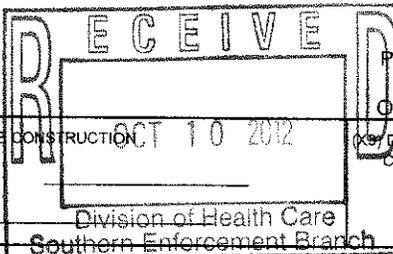


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 10/04/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185242	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/20/2012
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NAME OF PROVIDER OR SUPPLIER  WINDSOR CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 STERLING WAY MOUNT STERLING, KY 40353
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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
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F 000	INITIAL COMMENTS  A standard health survey was conducted on 09/18-20/12. Deficient practice was identified with the highest scope and severity at "D" level.	F 000	The following constitutes the facility's response to the findings of the Department for Health Services and does not constitute an admission of the facts alleged or conclusions set forth on the summary statement of deficiencies.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies and procedures, it was determined the facility failed to provide housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior. The facility failed to ensure the residents' whirlpool tubs were clean and without mildew and soap scum buildup.  The findings include:  Review of the facility's bathtub/shower chair and bed cleaning policy dated April 2011 revealed the whirlpool bathtub should be cleaned before and after each resident bath. Review of the Instruction for Cleaning Tub, undated, revealed all tub surfaces shall be scrubbed with a brush.  Observation on 09/18/12 at 6:30 PM, revealed the whirlpool tub in the Wisteria resident shower room had mildew, soap scum, and a dirt-like residue on the door of the whirlpool between the panel and the rubber seal. Further observation revealed a hairpin between the panel of the door	F 253	This plan of correction is prepared as required by the provisions of the Health Safety code, 42 CFR and constitutes the facility's written credible allegation of compliance.  F 253  No residents were harmed by the deficient practice.  Tubs/whirlpools deep cleaned on 9/19/12 by the environmental director and nurse management.  Environmental rounds of resident rooms, common areas, kitchen, shower rooms, bathrooms, activity room and dining room initiated on 9/21/12 and completed 9/25/12 by the QA Nurse to check for cleanliness of the environment, No other areas of concern identified.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rebecca Cooley</i>	TITLE Administrator	(X6) DATE 10/10/12
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  WINDSOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 125 STERLING WAY MOUNT STERLING, KY 40353	
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F 253	Continued From page 1 and the rubber seal and hair in the tub.  Observation on 09/19/12 at 5:30 PM, revealed the whirlpool tub in the Lakeview resident shower room also had mildew, soap scum, and dirt-like residue on the door of the whirlpool between the panel and the rubber seal. Further observation revealed hair in the tub.  Interview with SRNA #5 on 09/20/12 at 8:40 AM, revealed the process used to clean the whirlpool tub between each resident use was to spray a disinfectant on the inside of the whirlpool, fill with water, and then drain. Further interview revealed SRNA #5 did not scrub the tub with a brush between each resident use.  Interview with SRNA #4 on 09/20/12 at 8:45 AM, revealed the process used to clean the whirlpool tub between each resident use was to spray a shower foam cleaner into the tub, fill the tub with water, and scrub the tub with a brush.  The Wisteria Unit Manager acknowledged in interview conducted on 09/19/12 at 5:05 PM, that the whirlpool in the Wisteria resident shower room had hair in the tub and that the dirt-like residue on the panel of the tub at the rubber seal was mildew and soap scum. The Wisteria Unit Manager stated the shower technician should clean the whirlpool with the appropriate cleaning agent after each resident use.  Interview with LPN #2 on 09/19/12 at 5:50 PM, revealed the shower technician should clean the whirlpool with the appropriate chemical after each resident use. LPN #2 acknowledged the whirlpool in the Lakeview resident shower room	F 253	Housekeeping employees will be educated by 10/16/12 by the environmental services director to clean the tubs after the last shower is given, utilizing a disinfectant cleaner and a brush, then rinse completely.  Nursing assistants will continue to clean the tubs after each use; Protocol updated and posted in each shower room that has a tub on 9/24/12 by the ADON, nursing assistants will be educated on the tub cleaning procedure of using a disinfectant cleaner, brush and rinse completely by 10/16/12 by the ADON.  Cleanliness of tubs will be monitored weekly times four weeks then monthly thereafter by the environmental service director or QA Nurse  Environmental rounds will be completed monthly by the QA Nurse utilizing the QA audit tool and reviewed through the QA processes.	10/17/12

