

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

PRINTED: 11/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2010
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NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 279 SS-D	<p>A Recertification Survey was conducted 11/02/10-11/04/10, and a Life Safety Code Survey was conducted 11/03/10. Deficiencies were cited, with the highest Scope and Severity of an "E".</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to develop a Comprehensive Plan of Care for two (2) of twenty (20) sampled residents (Residents #7 and #15). The facility failed to include Resident #7's indwelling catheter on the care plan; and, Resident #15's vision was not care</p>	F 279	<p>RECEIVED JAN 13 2011 BY: _____</p> <p>1. Care Plan was corrected & updated immediately to reflect indwelling catheter care on resident #7 and eye drop usage on resident #15.</p> <p>2. Reviewed all care plans in facility for accuracy on 11-15-10 performed by MDS/Care Coordinator.</p> <p>3. D.O.N. conducted mandatory inservice on 11-5-10 for all nurses on care plans & instructed nurses to assist MDS/care plan coordinator to update the care plans quarterly and nurses to write in all additions with corresponding date on care plans. The MDS Assistant will Double check the MDS CAA's against the Care plans to ensure accuracy. Staff inserviced on F279 by D.O.N. on 11-5-10.</p> <p>4. Quality Assurance to monitor weekly by reviewing copies of all orders. D.O.N. to discuss all orders and updates to care plans every morning. MDS assistant to check all MDS CAA's against the care plans daily upon implementation.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Angela B. [Signature]</i>	TITLE <i>Administrator</i>	(X8) DATE <i>1-12-11</i>
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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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F-279	<p>Continued From page 1 planned.</p> <p>The findings include:</p> <p>1. Record review revealed Resident #7 was admitted to the facility on 02/01/09 with diagnoses which included Urinary Retention. Review of the Quarterly Minimum Data Set (MDS) dated 10/26/10, revealed Resident #7 had an indwelling catheter.</p> <p>Review of the Care Plan initiated on 02/10/10 and revised on 07/27/10, revealed Resident #7 was care planned to be checked and changed every two (2) hours and as needed and incontinent care would be provided. The Care Plan also revealed Resident #7 did not have a catheter and was to void to adult briefs. Further review of the Care Plan did not reveal any documented evidence of a urinary catheter.</p> <p>Review of the Physician's Orders dated 10/10/10, revealed an order for the catheter to be changed on 10/11/10. Review of the Admission Evaluation dated 09/10/10, revealed the resident was admitted with an indwelling catheter related to Urinary Retention.</p> <p>Observation of Resident #7 from 11/02/10 and 11/03/10 revealed an indwelling catheter to bedside drainage, draining clear yellow urine and enclosed in a dignity bag.</p> <p>Interview with Unit #3's Unit Coordinator on 11/03/10 at 11:30 AM revealed anyone could update the care plan. The nurse who transcribed or completed the admission should have developed the care plan.</p>	F 279	<p>The D.O.N./designee will review all resident changes daily. QA will monitor monthly through chart audits and Quarterly Care Plans.</p> <p>5.</p>	11-16-10

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F 279	<p>Continued From page 2</p> <p>2. Review of the medical record, revealed Resident #15 had diagnoses which included Cataracts & Diabetes Mellitus.</p> <p>Review of the Annual Minimum Data Set (MDS) dated 08/23/10, revealed diagnoses which included Cataracts. Further review of the Annual MDS and Resident Assessment Protocol Summary (RAPS) dated 08/23/10, revealed the facility assessed Resident #15 as having visual impairment.</p> <p>Review of the RAP Summary dated 08/23/10, revealed Resident #15 triggered for vision related to Cataracts, Diabetes and Impaired Vision. The RAP Summary also stated, "Will proceed to Care Plan."</p> <p>Review of the Comprehensive Plan of Care, initiated on 09/04/10, revealed no documented evidence the facility addressed the resident's visual function.</p> <p>Review of the Physician's Order Form dated November 2010, revealed an order for Xalatan 0.005% eye drops with administration start date of 04/14/10. (Xalatan is a topical eye medication used to reduce pressure inside the eye) Increased eye pressure can lead to gradual loss of vision. However, the facility failed to care plan eye drops for Resident #15.</p> <p>Interview, on 11/04/10 at 2:10 PM, with the MDS Registered Nurse, revealed it was the MDS Nurses' responsibility to develop care plans for RAPS that triggered. She acknowledged a care plan had not been developed for Resident #15 which addressed the resident's visual function.</p>	F 279		

