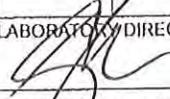


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/30/2012
NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10456 US HWY 62 CALVERT CITY, KY 42029	
(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	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure a homelike environment for one resident (#9), in the selected sample of 16 residents. Observations of the resident's room revealed no pictures, clock, or any decoration. Findings include: A review of the policy for the Patient's Environment, revised 10/31/12, revealed the facility provided a safe, clean, comfortable and homelike environment. A homelike environment de-emphasized the institutional character of the setting, to the extent possible, and allowed the resident to use personal belongings. An environment as close to that of the environment of a private home as possible. The patient's	F 252	F 252 All residents have the potential to be affected by the environment. Res#9 was provided with items to decorate his/her room on 11/30/12. An audit of the facility was completed by the Executive Director, Admissions Coordinator, and Social Services Director, and all rooms identified had décor placed in those rooms. Rooms will be reviewed prior to admission and upon discharge by the Admissions Coordinator and/or the Executive Director. Weekly audits will be completed by the Admissions Coordinator and/or Executive Director weekly for one (1) month, and monthly for three (3) months to ensure that a homelike environment is being provided. The Performance Improvement committee will address any concerns as needed, and décor will be replenished on a regular basis and reviewed in PI.	01/11/13

LABORATORY/DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
 Executive Director 1/14/13

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 252	Continued From page 1 opinion of the living environment was the guide for determining if their environment was "comfortable and homelike." The patient without family and friends and with few assets were assisted, to the extent possible, with making their bedroom homelike, if they so desire. An observation, on 11/27/12 at 3:45 PM, revealed Resident #9 was in his/her room watching television. The walls in the room were bare with no pictures or decorations and there was no clock in the room. Interview with Resident #9, at this time, revealed he/she had expressed a need for a clock to the staff; however, had not received one. The resident indicated a desire for a clock as "it would be nice to know what time it is." Further interview with Resident #9, on 11/29/12 at 10:45 AM, revealed his/her room was "kind of bare." The resident said it did not feel like home. He/she indicated all of his/her personal pictures were burned in a fire. The facility had not asked if he/she would like to decorate the room to make it more "homelike." Resident #9 expressed an interest in painting, stating it would be nice to decorate the room with pictures. An interview with the Activity Director and the Administrator, on 11/30/12 at 9:00 AM, revealed if a resident requested something specifically, then they tried to get it for them. The Activity Director revealed she encouraged family members to bring items in to decorate the resident's room; however, she does not decorate the rooms. The Administrator revealed there was no one specifically delegated to decorate resident rooms.	F 252	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280			

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F 280	<p>Continued From page 2</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure each resident's care plan was revised for two residents, (#1 and #4), in the selected sample of 16 residents. Resident #1's diagnosis included Peripheral Vascular Disease (PVD) and he/she had a darkened area on the right foot. Resident #4 was assessed as being a falls risk with an intervention and an order written to remove the wheelchair from the room when not in use.</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F280</p> <p>Resident #1 careplan has been updated on 11/29/12 to reflect Peripheral Vascular Disease diagnosis. The darkened area on Resident #1s left foot where third toe has been amputated has been added to careplan.</p> <p>Resident #4, the order from 11/16/11 for the wheelchair to be outside the room was added to the careplan and the SRNA assignment sheet on 11/30/12.</p> <p>An audit will be completed on residents with Peripheral Vascular Disease to ensure appropriate careplan and skin monitoring sheets are in place. A careplan audit will be conducted of residents identified as a fall risk for interventions and will be updated on the comprehensive careplan and the SRNA assignment sheet based upon audit findings.</p>	01/11/13

