 1996. An antifreeze loop was installed for the front canopy in 2008. Generator: Type II, Diesel, installed in 1996. A standard Life Safety Code survey was conducted on 08/21/2012. Salem Springlake Health and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census the day of the survey was fifty-three (53). The facility is certified for seventy five (75) The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (life Safety from Fire)	K 000	The statements contained in this plan of corrections are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain compliant with all federal and state regulations the facility has taken or will take the following actions set forth within the following corrections. The following corrections constitute the facility compliance such that all deficiencies cited will be corrected by 9/21/12.	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors	K 018	1. Doors identified have been repaired and are latching appropriately. 2. All doors inspected and any found not to be functioning properly were repaired. 3. Maintenance director educated on doors latching properly. 4. Maintenance director will check for improper latching doors monthly and repair as needed. Findings will be reported to the Quality Patient Care committee quarterly.	9/21/12

RECEIVED SEP 2012 OFFICE OF INSPECTOR GENERAL

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tammy Workman
TITLE: Administrator
(X6) DATE: 9/20/12

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 018	Continued From page 1 are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors to resident rooms would latch properly in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, 6 residents, staff and visitors. The facility is certified for seventy-five (75) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure three (3) corridor doors to the resident rooms were latching properly. The findings include: Observations, on 08/21/12 between 12:45 PM and 4:45 PM with the Maintenance Supervisor, revealed the corridor doors to rooms 508, 502, and 304 would not latch properly. Interviews, on 08/21/12 between 12:45 PM and 4:45 PM with the Maintenance Supervisor,	K 018		

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K 018	Continued From page 2 confirmed the observation of the doors not latching and revealed he was unaware these doors were not latching properly. The Maintenance Supervisor was aware that all resident room doors must latch in the event of an emergency. Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping	K 018		

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K 018	Continued From page 3 the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018		
K 029 SS=F	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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for seventy-five (75) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure thirteen (13) rooms were properly protected due to the storage in the rooms.	K 029	1. Door closures placed on all identified doors. Activity room door was adjusted so that it would remain open. The magnet was removed from the laundry room door as well. A checklist has been implemented to include hazardous area checks. 2. All doors were inspected and door closures were placed on these doors. 3. Maintenance was inservices on self-closing doors. 4. A checklist was implemented to include hazardous area checks and will be checked monthly. Findings will be reported to the Quality Patient Care committee quarterly.	9/21/12

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K 029	Continued From page 4 The findings include: Observation, on 08/21/12 between 12:45 PM and 4:45 PM, with the Maintenance Supervisor revealed: 1) The social service office did not have a door closer installed.. 2) The medical records office did not have a door closer installed. 3) The business office did not have a door closer installed. 4) The activities area room had locking door closers installed, which allowed both sides of the smoke barrier to be open to each other. 5) The medical records storage closet did not have a door closer installed. 6) The laundry door was propped open with an unapproved magnet device not on the fire alarm. 7) The therapy area did not have a door closer installed. 8) The activities office did not have a door closer installed. 9) The beauty salon storage closet did not have a door closer installed. 10) The nurses ' office on 300 hall did not have a door closer installed. 11) The two (2) storage offices in the business area did not have a door closer installed. 12) The copy room did not have a door closer installed. Any room larger than 50 ft2 with substantial combustible material must have a door that resists the passage of smoke and a closing device. Interview, on 08/21/12 between 12:45 PM and 4:45 PM, with the Maintenance Supervisor	K 029		

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K 029	Continued From page 5 revealed he was not aware the areas listed above were considered hazardous storage thus requiring a door, a self-closer, and separation. The life safety check sheets at the facility did not include hazardous area checks. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 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. 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	K 029		

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K 029	Continued From page 6 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=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiencies had the potential to affect one (1) of four (4) smoke compartments, twenty-seven (27) residents, staff and visitors. The facility is certified for seventy-five (75) beds with a census of fifty-three (53) on the day of the survey. The facility failed to onsure a means of egress was clearly marked. The findings include: Observation, on 08/21/12 at 11:35 AM with the Maintenance Supervisor, revealed the Ambulance exit, which is the main part of the evacuation route of the corridor, was blocked by a Velcro	K 038	1. The Velcro stop sign was removed and the exit sign was corrected to reflect the proper signage. 2. All residents have the potential to be affected, thus inspection of facility revealed no other Velcro stop signs in use and all exit signs were appropriate. 3. Maintenance educated on non-use of Velcro stop signs across exits and appropriate exit signs. 4. Maintenance director will inspect monthly for clear and appropriately marked means of egress.	9/21/12