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F-323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure an environment free of accidental hazards as evidenced by dangerous chemicals stored in an unlocked cabinet at the Unit 3 Nurse's Station.</p> <p>The findings include:</p> <p>Observation on 11/02/10 at 6:15 PM revealed an unlocked cabinet under the sink on the Unit 3 Nurse's Station that contained the following products: Lyeol disinfectant Spray, Glade Air Freshener, and Clorox Clean Up Spray.</p> <p>Review of the Material Safety Data Sheet (MSDS) for the Lysol Disinfectant revealed the product was an eye irritant and to call a Physician or Poison Control Centre immediately if ingested. Review of the MSDS for the Glade Air Freshener revealed the product could cause eye irritation. Review of the MSDS for the Clorox Clean Up Spray revealed the product was harmful if swallowed as well as a warning that the vapors may cause irritation to the eyes, nose, throat, and lungs.</p>	F 323	<p>1. Removed all items the day of survey and placed them under locked cabinet.</p> <p>2. All units were immediately checked by Director of Nursing and environmental supervisor for proper storage of harmful chemicals on 11-5-10. All residents were observed to be clear of the areas where deficiency was found. Two out of three units were found to be deficient and locks were placed on each cabinet by maintenance on 11-5-10. QA team conducted an environmental walk through of all units on 12-1-10 focusing on harmful chemical storage, locked carts, etc. The team also conducted a walk through on 12-8-10 with special focus on wheelchair and gerichair condition and all alarms in the facility. A carelift inservice was conducted on 12-14-10 by a Premier medical representative.</p> <p>3. A Mandatory Inservice was conducted On 11-5-10 by the Director of Nursing for All nursing personnel addressing Deficient practices and F323. Locks Were placed on cabinets on each Unit to ensure proper storage of chemicals As to maintain an environment free from Hazard.</p> <p>4. Weekly walk throughs conducted by Quality Assurance committee will By done to ensure compliance of Storage of hazardous chemicals And all other F323 issues. Also, Safety committee chair will monitor Weekly for compliance of stored Items and any F323 issues.</p> <p>5.</p>	11-6-10

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F 323	Continued From page 4 Interview with the Unit 3 Supervisor, on 11/02/10 at 6:30 PM revealed the Nurse's Station was a secured area. However observations revealed the Nurse's Station door was unlocked throughout the survey. Observation on 11/02/10 at 6:15 PM revealed four (4) unsampled, cognitively impaired residents ambulating and sitting outside the Unit 3 Nurse's Station.	F 323		
F 371 SS=E	Interview with the Maintenance Supervisor on 11/02/10 at 6:30 PM revealed the above mentioned items should be locked up. 483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure food was prepared, stored and distributed under sanitary conditions as evidenced by dented cans being stored along with none dented cans, outdated pure cocoa powder in dry storage, food items stored on an open cart in the refrigerator were not covered or dated, meat slicer and pans were stored dirty and inadequate hand washing were observed.	F 371	1. Dented cans were removed & thrown away. Expired cocoa thrown away. Open cart with uncovered items was covered. The meat slicer was taken apart & sanitized. Dirty pans were rewashed and air dried. Personnel was designated the task of calling nursing floors when carts were ready as opposed to tray line staff. 2. All residents have the potential to be affected by this deficient practice. All sanitation issues that fall under F371 were checked by Dietary Manager and Dietician for identified deficient practice on 11-4-10. 3. Staff was inserviced regarding all examples noted and cited under F371 on 11-11 performed by Dietary Manager, Kim Mullins. A daily inspection will be performed by DM and designee to investigate	