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F 280	<p>Continued From page 3</p> <p>Observation, conducted on 11/28/12 and 11/29/12, revealed the resident was in the bed and his/her wheelchair was left in the room.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Care Plans," dated 01/07/12, revealed the care plan addressed risk factors that may lead to an avoidable decline in functioning levels and was revised and updated to reflect the resident's current status.</p> <p>1. A record review revealed the facility admitted Resident #1 on 09/28/12 with diagnoses to include Chronic Kidney Failure and Dialysis, Coronary Artery Disease, and a Third Toe Amputation.</p> <p>A review of the admission Minimum Data Set (MDS) assessment, dated 10/25/12, revealed the facility identified Resident #1 as cognitively having difficulty in new situations, non-ambulatory, required the extensive assistance of one staff member with Activities of Daily Living (ADLs) and two staff members with transfers.</p> <p>An observation of Resident #1's skin assessment on 11/28/12 at 2:50 PM, revealed the resident had a darkened area to the right foot, between the second toe and forth toe, where the resident had a toe previously amputated and stated the toe had "rotted off."</p> <p>A review of the resident's care plan, and skin assessments revealed there was no documented evidence of the darkened area.</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Education will be completed by the Staff Development Coordinator regarding skin assessment procedure. Education will be conducted on revision of the comprehensive careplan and SRNA assignment sheet for implementation.</p> <p>Minimum Data Assessment Coordinator along with Interdisciplinary Team to include the Director of Nursing Services or Unit Manager, Social Services, Dietary, and Activities, will review initial interventions on admission, then annually, quarterly and with any significant change assessment to reflect careplan goals and interventions including adding interventions to the comprehensive careplan.</p> <p>Data Entry Clerk and/or Unit Manager will ensure fall careplan interventions will be added to the SRNA assignment sheets for each resident.</p> <p>Unit Manager will audit 4 resident skin assessments weekly for 4 weeks then monthly for 3 months and as needed thereafter.</p>	

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F 280	<p>Continued From page 4</p> <p>An interview with Registered Nurse (RN) #1, on 11/30/12 at 10:58 AM, revealed the RN stated the resident had the darkened area on admission, was unaware of a diagnosis of PVD, yet she was unsure why this was not documented on the admission records or monitored on the care plans.</p> <p>An interview with RN #2, on 11/30/12 at 11:05 AM, revealed he admitted the resident and completed a skin assessment. The RN stated if the resident had a darkened area, he would have documented this information. He stated the area was not there upon admission. He also stated when the area was noted, the Director of Nursing (DON) should have been made aware, a Non-Pressure Skin Condition Report should have been completed, and should have been care planned.</p> <p>An interview with the Director of Nursing (DON), on 11/29/12 at 1:28 PM, revealed she was unaware of the PVD diagnosis, which was mentioned on the Physician Progress Notes, or the darkened area to Resident #1's foot and would have expected this to be documented and care planned.</p> <p>2. A record review revealed the facility admitted Resident #4 on 11/22/10 with diagnoses to include Seizures, Parkinson's Disease, Weakness, and Parkinson's Dementia.</p> <p>A review of the quarterly MDS, dated 09/25/12, revealed the resident had a Brief Interview for Mental Status (BIMS) score of "15". Resident #4 was cognitively intact and able to make his/her own decisions.</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Findings will be reported to the Performance Improvement committee monthly for three months then as needed on a quarterly basis thereafter.</p> <p>The Director of Nursing Services will conduct an audit of 3 careplans a week for 4 weeks then monthly for 3 months and report findings of accuracy to the Performance Improvement committee monthly for three Months and then quarterly as needed thereafter.</p> <p>The Director of Nursing Services will also take report findings from the unit manager/of the skin assessment audit to the Performance Improvement committee.</p>	

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F 280	Continued From page 5 A review of the Interdisciplinary Team (IDT) note, dated 11/16/12, revealed an intervention of removing the resident's wheelchair from his/her room when it was not in use. Additionally, the nurse obtained a physician's order to remove the wheelchair from his/her room when it was not in use. Observation of Resident #4, on 11/28/12 at 1:25 PM, and on 11/29/12 at 2:00 PM, revealed the resident was in the bed, and the wheelchair was left in the bedroom in the corner. An interview with Certified Nurse Aide (CNA) #2, on 11/29/12 at 2:45 PM, revealed she was the staff assigned to provide care to the resident on 11/29/12. The aide revealed they stored the resident's wheelchair in his/her room when not in use. CNA #2 was unaware the resident's wheelchair was ordered to be removed from the room when it was not in use. Additionally, she reviewed the CNA assignment sheet and stated it did not indicate staff were to remove the wheelchair from Resident #4's room when it was not in use. An interview with the Unit Manager (UM), on 11/30/12 at 9:30 AM, revealed the information about removing the wheelchair from the resident's room, when not in use, was not on the CNA assignment sheet. The UM reported the information should be on the CNA assignment sheet, but was unaware why the information was not on it. An interview with the DON, on 11/30/12 at 2:35 PM, revealed she was unsure if removing the	F 280	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		