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F 253	Continued From page 2 had hair in the tub and the dirt-like residue on the panel of the tub at the rubber seal was mildew and soap scum.	F 253	F 431 No residents were harmed from the manufacturers expired dates on the saline, dressings or tubing on the crash carts, the items were sealed and had not been used on anyone.	
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 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.  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.  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.  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.	F 431	Expired items were removed from the crash carts identified on 9/20/12 by the supply clerk.  All other areas of biological storage, (medication carts, treatment carts, supply storage closets, lab room, and medication rooms) were checked for expired biologicals and supplies, 9/20/12 through 9/29/12 by the QA Nurse, No other expired items were found.  The facility has the services of a licensed pharmacy that keeps records of receipts and disposition of all controlled drugs and ensures all drugs and biologicals are labeled according to professional standards with expiration dates. All biologicals and drugs are kept in locked compartments with only authorized staff having access to the keys.	

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F 431	Continued From page 3  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure expired drugs and biologicals were not available for resident use.  The findings include:  Review of the facility's policy titled Medication Storage in the Facility, undated, revealed medications and biologicals would be stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Further review of the facility's policy revealed that outdated medications were to be immediately removed from stock and disposed of according to procedures for medication disposal.  Observation on 09/20/12 at 10:30 AM, revealed the crash cart in the Lakeview resident hall had one bottle of 250 milliliters Normal Saline with an expiration date of April 2012 and had been available for resident use four months past the expiration date. In addition, two non-conductive connection tubings had an expiration date of April 2010 and were available for resident use two years and four months past the expiration date.  Observation on 09/20/12 at 10:45 AM, revealed the crash cart in the Sterling resident hall had an Intravenous Access Device with an expiration date of March 2011 and was available for resident use one year and five months past the expiration date.	F 431	The facility has separately locked permanently affixed compartments for storage of Schedule II narcotics.  No areas of concern where noted with meeting the requirements of the regulation other than the crash cart. The pharmacy does not distribute supplies for the crash cart; they come from our medical supply closet.  In-service was conducted 9/21/12, for the unit managers and the central supply clerk on checking for expired biologicals and supplies by DNS and The QA nurse.  A list of crash cart items were reviewed by the DNS and the QA Nurse on 9/25/12, list revised to remove any non- essential items from the cart therefore reducing the risk of expired items in the cart.  The crash cart, medication rooms and lab room will be audited two times a month times three months then monthly by the QA nurse or ADON.  Pharmacy will continue to check the medication carts and room monthly and provide QA reports.		

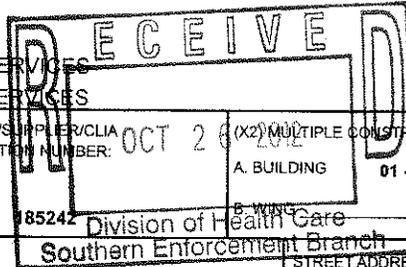
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F 431	Continued From page 4 Interview with LPN #2 on 09/20/12 at 10:30 AM, revealed the items identified were expired and should not be available for resident use. Interview further revealed the Materials Manager was responsible for stocking the crash cart.  The Materials Manager acknowledged in interview conducted on 09/20/12 at 10:45 AM, the observed items were expired and should not have been available for resident use.	F 431	Treatment carts and medication carts will be audited weekly times four then monthly thereafter by unit managers.  Medical supply closets will be audited monthly times three months and then quarterly by the central supply clerk with one random audit monthly by the QA Nurse and reviewed through the QA processes	9/30/12	