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F 371	<p>Continued From page 5</p> <p>The findings include:</p> <p>1. Observation on 11/02/10 at 9:08 AM revealed nine (9) dented cans which were stored in dry storage on racks along with non-dented cans.</p> <p>Interview with the Dietary Manager on 11/02/10 at 9:10 AM revealed the cans were to be separated by another staff member, placed on a cart outside of her office and then returned to the supplier because they were not safe to use for cooking.</p> <p>2. Observation on 11/02/10 at 9:15 AM revealed a container of pure natural cocoa with ten (10) to twelve (12) percent butterfat which had been opened and dated 09/28/06.</p> <p>3. Observation on 11/02/10 at 9:30 AM revealed forty eight (48) plates of cheese cake with blue berry topping stored on an open cart in the refrigerator which were not dated or covered. It was noted some of the items on the cart were covered with plastic wrap.</p> <p>Interview with the Dietary Manager on 11/02/10 at 9:32 AM revealed the plates were normally covered by a plastic cart cover, however, the facility had ran out of those covers and would receive a new shipment on Thursday. She further indicated the items on the cart were for the lunch meal service.</p> <p>Observation on 11/02/10 at 4:45 PM revealed approximately seventy (70) bowls of fruit salad, seventy (70) bowls of salad and (15) bowls of pureed fruit salad stored on an open cart not covered or dated. It was noted some of the other items on the cart were covered.</p>	F 371	<p>compliance issues under F371. along with weekly Quality Assurance monitoring checking for Sanitary conditions in the dining services area.</p> <p>4. The Dietary Manager will monitor daily for compliance of F 371. A checklist was implemented to monitor cleanliness of meat slicer each time it is used. The list will receive a double signature and double ck. by Dietary Manager and cleaning aide Daily. Stock staff will monitor the store room for dented cans and expired spices daily and weekly. The dietician will observe the tray line for proper phone usage with barrier towel use. In addition, all sanitation issues will be monitored weekly by Quality assurance committee walk through. All Food Procure, store/prepare/serve issues will be monitored by Quality Assurance weekly.</p> <p>5.</p>	11-11-10

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F 371	Continued From page 6 3. Observation on 9:40 AM revealed the meat slicer spikes used to hold the meat in place had particles which were pink in color on many of the spike surfaces. The slicer was noted to be covered and stored in this manner. Interview with the Dietary Manager on 11/02/10 at 6:05 PM, revealed the meat slicer should be cleaned with each use before being covered and stored. 4. Observation on 11/02/10 at 9:45 AM revealed four (4) deep half size hotel pans and seven (7) one quarter size hotel pans were stored wet, with food particles on them and greasy. Interview with Dietary Aide #4 on 11/02/10 at 9:48 AM revealed the pans should be clean and air dried before being stored because when they are stored wet and dirty bacteria could grow. 5. Observation on 11/02/10 at 5:50 PM and again at 6:15 PM, revealed Dietary Aide #3 using the telephone to call out when a cart was ready to transport resident trays to the floor. The Aide did not wash her hands prior to returning to the trayline to place lids on resident trays and glasses on resident trays. Interview with Dietary Aide #3 on 11/02/10 at 6:20 PM revealed she should have washed her hands before returning to resident trayline after using the telephone.	F 371			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431			