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F 280	Continued From page 6 resident's wheelchair was ordered or an intervention. She revealed the removing the wheelchair should be on the care plan.	F 280	<i>This Plan of Correction is the center's credible allegation of compliance.</i>		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy/procedure review, it was determined the facility failed to ensure standards of practice were followed for one resident (#7), in the selected sample of 16 residents, and for one resident, not in the selected sample (#17). Resident #7 was ordered intravenous fluids (IVF) at a rate of 125 milliliters(ml)/minute, then decreased to 35 ml/minute; however, the staff was unable to determine that the resident received the ordered dosage of IVF. Resident #17 was ordered a medication due at 8:00 AM and the staff administered the medication outside of the timeframe for administration. Findings include: 1. A review of the facility's policy/procedure for Fluid Intake and Output (I&O) Measurement, revised 10/31/06, revealed I&O measurement was recorded according to the following criteria, including residents receiving intravenous therapy for duration of treatment (Intake only). A review of the facility's policy/procedure for IV	F 281	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> F281 Resident #7 was placed on an IV pump on 11/29/12. IV intake monitoring record was also initiated on 11/27/12. Resident #17's medication variance was completed on Norvir, Insentress, Prezista, Keppra, and Senokot. The physician was notified on 11/29/12. The responsible party was notified on 11/29/12. The physician gave an order to change resident #17's medication times to his/her preference of 10AM for morning medications. Licensed Nurse education will be completed on medication administration with medication administration competency completed on all licensed nurses and Certified Medication Technicians. Licensed Nurses will also be educated on IV intake monitoring records and the initiation of the record when IV fluids are initiated At this time, no other residents are receiving IV therapy.	01/11/13	

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F 281	<p>Continued From page 7</p> <p>Therapy, revised 01/15/10, revealed compliance guidelines included administering IV solutions according to the prescriber orders.</p> <p>A record review revealed Resident #7 was admitted to the facility on 08/08/12 with a readmission date of 10/19/12. Diagnoses include Chronic Kidney Disease (Stage II), Dysphagia, Senile Depressive Disorder, Bipolar Disorder, and Alzheimer's Disease. A review of the quarterly Minimum Data Set (MDS), dated 09/04/12, revealed the facility assessed the resident as severely cognitively impaired. A review of the Physician's Orders, dated 11/27/12, revealed the resident was placed on comfort measures only, the IV fluids were decreased to 35 ml per hour, continue medications by mouth; however, no weights, labs, or hospitalization.</p> <p>An observation of Resident #7, on 11/27/12 at 10:00 AM, revealed a bag of IV fluids (D5 1/2 NS) with approximately 700 ml remaining. The bag was dated/timed 11/27/12 at 6:00 AM. An observation, on 11/28/12 at 8:50 AM, revealed approximately 200 ml of IV fluids hanging from the same bag (dated/timed 11/27/12 at 6:00 AM). A review of the Physician's Order, dated 11/27/12, revealed an order for D5 1/2 NS at 35 ml per hour. The two observations revealed the resident received approximately 500 ml of IV fluid over approximately 23 hours; however, the resident should have received 805 ml of fluid.</p> <p>An observation of Resident #7, on 11/28/12 at 2:45 PM, revealed approximately 900 ml of IV fluid in a bag timed/dated 11/28/12 at 12:30 PM. Observation, on 11/29/12 at 8:45 AM, revealed approximately 500 ml of IV fluid left in the same</p>	F 281	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>All medications records were reviewed on 11/28/12 with medication times adjusted to each hall group time with the room the resident is in at this time.</p> <p>Director of Nursing Services will monitor 5 resident MAR/TAR/IV intake record weekly for 4 weeks, then monthly for 3 months. Results will be discussed and reviewed in the Performance Improvement meeting monthly for three months and quarterly as needed thereafter.</p>		