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K 038	Continued From page 7 stop sign. Further observation revealed the exit sign was pointing to a different means of egress than what the evacuation route stated. Interview, on 08/21/12 at 11:35 AM with the Maintenance Supervisor, revealed he was not aware the stop sign could not be placed across an exit. Further interview revealed he was unaware the arrow on the exit sign was directing to not use the exit. The maintenance supervisor confirmed this was exit was to be used in the event of an evacuation. Reference: NFPA 101 (2000 Edition). 4.5.3.3 Awareness of Egress System. Every exit shall be clearly visible, or the route to reach every exit shall be conspicuously indicated. Each means of egress, in its entirety, shall be arranged or marked so that the way to a place of safety is indicated in a clear manner.	K 038		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to tho building fire alarm system. 19.3.5	K 056		

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K 056	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for seventy-five (75) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure all areas of the building had proper sprinkler coverage. The findings include: Observation, on 08/21/12 between 12:45 PM and 4:45 PM with the Maintenance Supervisor, revealed the peak of the main entrance was not sprinkler protected. Further observation revealed the areas above the wood trim at both nurses stations were not sprinkler protected. Interview, on 08/21/12 between 12:45 PM and 4:45 PM with the Maintenance Supervisor, he was not aware that the areas listed did not have proper sprinkler protection. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.	K 056	1. Tri State Fire Protection to install sprinklers in the main entrance lobby and both nurses station areas on 9/19. 2. Tri State Fire Protection to install sprinklers in the main entrance lobby and both nurses station areas on 9/19. 3. No additional sprinkler needed in the facility. 4. No additional sprinkler needs identified.	9/21/12

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K 056	Continued From page 9 Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. Reference: NFPA 13 (1999 edition) 5-13.8.1. Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		

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K 062	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for seventy-five (75) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure all sprinkler heads were equipped with an escutcheon ring. The findings include: Observations, on 08/21/12 between 12:45 PM and 4:45 PM with the Maintenance Supervisor, revealed the sprinkler head in the bathroom of room# 305 and in room 507 were missing the escutcheon ring. Interview, on 08/21/12 between 12:45 PM and 4:45 PM with the Maintenance Supervisor, revealed he was unaware the sprinkler head escutcheon rings were missing. Observations were confirmed with the Administrator during the exit conference. Reference: NFPA 25 (1998 Edition). 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062	1. Escutcheon rings were replaced in Room 305 bathroom and room 507. 2. Inspection of facility revealed no other escutcheon rings were missing. 3. Facility maintenance was education on escutcheon rings 4. Facility maintenance will inspect and document facility on monthly basis for missing escutcheon rings and address any concerns noted. Findings of inspections will be reported to the Quality Patient Care committee quarterly.	9/21/12

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K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain the installation of portable fire extinguishers per NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for seventy-five (75) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure the fire extinguishers throughout the facility were mounted below five (5) feet above the surface of the floor. Findings include: Observations, on 08/21/12 between 11:19 AM and 4:45 PM with the Maintenance Supervisor, revealed the wall mounted, portable fire extinguishers located throughout the facility were mounted above the maximum allowable height of five (5) feet above the finish floor. Interview, on 08/21/12 between 11:19 AM and 4:45 PM with the Maintenance Supervisor, revealed that he was unaware of the height limitations for wall mounted portable fire extinguishers and acknowledged that they were mounted above the height of five (5) feet above	K 064	1. Fire extinguishers will be re-installed at height not to exceed 5 ft by vendor Doug Wooley Construction, Inc. 2. Fire extinguishers will be re-installed at height not to exceed 5 ft by vendor Doug Wooley Construction, Inc. All work will be completed by 10/15/12. 3. Maintenance director was education on the proper height of portable fire extinguishers. 4. Maintenance director will inspect and document on monthly checklist fire extinguishers for appropriate heights.	10/15/12

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K 064	Continued From page 12 the finish floor. Reference NFPA 10 (1998 Edition). 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064		
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 deficiency had the potential to affect three (3) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for seventy-five (75) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure decorations brought into the facility were being properly fire treated. The findings include: Observation, on 08/21/12 between 12:45 PM and	K 073		

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K 073	Continued From page 13 4:45 PM with the Maintenance Supervisor, revealed several stuffed animals, curtains, wreaths, and fake floral arrangements throughout the facility with no flame retardant applied. Room numbers 210, 208, 601, 604, 501, 503, 512, 305, and 302 are some examples of this deficiency. Interview, on 08/21/12 between 12:45 PM and 4:45 PM with the Maintenance Supervisor, revealed he was aware decorations were required to be treated with a fire retardant spray and that any item brought into the facility was supposed to be checked in on arrival. Further interview determined the Maintenance Supervisor was more aware of the wreaths needing treating instead of the stuffed animals and fake floral arrangements. The facility was made aware the decorations are not required to be removed, but if the decorations are going to be in the rooms they must be treated with a flame-retardant spray. 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	1. Identified items in Rooms 210, 208, 601, 501, 503, 512, 305, and 302 have been treated with fire retardant. 2. Inspection of facility completed by facility maintenance and identified items were treated with fire retardant. 3. Maintenance was educated on the need for treating items with fire retardant. 4. A log will be utilized for documenting treating of items with fire retardant. Monthly inspection will be conducted by maintenance or designee for compliance and will be reported to Quality Patient Care committee quarterly.	9/21/12
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 147		