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F 431	<p>Continued From page 7</p> <p>controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure proper storage of drugs and biologicals, including controlled narcotics as evidenced by the Unit 3 medication and treatment carts being unlocked. In addition, observation revealed an</p>	F 431	<ol style="list-style-type: none"> 1. The med cart, treatment cart and Overflow cabinet were all locked immediately. 2. All three nursing units were checked to ensure all carts were locked and that cabinets were secured. This was performed by the Director of Nursing. All checked out fine. 11-4-10 3. All nurses were inserviced on 11-5-10 by D.O.N. on the importance of locking cabinets and carts. Orientation checklists updated to make sure ALL new staff aware of importance. See Attached. 4. Weekly walk throughs to be conducted by Quality Assurance committee to check for all requirements under F431 including locked cabinets and locked carts and proper storage of drugs and biologicals. 5. 	11-29-10
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F 431	<p>Continued From page 8</p> <p>unlocked cabinet in the Unit 3 Nurse's Station which contained multiple overflow medications.</p> <p>The findings include:</p> <p>Observation on 11/02/10 at 6:15 PM revealed an unlocked medication cart in the Unit 3 Nurse's Station. At this time, observation revealed no facility staff were present at the Nurse's Station. Observation revealed the medication cart contained a locked drawer with multiple Schedule II narcotics in the drawer. Because the medication cart was unlocked, the narcotics were not secured under a double lock system.</p> <p>Further observation revealed the treatment cart in the Unit 3 Nurse's Station was unlocked. The cart contained the following treatment medications: Nystatin Ointment, Lidocaine and Prilocaine Cream 2.5%/2.5%, Hydrocortisone 2.5% Cream, Nystatin Powder, Fluocinonide 0.05% Cream and Trolamine Salicylate 10%.</p> <p>In addition, observation revealed an unlocked cabinet on the Unit 3 Nurse's Station that contained the residents' overflow medications.</p> <p>Interview with the Unit 3 Supervisor, on 11/02/10 at 6:30 PM revealed the Nurse's Station was not usually locked but was a secured area. She further stated the medication and treatment cart should be locked and that the narcotics were not under a double lock, as required.</p> <p>Observations revealed the Nurse's Station door was unlocked throughout the survey.</p> <p>Observation on 11/02/10 at 6:15 PM revealed four (4) unsampled, cognitively impaired residents ambulating and sitting outside the Unit 3 Nurses</p>	F 431			

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F 431	Continued From page 9 Station. Review of the facility policy related to medication storage revealed medications should be locked up at all times and narcotic medications should be double locked at all times.	F 431			

F431

ORIENTATION CHECK LIST FOR NURSES

All new nurses must check off on the following before beginning to work alone. If there are any questions please see Deanna Eads Director of Nursing.

- _____ Knows location and procedure for obtaining oxygen for residents.
- _____ Demonstrates proper safety measures by locking the medication cart, treatment cart, and medication cabinets when not removing or adding items to them.
- _____ Notifies physician and responsible party about new orders and change of condition in the residents and signs off notification log.
- _____ Practices the five rights in medication administration and counts and disposes of narcotics properly.
- _____ Is aware that secure care bracelets are marked off on the TARS to be checked by nursing every Wednesday and documented on the SCB sheet in front of chart.
- _____ Is familiar with the telephone system.
- _____ Fills out proper paper work after each fall/incident.
- _____ Shows competency when documenting weights and notifies proper persons when there is a significant weight loss/gain ie; MD, family and dietician.
- _____ Makes out assignments for the SRNA's.
- _____ Is aware of the Administrator on call list for all weekend and emergency help.
- _____ Is familiar with the location of all supplies and who to contact for them.
- _____ Contacts proper disciplines with new orders and notifies dietary of all changes.
- _____ Updates care plans as the need arises and notifies the MDS office.
- _____ Performs and documents assessments.
- _____ Completes admissions and readmissions
- _____ Verifies physician orders with another nurse and places on the Physicians order sheet.