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F 281	<p>Continued From page 8</p> <p>bag. The two observations revealed the resident received approximately 400 ml over an 18 hour period; however, the resident should have received 630 ml of fluid.</p> <p>The facility was unable to provide an intake record for Resident #7 while on IV fluids.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 11/29/12 at 1:35 PM, revealed the resident was placed on comfort measures only; therefore, the facility was not recording the resident's IV intake. She was the dayshift nurse on 11/28/12 and 11/29/12. She monitored the resident's IV site several times on her shift; however, there was no way to monitor how much fluid the resident received as she did not document the intake.</p> <p>An interview with LPN #2, on 11/30/12 at 9:30 AM, revealed she was the nurse for night shift 11/27/12 and 11/28/12. She revealed it was reported how much was in the IV bag at the end of her shift; however, it was not documented. She indicated it should be monitored to ensure the resident received adequate fluid intake, per the physician's orders.</p> <p>An interview with the Director of Nursing (DON), on 11/30/12, revealed the facility's standard of practice for IV therapy was the policy that indicated IV intake should be monitored and documented. The resident was receiving daily labs until 11/27/12, but staff should have been documenting the resident's intake afterwards.</p> <p>2. A review of the facility's Medication Administration policy/procedure, revised 08/31/12, revealed medications were</p>	F 281	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>		

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F 281	<p>Continued From page 9</p> <p>administered within 60 minutes of the scheduled time of administration. Unless specified by the prescriber, medications were administered by the center's established medication administration schedule. An interview with the DON, on 11/30/12 at 12:15 PM, revealed she expected staff to follow the policy.</p> <p>A review of the Physician's Orders for Resident #17, dated 11/29/12, revealed an order for Norvir 100 mg every twelve hours, Isentress 400 mg every twelve hours, Prezista 600 mg every twelve hours, Keppra 1500 mg every twelve hours, and Senokot-S twice daily. A review of the Medication Administration Record (MAR), dated November 2012, revealed the Norvir, Isentress, Prezista, and Keppra were scheduled for 8:00 AM and 8:00 PM. The Senokot-S was scheduled for 8:00 AM and 5:00 PM.</p> <p>An observation of a medication pass, on 11/29/12 at 9:50 AM, revealed Licensed Practical Nurse (LPN) #1 administered Norvir 100 milligrams (mg), Isentress 400 mg, Prezista 600 mg, Keppra 1500 mg, and Senokot (one tablet) to Resident #17.</p> <p>An interview with LPN #1, on 11/29/12 at 1:35 PM, revealed she was suppose to administer medications no more than one hour or before the scheduled medication time. She indicated that the resident refused the scheduled medications daily until after breakfast; however, she did not notify the physician to ensure it was acceptable to give the medications later than scheduled.</p> <p>An interview with the DON, on 11/30/12 at 12:15 PM, revealed she expected staff to call the</p>	F 281	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/30/2012	
NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10466 US HWY 62 CALVERT CITY, KY 42029		
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F 281 F 328 SS=D	<p>Continued From page 10 physician if a resident requested medications at a different time than scheduled.</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure proper treatment and care for the administration of intravenous (IV) fluids for one resident (#7), in the selected sample of 16 residents. A physician's order was received, on 11/20/12, for five percent (5%) dextrose in one-half (1/2) normal saline (D5 1/2 NS) at 125 milliliters (ml) per hour via IV, which was decreased to 35 ml per hour on 11/27/12. During several observations, Resident #7 was not receiving the fluid according to the physician's order. Additionally, the facility failed to monitor and document the resident's intake while on IV fluids.</p> <p>Findings include:</p>	F 281 F 328	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F328</p> <p>Resident #7 was placed on a IV pump on 11/29/12. IV intake monitoring record was initiated on 11/27/12 for resident #7.</p> <p>No other residents effected at this time</p> <p>Licensed Nurse Education will be completed on proper documentation and form to use when IV fluids are being administered.</p> <p>Director of Nursing Services will monitor IV fluid administration for proper form and documentation of IV fluid intake weekly times 4 weeks then monthly times 3 months. Director of Nursing Services will report findings to the Performance Improvement committee monthly for three months then quarterly as needed thereafter.</p>	01/11/13