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NAME OF PROVIDER OR SUPPLIER <b>WINDSOR CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>125 STERLING WAY MOUNT STERLING, KY 40353</b>
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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: 1976, 1995, 2002, 2008</p> <p>Survey under: 2000 Existing</p> <p>Facility type: SNF/NF</p> <p>Type of structure: One story Type V000 with partial basement.</p> <p>Smoke Compartments: 5</p> <p>Fire Alarm: Complete fire alarm system with new panel upgrade in 2008</p> <p>Sprinkler System: Complete automatic (dry and wet) sprinkler system.</p> <p>Generator: Type II 60 KW Natural gas generator installed in 1976, Type II 150 KW diesel generator installed in 2002.</p> <p>A Life Safety Code survey was conducted on 09/19/12. Windsor Care Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was 135 residents. The facility is licensed for 144 residents.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000	<p>The following constitutes the facility's response to the findings of the Department for Health Services and does not constitute an admission of the facts alleged or conclusions set forth on the summary statement of deficiencies.</p> <p>This plan of correction is prepared as required by the provisions of the Health Safety code, 42 CFR and constitutes the facility's written credible allegation of compliance.</p> <p>K 029</p> <p>The room identified during the survey process (medical supply room) to not have a self-closure now has a self-closure device attached to the door.</p> <p>All other doors were checked and we identified a total of 6 doors that needed closures. The closures were purchased and all have been installed as of 9/24/12 by maintenance staff.</p> <p>Maintenance and central supply will be educated on reporting any malfunctioning with door closures</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rebecca Cooley</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10/25/12</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 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were protected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one smoke compartment, twenty-nine residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 09/19/12 at 12:18 PM, revealed the medical supply room, approximately 10 feet by 12 feet, located on Sterling Place Hall was being used to store combustible storage (cardboard boxes containing medical supplies). The door did not have a self-closure. Rooms larger than 50 square feet used as storage must be protected with a self-closure to prevent the spread of smoke during a fire. The observation was confirmed with the Maintenance Director.</p>	K 029	<p>was done on 10/18/12 by Environmental Services Director.</p> <p>Door closures will be checked monthly by Environmental Services Director or Maintenance Staff utilizing audit tool to ensure continued compliance by checking doors on one of four wings each month times four months and then one wing per quarter thereafter.</p>	10/19/12

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K 029	Continued From page 2  Interview on 09/19/12 at 12:18 PM, with the Director of Housekeeping revealed the facility was not aware the door needed to be equipped with a self-closure due to the room being a hazardous area.  Reference: NFPA 101 (2000 Edition).  19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be	K 029			

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K 029	Continued From page 3 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	K038	
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 provide exits readily accessible at all times according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one smoke compartment, ten residents, staff, and visitors.  The findings include:  Observation on 09/19/12 at 11:57 AM, revealed the double doors of the nursing storage area located in Wisteria Hall projected more than 7 inches into the corridor while in the fully open position. The actual projection was 8.97 inches. Doors cannot project more than 7 inches into the corridor when in the fully open position due to being an impediment to egress. The observation was confirmed with the Director of Housekeeping.	K 038	The nursing storage area identified during the survey process that projected more than 7 inches into the corridor while in the fully open position, has been fitted with a closure that prevents it from projecting more than 7 inches and impeding means to egress.  All other doors were checked and we identified a total of 6 doors that needed closures. The closures were purchased and all have been installed as of 9/24/12 by maintenance staff.  Maintenance and central supply will be educated on reporting any malfunctioning with door closures was done on 10/18/12 by Environmental Services Director.  Door closures will be checked monthly by Environmental Services Director or Maintenance Staff utilizing audit tool to ensure continued compliance compliance by checking doors on one of four wings each month times four months and then one wing per quarter thereafter.	10/19/12