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JAN 13 2011
BY: _____

NURSE'S ORIENTATION

Here is some of the duties that you will be doing while out on the floor;

- 1. MD orders:**
 - Double checked by another nurse and signed
 - Write all orders on Physician statement
 - Call MDS coordinator of all new orders
 - Assist and update Care Plans in chart of all new orders
 - Notify MDS office of any changes

- 2. Make sure end of your shift no "holes" are in MARS/TARS or SRNA's care plan books.**

- 3. SCB checked every Wednesday, sign off on TARS and sheet in front of every person's chart that is wearing SCB's chart.**

- 4. There is a binder(Orientation Manual) on every Unit and DON office that has every form used at the nurse's station, please look over this.**

- 5. Appointments and Labs may be written on calenders at nurse's station, please look at this beginning of every shift.**

- 6. Falls – When a fall happens there are 2 forms to fill out.**
 - Write any interventions on form that was put into place.
 - Notify MDS office of any interventions.
 - Write on Care Plans in Charts of Interventions.

11/2010

Hold the right to make changes or updates when needed.

T. Earlywine, LPN/QA

Please sign that you have read and understand this information:

Date _____ Signature: _____

November 5, 2010
Mandatory In-Service
2010 Survey Follow Up

Survey deficiencies:

- Care plans failure to develop a care plan for catheter use and failure to develop one for a resident with vision problems
- Failed to revise a care plan for a residents diet and failed to revise a care plan for a protein supplement
- Quality of care failed to keep residents free from accidents by not locking the cabinet under a sink that contained chemicals
- Pharmacy failed to ensure medications were filled and available for residents
- Labeling and storage of medications was not followed by leaving a med cart unlocked in the nurses station, medicine cabinet unlocked in nurses station, refrigerator left unlocked in nurses station and cabinet under sink left unlocked in nurses station
- Secure care bracelet for resident was not checked weekly per policy after an elopement

Plan to correct by:

- Having nurses to assist the MDS office by helping them to update care plans as you receive orders and notify the MDS office that you have done this.
- Assist the MDS office by helping to revise care plans when you receive orders. Notify the MDS office when you do this.
- All items have been removed and placed under a lock until current cabinets have locks placed on them.
- Pharmacy has in serviced their staff of the deficient practice and will be filling meds as soon as requests are received. Nursing staff is to contact pharmacy immediately of any missing medication and request back up pharmacy bring it immediately.
- All refrigerators, cabinets, treatment carts and medication carts are to be kept locked at all times unless the staff are removing or replacing items on the carts or in the cabinets and refrigerators.
- All secure care bracelets were checked for proper functioning on 11-4-2010 on the 3-11 shift, none were found to be faulty in performance. All secure care bracelets will be placed on the TARS and checked every week on Wednesday by the staff to ensure they are working properly.

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NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		
K 018 SS-F	<p>A Life Safety Code survey was initiated and concluded on November 2, 2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations. In all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain corridor doors that were capable of resisting the passage of smoke. The doors found deficient were located in all six (6) smoke compartments.</p>	K 018	<ol style="list-style-type: none"> 1. Fire Doors were adjusted to meet code. 2. All residents have the potential to be affected by this deficient practice. 3. Maintenance will perform weekly checks and log each task. Maintenance is also pricing out all new fire doors for the facility to be purchased. 4. Quality Assurance Department will monitor weekly for compliance during walk through. 5. 12-1-10 	12-1-10

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DEC - 1 2010
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Angela M. [Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>12-1-10</i>
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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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K 018	Continued From page 1 Double doors in Zone 1, two (2) sets of double doors in Zone 2; and, one (1) set of double doors in Zone 3, all in the same locations on the first and second floors. This deficient practice has the potential to affect staff and all ninety-eight (98) residents. The facility has the capacity for ninety-nine (99) beds and at the time of the survey the census was ninety-eight (98). The findings include: Observation on 11/02/10 at 11:00 AM revealed upon testing and inspection of eight (8) fire doors all eight (8) doors failed to close all the way to resist the passage of smoke as required. This was confirmed by the Maintenance Director. Interview with the Maintenance Director on 11/02/10 at 11:00 AM, revealed he was getting prices for new doors and he couldn't do much more with the old ones. Actual NFPA Standard: NFPA 101, 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 1-3/4 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. 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.	K 018		
K 025	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		