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F 328	<p>Continued From page 11</p> <p>A review of the facility's policy/procedure for Fluid Intake and Output (I&O) Measurement, revised 10/31/06, revealed I & O measurement was recorded according to the following criteria, including residents receiving intravenous therapy for duration of treatment (intake only).</p> <p>A review of the facility's policy/procedure for IV Therapy, revised 01/15/10, revealed compliance guidelines included administering IV solutions according to the prescriber orders.</p> <p>A record review revealed Resident #7 was admitted to the facility on 08/08/12 with a readmission date of 10/19/12. Diagnoses include Chronic Kidney Disease (Stage II), Dysphagia, Senile Depressive Disorder, Bipolar Disorder, and Alzheimer's Disease. A review of the quarterly Minimum Data Set (MDS), dated 09/04/12, revealed the facility assessed the resident as severely cognitively impaired. A review of the Physician's Orders, dated 11/27/12, revealed the resident was placed on comfort measures only, the IV fluids were decreased to 35 ml per hour, continue medications by mouth; however, no weights, labs, or hospitalization.</p> <p>An observation on initial tour of the facility, on 11/27/12 at 10:00 AM, revealed a bag of IV fluids (D5 1/2 NS) with approximately 700 ml remaining. The bag was dated/timed 11/27/12 at 6:00 AM.</p> <p>An observation, on 11/28/12 at 8:50 AM, revealed approximately 200 ml of IV fluids hanging from the same bag (dated/timed 11/27/12 at 6:00 AM).</p> <p>A review of the Physician's Order, dated 11/27/12, revealed an order for D5 1/2 NS at 35 ml per hour.</p> <p>The two observations revealed the resident</p>	F 328	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>		

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F 328	<p>Continued From page 12</p> <p>received approximately 500 ml of IV fluid over approximately 23 hours; however, the resident should have received 805 ml of fluid.</p> <p>An observation of Resident #7, on 11/28/12 at 2:45 PM, revealed approximately 900 ml of IV fluid in a bag timed/dated 11/28/12 at 12:30 PM. Observation on 11/29/12 at 8:45 AM, revealed approximately 500 ml of IV fluid left in the same bag. The two observations revealed the resident received approximately 400 ml over an 18 hour period; however, the resident should have received 630 ml of fluid.</p> <p>The facility was unable to provide an intake record for Resident #7 while on IV fluids.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 11/29/12 at 1:35 PM, revealed the resident was placed on comfort measures only; therefore, the facility was not recording the resident's IV intake. She was the dayshift nurse on 11/28/12 and 11/29/12. She monitored the resident's IV site several times on her shift; however, there was no way to monitor how much fluid the resident received as she did not document the intake.</p> <p>An interview with LPN #2, on 11/30/12 at 9:30 AM, revealed she was the nurse for night shift 11/27/12 and 11/28/12. She revealed it was reported how much was in the IV bag at the end of her shift; however, it was not documented. She indicated it should be monitored to ensure the resident received adequate fluid intake.</p> <p>An interview with the Director of Nursing (DON), on 11/30/12, revealed the facility's policy indicated IV intake should be monitored and documented.</p>	F 328	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>		

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F 328	Continued From page 13	F 328	<i>This Plan of Correction is the center's credible allegation of compliance.</i>		
F 332 SS=D	<p>The resident was receiving dally labs until 11/27/12, but staff should have been documenting the resident's intake afterwards.</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure the facility was free of medication administration errors of five (5) percent (%) or greater. Observation of the medication pass, on 11/29/12 and 11/30/12, revealed a total of 49 medications were administered with six (6) medication errors, resulting in a 12% medication error rate.</p> <p>Findings include:</p> <p>A review of the facility's Medication Administration policy/procedure, revised 08/31/12, revealed medications were administered within 60 minutes of the scheduled time of administration. Unless specified by the prescriber, medications were administered by the center's established medication administration schedule. An interview with the Director of Nursing (DON), on 11/30/12 at 12:15 PM, revealed she expected staff to follow the policy.</p> <p>An observation of a medication pass, on 11/29/12 at 9:50 AM, revealed Licensed Practical Nurse</p>	F 332	<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F332</p> <p>Resident #17 medication variance was completed on Norvir, Insentress, Prezista, Keppra and Senokot. The physician and Responsible party were notified on 11/29/12. The physician gave an order to change resident #17's medication times to his/her preference of 10AM for morning medications. Resident # 18, a medication variance report was completed.</p> <p>Review of resident's medication times and their area of the hall were reviewed and any times changes were addressed with physician notification as needed.</p> <p>Licensed Nurses/Certified Medication Assistance will be educated on medication administration with medication competency completed.</p> <p>License Nurses/ Certified Medication Assistance will be observed with medication administration 2 times weekly x 4 weeks then 2 monthly times 3 months.</p>	01/11/13	

