

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

PRINTED: 08/11/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185217	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/15/2010
NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE, PO BOX 115 EDMONTON, KY 42129		
(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 279	Continued From page 17 and symptoms of tuberculosis or to direct the care needs of resident #11 related to the positive PPD status. Interview on July 15, 2010, at 1:00 p.m., with the MDS Coordinator, revealed a comprehensive care plan should have been developed for resident #1 and resident #11 upon the resident's admission to the facility. The MDS Coordinator stated the care plan should direct staff of sign and symptoms of tuberculosis and the interventions staff should take if the symptoms occurred.	F 279			
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Observations on July 13-15, 2010, revealed several areas in need of repair/cleaning that included chipped/cracked drywall, lights not working, dust on overbed lights, and discolored light covers. The findings include: 1. Observation of the facility during the environmental tour on July 13-15, 2010, revealed the following items in need of maintenance/repair: -the doors that covered the air conditioner	F 465	1. The control covers on the heat/air units have been removed on room E102, E115, 208, 215, and 220. The drywall will be repaired in rooms 213 and 216. The drywall will be repaired in the bathroom of rooms E111, E112, and E116. The floor below the air conditioner in room 216 will be replaced. The protective cover on the lights over the sinks will be replaced in rooms E103, 212, and 303. The light fixture will be replaced over the sink in room E103 and 220. The overbed lights in room E115, and 301 have been cleaned. The lights over the sinks in room E104, E112, and 301 will be replaced. The entry door to room E115 has been repaired. The pipes and foot pedal in room 305 have been removed. The floor tiles in room 308 will be replaced. The protective panels on the lights in room E104, E112, and E116 will be replaced. The light covers over the sink and over the resident bed in room E116 will be replaced. The baseboard will be replaced, and the bathroom floor will be replaced. The commode in room E104 has been repaired. The drain covers in the	8/27/10	

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F 465	Continued From page 18 controls in resident rooms E102, E115, 208, 215, and 220 were missing/broken, -the drywall was chipped near the air conditioner in resident rooms 213 and 216, -the drywall was cracked behind the commode in resident bathrooms E111, E112, and E116, -a rust colored stain was noted on the floor below the air conditioner in resident room 216, -the protective cover on the lights over the sinks was missing in resident rooms E103, 212, and 303, -a bulb was not working in the light over the sink in resident room E103, -the light over the sink in resident room 220 was very dim, -an accumulation of dust was observed on the overbed lights in resident rooms E115 and 301, -the lights over the sinks in resident rooms E104, E112, and 301 did not work, -the entry door to resident room E115 would drag and make a loud noise when opened, -pipes were protruding from the wall with a foot pedal that extended into the resident's pathway to the commode in resident room 305, -several floor tiles in resident room 308 were cracked, -the protective panels on the lights were discolored (yellowed) in resident rooms E104, E112, and E116, -the lights over the sink and over the resident's bed were broken in resident room E116, -the baseboard was loose under the sink and a brownish stain was observed around the commode in resident room E116, -the water ran continuously in the commode in resident room E104, and -the drain covers in the hallway near resident room 305 and at the Therapy entrance were sunken approximately one-half inch, creating an	F 465	in the hallway near room 305 and at the therapy entrance will be repaired. 2. The housekeeping and maintenance staff have inspected the facility overbed and over sink light fixtures; the covers on the heat/air units, and the flooring/walls in the residents bathrooms. All issues requiring repair and/or cleaning have been addressed. 3. The housekeeping and maintenance staff have received in-service education on the need to inspect facility overbed and over sink light fixtures, control covers, for the heat/air units; and flooring/walls in the resident bathrooms to identify issues requiring repair and/or cleaning as provided by the Administrator on July 23, 2010. 4. The CQI indicator for the monitoring of the facility interior and equipment will be utilized monthly X 2 months and then in accordance with the established CQI calendar under the supervision of the Housekeeping Supervisor.		

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F 465	Continued From page 19 unevel walkway. Interview on July 14, 2010, at 1:30 p.m., with the Environmental Services Supervisor (ESS) revealed daily rounds were conducted by the ESS to detect any items in need of repair and to check for items in need of cleaning. The ESS stated it was the responsibility of all staff to report any items in need of repair. The ESS stated a book is kept at the nurses' stations and in the kitchen so staff could record any items in need of repair. The ESS stated the items identified had not been reported and were missed on the daily rounds.	F 465			

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NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE, PO BOX 115 EDMONTON, KY 42129	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROBABLE CAUSE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on July 14, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the outside canopy and overhangs at the facility were sprinkler protected as required. This deficient practice affected two (2) of five (5) smoke compartments, staff, and approximately twenty (20) residents. The facility has the capacity for 101 beds with a census of 87 on the day of the survey. The findings include: During the Life Safety Code survey on July 14, 2010, at 9:20 a.m., with the Director of Maintenance, a combustible canopy exceeding four feet in width at the front of the facility was noted not to be sprinkler protected. Combustible canopies and overhangs exceeding four feet in width must be sprinkler protected. An interview with the Director of Maintenance on July 14, 2010, at 9:20 a.m., revealed the Director of	K 012	1. The canopies on the front and back sides of the facility have been assessed for sprinkler installation with bids obtained and service scheduled. The third exterior overhang will be removed. 2. The canopies on the front and back sides of the facility have been assessed for sprinkler installation with bids obtained and service scheduled. The third exterior overhang will be removed. 3. The Director of Maintenance will review code compliance for the sprinkler system with the quarterly contracted inspection. 4. The CQI indicator for the monitoring of sprinkler systems will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Director of Maintenance/Housekeeping.	8/27/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Amy Neighbor* TITLE *Administrator* (X6) DATE *8/4/10*

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

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K 012	Continued From page 1 Maintenance was not aware the canopy should be sprinkler protected. During the survey two other exterior overhangs exceeding four feet in width were observed not to be sprinkler protected. 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 012		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain fire/smoke dampers that penetrated the fire/smoke barrier walls in the attic area. This deficient practice affected five (5) of five (5) smoke compartments, staff, and eighty-seven (87) residents. The facility has the capacity for 101 beds with a census of 87 on the day of the survey.	K 025	1. The dampers in the duct work above the ceiling have been inspected and cleaned with a schedule established to perform this every 4 years. 2. The contracted staff have inspected and cleaned the dampers in the duct work above the ceiling. 3. Maintenance staff have received in-service education from the Administrator on July 20, 2010 on the need to have the dampers in the duct work above the ceiling inspected and cleaned as scheduled every 4 years. 4. The CQI indicator for the monitoring of the cleaning of the dampers in the duct work above the ceiling will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Director of Maintenance/Housekeeping.	8/16/10

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K 025	<p>Continued From page 2</p> <p>The findings include:</p> <p>During the Life Safety Code survey on July 14, 2010, at 10:00 a.m., with the Director of Maintenance, in the attic next to room 205 a fire/smoke barrier wall was observed to have ductwork that contained a fire/smoke damper. A fire/smoke damper closes to prevent fire and hot gases from penetrating the fire/smoke barrier wall and is required to be inspected and maintained every four years. Review of facility maintenance records and interview with the Director of Maintenance on July 14, 2010, at 10:00 a.m., revealed no evidence the fire/smoke damper had been maintained/inspected per the requirement. The Director of Maintenance voiced being unaware of the requirements pertaining to fire/smoke dampers. During the survey two other fire/smoke dampers that have not been maintained were observed in the attic area.</p> <p>Reference: NFPA 90a (1999 Edition).</p> <p>3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.</p>	K 025		