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K 025 SS=D	<p>Continued From page 2</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review it was determined the facility failed to provide the required testing and maintenance records on the fire/smoke dampers.</p> <p>The findings include:</p> <p>Record review on 11/02/10 at 2:30 PM with the Maintenance Director, revealed the facility had no written documentation for review of the fire/smoke dampers being tested and maintained.</p> <p>Interview with the Maintenance Director on 11/02/10 at 2:30 PM, indicated he was not aware of this requirement.</p> <p>Reference: NFPA 90A(99), Sec. 3-4.7 Requires that fire and smoke dampers undergo maintenance at least every (4) years to include: Operation of the dampers to ensure that they fully close. Removal of fusible links (where applicable).</p>	K 025	<ol style="list-style-type: none"> Scheduled Total Comfort to come in to perform maintenance. All residents have the potential to be affected by deficient practice. Total Comfort came in the day before Thanksgiving and performed maintenance on the smoke dampers. Maintenance is to contact a company to perform service every 4 years.per code. 	11-24-10

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K 025	Continued From page 3	K 025		
K 027 SS=F	<p>A check of latches, if provided. Lubrication of all moving parts as necessary.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure access doors in smoke barriers were, according to NFPA Code.</p> <p>The findings include:</p> <p>Observation with the Maintenance Director on 11/02/10 at 10:30 AM, revealed two (2) smoke barrier access doors located in the attic were not designed to close and latch properly. This has the potential to affect all residents and staff. The bed capacity is ninety-nine (99) with the census of ninety-eight (98) residents on the day of the survey.</p> <p>Interview with the Maintenance Director on 11/02/10 at 10:30 AM, indicated he was unaware that the doors must be designed for this use.</p>	K 027	<ol style="list-style-type: none"> 1. Maintenance installed two Sargent lock kits on doors. 2. All residents have the potential to be affected by this deficient practice. 3. Maintenance installed lock kits making all doors in the attic up to code. 4. Maintenance will check attic monthly to ensure doors are closing properly. 5. 	11-3-10

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K 027	Continued From page 4 Reference: NFPA 101 (2000 Edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Continuity 8.3.2 Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.	K 027		
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 that exits were properly marked according to NFPA standards The findings include: Observation on 11/02/10 at 9:40 AM, revealed the facility had delayed egress locks on a door leading from the dining hall to the outside, but there were no markings on the door indicating	K 038	1. Removed the "not an exit" sign immediately. 2. All residents have the potential to be affected by this deficient practice. 3. "Not an Exit" sign put into place last year during life safety code survey per instruction of surveyor due to unavailability of ramp. This year's survey resulted in an Exit sign being placed at door on the day of survey. 4. Quality Assurance and safety committee chair will monitor monthly for signage compliance. 5.	11-2-10

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K 038	<p>Continued From page 5</p> <p>such. Further observation revealed a sign on the door stating, "Not an Exit". This was confirmed by the Director of Maintenance during the observations. Exits are to be readily accessible at all times.</p> <p>Interview on 11/02/10 at 9:40 AM, with the Director of Maintenance, revealed they were trying to deter everyone from using that particular door.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of</p>	K 038			

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K 038	Continued From page 6 the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS NFPA 101 LIFE SAFETY CODE STANDARD	K 038			
K 040 SS=F	Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to meet the minimum clear width for doors from the resident sleeping rooms. The findings include: Observations during the Life Safety Code inspection on 11/02/10 at 10:30 AM revealed that wooden gates had been installed on the door frames of the resident rooms. Further observation revealed the gates, when fully opened, extended out into the corridor forty-two (42) inches. The gates would be considered an obstruction in the event the residences would have to evacuate or relocate in the event of fire or	K 040	1. All wooden gates removed immediately. 2. Seven residents were found to be affected by this deficient practice. 3. No gates will be allowed in facility. A letter was sent to families of residents explaining why we could not allow the gates. Velcro stop signs will be used to deter wandering residents. 4. Maintenance department has been inserviced on not putting gates in facility 5.	11-3-10	