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F 332	<p>Continued From page 14</p> <p>(LPN) #1 administered Resident #17 Norvir 100 milligrams (mg), Isentress 400 mg, Prezista 600 mg, Keppra 1500 mg, and Senokot (one tablet) at 9:50 AM.</p> <p>A review of the Physician's Orders for Resident #17, dated 11/29/12, revealed an order for Norvir 100 mg every twelve hours, Isentress 400 mg every twelve hours, Prezista 600 mg every twelve hours, Keppra 1500 mg every twelve hours, and Senokot-S twice daily. A review of the Medication Administration Record (MAR), dated November 2012, revealed the Norvir, Isentress, Prezista, and Keppra were scheduled for 8:00 AM and 8:00 PM. The Senokot-S was scheduled for 8:00 AM and 5:00 PM.</p> <p>An interview with LPN #1, on 11/29/12 at 1:35 PM, revealed she was suppose to administer medications no more than one hour or before the scheduled medication time. She indicated that the resident refused the scheduled medications daily until after breakfast; however, she did not call the physician to ensure it was acceptable to give the medications later than scheduled.</p> <p>An observation of a medication pass, on 11/30/12 at 9:07 AM, revealed Resident #18 received two Bisacodyl five (5) milligram (mg) tablets. A review of the physician's orders, dated November 2012, revealed the resident had an order for Bisacodyl five (5) mg po every day.</p> <p>An interview with LPN #3, on 11/30/12 at 9:45 AM, revealed this was ordered as one tablet, except on Wednesdays and Sundays, since 09/21/10, according to the pharmacy orders, and "guessed she mistakenly gave two tablets."</p>	F 332	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>The Staff Development Coordinator will report to Performance Improvement Committee the findings monthly for three Months then quarterly as needed thereafter.</p>	

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F 332	Continued From page 15 An interview with the DON, on 11/30/12 at 12:15 PM, revealed she expected staff to call the physician if a resident requested medications at a different time than scheduled.	F 332	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1965 Remodeled: 1977 Third Wing Added.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1967 and upgraded in 2009, with 33 smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1965.</p> <p>GENERATOR: Type II generator installed prior to 1997. Fuel source is 2000 gallons of Liquid Propane.</p> <p>A standard Life Safety Code survey was conducted on 11/27/12 and 11/28/12. Oakview Nursing and Rehabilitation Center was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred (100) beds with a census of Seventy-Six (76) on the day of the survey.</p>	K 000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>		

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

TITLE

(X6) DATE



Executive Director

1/14/13

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

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K 000	Continued From page 1 The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
K 025 SS=E	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 observations and interview, it was determined the facility failed to maintain smoke barriers in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, fifty-one (51) residents, staff and visitors. The facility is certified for one-hundred (100) beds with a census of seventy-six (76) on the day of the survey. The facility failed to ensure the smoke barrier walls on the 100 hall and 200 hall had a thirty minute rating. The findings include:	K 025	K 025 Edwards Drywall construction will have 5/8 inch drywall installed on or before 01/01/13. Installation will include two forty (40) foot spans. Audit of all smoke barriers was completed 11/28/12 with no other areas identified. The Maintenance Supervisor will perform monthly audits of smoke barriers X 3 months to ensure that all are at least one half hour fire resistance rating. Any identified issues will be corrected and reported in PI Committee.	01/11/13