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K 147	Continued From page 14 determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, twenty-seven (27) residents, staff and visitors. The facility is certified for seventy-five (75) beds with a census of fifty-three (53) on the day of the survey. The facility failed to ensure electrical panels maintained three (3) feet of clearance around them and proper electrical wiring. The findings include: Observations, on 08/21/12 between 12:45 PM and 4:45 PM with the Maintenance Supervisor, revealed the electrical panel in the clean linen room, at station 2, had storage within 3 feet of the electrical panels. The panel was blocked by refreshment carts and storage shelves. Interview, on 08/21/12 between 12:45 PM and 4:45 PM with the Maintenance Supervisor, revealed he was unaware the items in the clean linen room were stored within 3 ' ef the electrical panel. Observations, on 08/21/12 between 12:45 PM and 4:45 PM with the Maintenance Supervisor, revealed a power strip plugged into a multi-plug adapter in the social services office. Further observation revealed a power strip plugged into another power strip in the business office. The final observation revealed the vending machines adjacent from the beauty salon were plugged into a multi-plug adapter. Interview, on 08/21/12 between 12:45 PM and	K 147	1. Refreshment cart and storage shelves were removed from the electrical panel area. Power strips/adapters were removed from the social service office and business office. Multi plug adapter was removed from vending machine plug. 2. Inspection of facility was conducted by maintenance to onsure facility electrical panels had 3 ft clearance, ensure appropriate uso plugs, and all vending machine for use of multi plug adapter. 3. Maintenence has applied red tape to floor of electrical panel areas to identify a 3 ft barrier. Department heads have been educated on use of electrical adapter/power strips/plugs. 4.Maintenance will monitor via monthly inspection for compliance with storage away from electrical panel and compliance with elocirical plugs.	9/21/12

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K 147	Continued From page 15 4:45 PM with the Maintenance Supervisor, revealed he was unaware of the items not being properly plugged in. Reference: NFPA 99 (1999 edition) 110-26. Spaces 10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed. Table 110.26(A)(1) Working Spaces Nominal Voltage to Ground Minimum Clear Distance Condition 1 Condition 2 Condition 3 0-150 900 mm (3 ft) 900 mm (3 ft) 900 mm (3 ft) 151-600 900 mm (3 ft) 1 m (3½ ft)	K 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185046	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/21/2012

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K 147	Continued From page 16 1.2 m (4 ft) Note: Where the conditions are as follows: Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts. Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as grounded. Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between. (a) Dead-Front Assemblies. Working space shall not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other than the back or sides. Where rear access is required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided. (b) Low Voltage. By special permission, smaller working spaces shall be permitted where all uninsulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc. (c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have	K 147		

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K 147	Continued From page 17 been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service the installation. (2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. (3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or platform to the height required by 110.26(E). Within the height requirements of this section, other equipment that is associated with the electrical installation and is located above or below the electrical equipment shall be permitted to extend not more than 150 mm (6 in.) beyond the front of the electrical equipment. (B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded. (C) Entrance to Working Space. (1) Minimum Required. At least one entrance of sufficient area shall be provided to give access to working space about electrical equipment. (2) Large Equipment. For equipment rated 1200 amperes or more and over 1.8 m (6 ft) wide that contains overcurrent devices, switching devices, or control devices, there shall be one entrance to the required working space not less than 610 mm (24 in.) wide and 2.0 m (6½ ft) high at each end of the working space. Where the entrance has a personnel door(s), the door(s) shall open in the direction of egress and be equipped with panic	K 147		

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K 147	Continued From page 18 bars, pressure plates, or other devices that are normally latched but open under simple pressure. A single entrance to the required working space shall be permitted where either of the conditions in 110.26(C)(2)(a) or (b) is met. (a) Unobstructed Exit. Where the location permits a continuous and unobstructed way of exit travel, a single entrance to the working space shall be permitted. (b) Extra Working Space. Where the depth of the working space is twice that required by 110.26(A)(1), a single entrance shall be permitted. It shall be located so that the distance from the equipment to the nearest edge of the entrance is not less than the minimum clear distance specified in Table 110.26(A)(1) for equipment operating at that voltage and in that condition. (D) Illumination. Illumination shall be provided for all working spaces about service equipment, switchboards, panelboards, or motor control centers installed indoors. Additional lighting outlets shall not be required where the work space is illuminated by an adjacent light source or as permitted by 210.70(A)(1), Exception No. 1, for switched receptacles. In electrical equipment rooms, the illumination shall not be controlled by automatic means only. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet	K 147		

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K 147	Continued From page 19 adapters.	K 147		