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K 040	Continued From page 7 disaster. Interview with the Maintenance Director, at this time, confirmed the findings. Interview with the Maintenance Director on 11/02/10 at 10:30 AM, revealed the gates were put up to deter other residents from wandering into the wrong rooms. He further stated he was not aware the gates could not be used. NFPA 101 2000 Edition 19.2.3.5 The minimum clear width for doors in the means of Egress from hospitals; nursing homes; limited care facilities; Psychiatric hospital sleeping rooms; and diagnostic and treatment Areas, such as x-ray, surgery, or physical therapy, shall be Not less than 32 in. (81 cm) wide. Exception No. 1: Existing 34-in. (86-cm) doors Exception No. 2: Existing 28-in. (71-cm) corridor doors in facilities Where the fire plans do not require evacuation by bed, gurney, or wheelchair. 19.2.3.3* Any required aisle, corridor, or ramp shall be not Less than 4 ft (1.2 m) in clear width where serving as means of Egress from patient sleeping rooms. The aisle, corridor, or Ramp shall be arranged to avoid any obstructions to the convenient removal of nonambulatory persons carried on stretchers or on mattresses serving as stretchers.	K 040		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		

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K 050	<p>Continued From page 8</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure fire drills were conducted quarterly on each shift.</p> <p>The findings include:</p> <p>Record review on 11/02/10 with the Maintenance Director at 3:00 PM, revealed the fire drills were not being conducted on each shift quarterly, as required. The deficient practice has the potential to affect all smoke compartments, staff and all residents. The facility has the capacity for ninety-nine (99) beds with a census of ninety-eight (98) residents on the day of the survey.</p> <p>During the interview with the Maintenance Director on 11/02/10 at 3:00 PM, he indicated he was not aware of the wording in this code.</p> <p>Reference: NFFPA Standard NFFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.</p>	K 050	<ol style="list-style-type: none"> 1. Conducted a fire drill on each shift on November 10, 2010 2. All residents have the potential to be affected by this deficient practice. 3. An inservice of maintenance department was conducted to address the importance of having fire drills seperate on all three shifts per code. 4. Fire drills will now be on all three shifts; none will be overlaped as before. QA will monitor monthly to ensure compliance. 5. 	1-10-10
K 061	NFFPA 101 LIFE SAFETY CODE STANDARD	K 061		

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K 061 SS=F	<p>Continued From page 9</p> <p>Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72; 9.7.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the sprinkler system, according to NFPA standards. This deficiency has the potential to affect all residents and staff.</p> <p>The findings include:</p> <p>Observation on 11/02/10 at 2:30 PM with the Maintenance Director, revealed the post indicator valve was not electronically supervised. The post indicator valve must be electronically supervised to prevent the post indicator valve from being mistakenly turned off and shutting off the outside supply of water to the sprinkler system.</p> <p>Interview on 10/02/10 at 2:30 PM with the Maintenance Director, revealed he was unaware of the post indicator valve not meeting the code.</p> <p>Reference: NFPA 101 (2000 Edition) Supervisory Signals 9.7.2.1 Where supervised automatic sprinkler systems are required by another section of this code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a</p>	K 061	<ol style="list-style-type: none"> Maintenance director spoke with contracted fire/sprinkler inspector regarding our system. We are in fact, covered under a system that alarms when the water flow is decreased. Maintenance Director has contacted American Fire and Security to inquire about a solution to the Supervisory Signal issue. All residents have the potential to be affected by this deficient practice. We are working with Bobby Rogers at American Fire and Security to have an indicator valve installed. Issue anticipated to be resolved within 45 days. Maintenance Supervisor will monitor board 3 times weekly to ensure there are no problems. Also, the whole system will be monitored by Simplex/Grinnell. Contract Date 	12-17-10