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K 025	Continued From page 2' Observation, on 11/27/12 between 11:35 AM and 12:30 PM, with the Maintenance Supervisor revealed the smoke partition, extending above the ceiling located next to the Dietary Office and the partition next to the laundry was constructed of 5/8 inch drywall on one side of the studs. The wall did not provide a ½ hour fire resistance rating due to the studs of the wall being exposed. Interview, on 11/27/12 between 11:35 AM and 12:30 PM, with the Maintenance Supervisor revealed he was not aware of the requirement for the wall to have a fire resistance rating since it has been there since construction of the facility. 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.	K 025	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
K 029 SS=E	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	K 029	K 029 Door closers were installed on Accounts Payable Office, Business Office, and Activities/ Social Services Office on 12/05/12.	01/11/13	

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K 029	Continued From page 3 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 three (3) of four (4) smoke compartments, fifty-one (51) residents, staff and visitors. The facility is certified for one-hundred (100) beds with a census of seventy-six (76) on the day of the survey. The facility failed to ensure two (2) rooms were properly protected due to the storage in the rooms. The findings include: Observation, on 11/27/12 between 2:00 PM and 4:00 PM, with the Maintenance Supervisor, revealed the Accounts Payable Office and the Activities/Social Services Office did not have a closer added to the door. This requirement is due to the storage of combustible items inside the areas. Interview, on 11/27/12 between 2:00 PM and 4:00 PM, with the Maintenance Supervisor, revealed he was unaware the storage in a room determined whether the room was a hazardous storage area or not. 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	K 029	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> Doors with automatic closers will be audited monthly X 3 months to ensure that doors are self closing. Any identified issues will be corrected and reported in PI Committee.	

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K 029	Continued From page 4 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 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	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
K 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	K 056	K 056 Premier Fire has ordered sprinkler head parts and will be installed by 01/11/13.	01/11/13

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K 056	<p>Continued From page 5</p> <p>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 the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, sixty-three (63) residents, staff and visitors. The facility is certified for one-hundred (100) beds with a census of seventy-six (76) on the day of the survey. The facility failed to ensure ten (10) sprinkler heads were not blocked by light fixtures and all sprinkler heads were the same type in a compartment of the facility.</p> <p>The findings include:</p> <p>Observations, on 11/27/12 between 2:00 PM and 4:00 PM with the Maintenance Supervisor, revealed the sprinkler heads located in the kitchen, rooms # 362, 360, 358, 356, 352, 346, 344, and 118 were blocked by light fixtures, within 1 foot of the sprinkler head, extending below the sprinkler heads.</p> <p>Interview, on 11/27/12 between 2:00 PM and 4:00 PM with the Maintenance Supervisor, revealed he</p>	K 056	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Audit of sprinkler heads was conducted by the Maintenance Supervisor on 11/28/12. Identified sprinkler heads were replaced on 01/07/13 by vendor. Monthly reviews of sprinkler head placement will be completed by the Maintenance Supervisor and any identified areas will be replaced and follow up will be reported in PI Committee.</p>	

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K 056	<p>Continued From page 6</p> <p>was unaware that the light fixtures could block the spray pattern of the sprinkler head.</p> <p>Observations, on 11/28/12 at 10:30 AM with the Maintenance Supervisor, revealed several standard response sprinkler heads and a quick response sprinkler head in the same compartment, located in the dining room area, which would not allow both types of sprinkler heads to engage at the same heat level.</p> <p>Interview, on 11/28/12 at 10:30 AM with the Maintenance Supervisor, revealed he was not aware that the sprinklers had to have the same engagement heat if the sprinkler heads are located in the same compartment.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="0"> <tr> <td></td> <td style="text-align: center;">Maximum Allowable Distance</td> </tr> <tr> <td>Distance from Sprinklers to above Bottom of Side of Obstruction (A)</td> <td style="text-align: center;">of Deflector Obstruction (in.)</td> </tr> <tr> <td>(B)</td> <td></td> </tr> <tr> <td>Less than 1 ft</td> <td style="text-align: center;">0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td style="text-align: center;">2 1/2</td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td style="text-align: center;">3 1/2</td> </tr> </table>		Maximum Allowable Distance	Distance from Sprinklers to above Bottom of Side of Obstruction (A)	of Deflector Obstruction (in.)	(B)		Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	K 056	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	
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K 056	Continued From page 7 2 ft to less than 2 ft 6 in. 51/2 2 ft 6 in. to less than 3 ft 71/2 3 ft to less than 3 ft 6 in. 91/2 3 ft 6 in. to less than 4 ft 12 4 ft to less than 4 ft 6 in. 14 4 ft 6 in. to less than 5 ft 161/2 5 ft and greater 18 For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 Edition) 7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use	K 056	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	

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K 056	Continued From page 8 of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 056	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
K 073 SS=F	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 four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for one-hundred (100) beds with a census of seventy-six (76) 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 11/27/12 between 2:00 PM and 4:00 PM with the Maintenance Supervisor, revealed several stuffed animals, wreaths, and artificial floral arrangements throughout the facility had no flame retardant applied. Interview, on 11/27/12 between 2:00 PM and 4:00 PM with the Maintenance Supervisor, revealed he was aware decorations were required to be treated with a fire retardant spray. He stated the facility has a policy to not apply fire retardant to decorations.	K 073	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> K 073 Flammable décor will be removed from resident areas on 12/31/12. Families, visitors, and residents have been educated regarding flammable décor. An audit of the facility was completed by the Executive Director, Admissions Coordinator, and Maintenance Supervisor. All flammable décor was removed from the facility. Education was provided to staff, residents, and visitors on 12/26/12 regarding the removal of stuffed animals and flammable décor. The Executive Director or Admissions Coordinator will conduct weekly audits X 4 weeks, then monthly X3 months to ensure that the facility is free of flammable décor. Upon admission, all new residents are educated regarding this matter. Finding will be reported to PI Committee.	01/11/13

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K 073	Continued From page 9	K 073	<i>This Plan of Correction is the center's credible allegation of compliance.</i>		
K 076 SS=E	<p>Interview, on 11/28/12 at 11:00 AM with the Administrator, revealed there was no policy in place for flammable decorations in resident rooms. She stated the company does not allow for flame treating decorations.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments,</p>	K 076	<p>K 076 Signage permanently fastened on oxygen storage room on 11/29/12.</p> <p>The Maintenance Supervisor will audit oxygen storage room doors for proper signage X 3 months, and any issues will be corrected and reported to PI Committee.</p>	01/11/13	

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K 076	Continued From page 10 all residents, staff and visitors. The facility is certified for one-hundred (100) beds with a census of seventy-six (76) on the day of the survey. The facility failed to ensure oxygen storage room had a no smoking sign placed on the door. The findings include: Observation, on 11/27/12 at 3:43 PM, with the Maintenance Supervisor, revealed an oxygen storage room without the proper signage for no smoking on the door for the room. Interview, on 11/27/12 at 3:43 PM, with the Maintenance Supervisor, revealed he was aware the room was required to have a no smoking sign but revealed the signage was moved to the inside of the door. Reference: NFPA 99 (1999 edition) 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING NFPA 101 LIFE SAFETY CODE STANDARD	K 076	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
K 144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	K 144 Walls constructed to separate generator from storage in maintenance garage completed 12/17/12.	01/11/13

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K 144	Continued From page 11 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained 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 one-hundred (100) beds with a census of seventy-six (76) on the day of the survey. The facility failed to ensure the generator enclosure did not have any storage inside. The findings include: Observation, on 11/27/12 at 3:43 PM, with the Maintenance Supervisor, revealed the facility was equipped with an emergency generator. The enclosure for the generator had storage throughout the room. Interview, on 11/27/12 at 3:43 PM, with the Maintenance Supervisor, revealed he was not aware items could not be stored in the same room as the generator. Reference: NFPA 110 (1999 Edition) 5-2.1 The EPS shall be installed in a separate room for Level 1 installations. EPSS equipment shall be	K 144	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> Education provided 11/28/12 to the Maintenance Supervisor related to items not being stored in the same room as the generator. Monthly rounds will be conducted by the Executive Director to ensure that no items are stored in the generator room. Any issues identified will be corrected and reported in the PI Committee.		

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K 144	Continued From page 12 permitted to be installed in this room. The room shall have a minimum 2-hour fire rating or shall be located in an adequate enclosure located outside the building capable of resisting the entrance of snow or rain at a maximum wind velocity required by local building codes. No other equipment, including architectural appurtenances, except those that serve this space, shall be permitted in this room.	K 144	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		