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 061 SS=F	<p>Continued From page 9</p> <p>Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the sprinkler system, according to NFPA standards. This deficiency has the potential to affect all residents and staff.</p> <p>The findings include:</p> <p>Observation on 11/02/10 at 2:30 PM with the Maintenance Director, revealed the post indicator valve was not electronically supervised. The post indicator valve must be electronically supervised to prevent the post indicator valve from being mistakenly turned off and shutting off the outside supply of water to the sprinkler system.</p> <p>Interview on 10/02/10 at 2:30 PM with the Maintenance Director, revealed he was unaware of the post indicator valve not meeting the code.</p> <p>Reference: NFPA 101 (2000 Edition) Supervisory Signals 9.7.2.1 Where supervised automatic sprinkler systems are required by another section of this code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a</p>	K 061	<ol style="list-style-type: none"> 1. Maintenance director spoke with contracted fire/sprinkler inspector regarding our system. We are in fact, covered under a system that alarms when the water flow is decreased. 2. All residents have the potential to be affected by deficient practice. 3. Maintenance director place a Harden steel lock outside on the main water flow valve. He confirmed, also, that we do have a water flow switch that alarms when water flow decreases or is interrupted. Our system also calls the fire department automatically. 4. The system monitors itself. 5. 	11-18-10

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K 061	Continued From page 10 condition that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.	K 061		
K 082 SS=D	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 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, according to NFPA standards. The findings include: Observation on 11/02/10 at 11:30 AM revealed that a sprinkler head located in the basement Medical Records Room was located too close to the wall. The observations were confirmed with the Maintenance Director. Interview on 11/02/10 at 11:30 AM, with the Maintenance Director, revealed he had no knowledge of this requirement.	K 062	1. Kitchen sprinkler head was correctly mounted immediately. Record Room head was moved to meet code. 2. All residents have the potential to be affected by deficient practice. 3. Contracted fire/sprinkler inspector will monitor quarterly for compliance of all sprinkler head clearance. 4. Maintenance department inserviced on sprinkler head code. Quality Assurance department will monitor on weekly walk through's for compliance. 5.	12-1-10

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K 062	<p>Continued From page 11</p> <p>Observation on 11/02/10 at 11:45 AM revealed a sprinkler head located in the Kitchen area hallway near the exit was not mounted correctly; the deflector was flush with the ceiling tile not allowing the head to function properly.</p> <p>Interview on 11/02/10 at 11:45 AM with the Maintenance Director revealed he had not noticed the head.</p> <p>Reference: NFPA 13 (1999 edition) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall. 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. Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 062		
K 072 SS=F		K 072		

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K 072	<p>Continued From page 12</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that corridors were maintained free from obstructions to the full instant use in the case of fire or other emergencies. Exits must be maintained to ensure their use in an emergency. The deficiency has the potential to affect all staff and residents.</p> <p>The findings include:</p> <p>Observation on 11/02/10 at 9:12 AM, revealed four (4) clean linen carts not in use and stored in the corridor in front of rooms 122, 124, 214, 248. Additional observations revealed three (3) soiled linen carts not in use, parked in front of rooms 140, 246 and 234. The observation was confirmed with the Maintenance Director.</p> <p>An interview, on 11/02/2010 at 9:12 AM, with the Maintenance Director, revealed the carts were routinely left in the halls due to lack of storage space.</p> <p>Reference: NFPA 101 (2000 edition) 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained</p>	K 072	<ol style="list-style-type: none"> 1. Carts were immediately removed from hallway. 2. All resident have the potential to be affected by this deficient practice. 3. Nursing Staff was inserviced the day of survey regarding the importance of not leaving carts or any object in the hallways of the facility. Ongoing inservicing has been done each week to ensure ALL staff is aware. 4. Quality Assurance Department will monitor daily for compliance and the safety committee chair will monitor weekly, as well. 5. 	11-2-10

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K 072	Continued From page 13 free of all obstructions or impediments to full instant use in the case of fire or other emergency	K 072			