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K 038	Continued From page 4 Interview on 09/19/12 at 11:57 AM, with the Director of Housekeeping revealed the facility was not aware the door could not project more than 7 inches into the corridor while in the fully open position.  Reference: NFPA 101 (2000 Edition).  7.2.1.4.4* During its swing, any door in a means of egress shall leave not less than one-half of the required width of an aisle, corridor, passageway, or landing unobstructed and shall not project more than 7 in. (17.8 cm) into the required width of an aisle, corridor, passageway, or landing, when fully open. Doors shall not open directly onto a stair without a landing. The landing shall have a width not less than the width of the door. (See 7.2.1.3.)  Exception: In existing buildings, a door providing access to a stair shall not be required to maintain any minimum unobstructed width during its swing, provided that it meets the requirement that limits projection to not more than 7 in. (17.8 cm) into the required width of a stair or landing when the door is fully open.	K 038		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler	K 056	The facility contacted 3 separate vendors (Sentry Fire Protection, Landmark Sprinklers, and Simplex/Grinnell Fire Protection) on September 20, 2012 for bids to install sprinklers in the 7 areas identified during the survey process of being in need of sprinklers. Bid has been awarded to Simplex/Grinnell on 10/23/12.	

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NAME OF PROVIDER OR SUPPLIER  WINDSOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 125 STERLING WAY MOUNT STERLING, KY 40353	
(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 056	Continued From page 5 systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide complete sprinkler coverage according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two smoke compartments, forty-one residents, staff, and visitors.  The findings include:  Observation on 09/19/12 at 11:03 AM, revealed the sprinkler riser room (location where sprinkler piping comes into the building from municipal water supply) was not protected by sprinkler coverage. Building construction requiring sprinkler protection must be completely covered by the sprinkler system. The observation was confirmed with the Director of Housekeeping.  Interview on 09/19/12 at 11:03 AM, with the Director of Housekeeping revealed the facility was unaware the sprinkler riser room was not provided with sprinkler protection.  Observation on 09/19/12 at 1:04 PM, revealed four canopies larger than four feet wide were constructed of combustible material (wood trusses). The canopies were not provided with sprinkler protection. The canopies were located at the Sterling Place Hall. Further observation	K 056	Simplex/Grinnell has provided a schedule for installation of the sprinklers as follows:  Start date for the project is 10/25/12 and expected completion date is 11/25/12.  To ensure safety of residents and staff until completion of project we installed battery operated smoke detectors on 10/23/12 in the areas that are not covered by the sprinkler system. The smoke detectors will be checked weekly by Maintenance staff or the Environmental Services Director until the project is completed.  All staff will be educated by November 1, 2012 on the location and responding to the smoke detectors that have been installed in areas identified.  Once the newly installed sprinklers are operational, they will be added to the monthly maintenance logs to be inspected and will be monitored by Environmental Services Director for completion and will be reviewed in quarterly QA processes.	11/26/12

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K 056	<p>Continued From page 6 .</p> <p>revealed two additional canopies constructed of combustible material (wood trusses) were not sprinkler protected at the Wisteria Hall Exit and outside the Wisteria Hall nursing station.</p> <p>Interview on 09/19/12 at 1:04 PM, with the Director of Housekeeping revealed the facility was not aware of the canopy's lack of sprinkler coverage.</p> <p>Reference: NFPA 13 (1999 Edition).</p> <p>5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width.</p> <p>Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.</p> <p>NFPA 101 (2000 Edition).</p> <p>19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.)</p> <p>Exception:* Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met:</p> <p>(a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings.</p> <p>(b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 21/2 in. (6.4</p>	K 056			

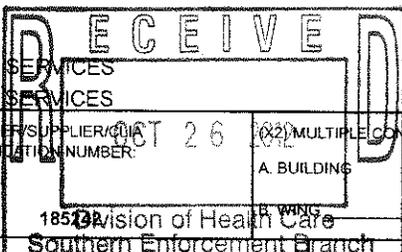
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K 056	<p>Continued From page 7</p> <p>cm) of concrete or gypsum fill.</p> <p>(c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.</p> <p>Table 19.1.6.2 Construction Type Limitations</p> <table border="1"> <thead> <tr> <th rowspan="2">Construction Type</th> <th colspan="4">Stories</th> </tr> <tr> <th>1</th> <th>2</th> <th>3</th> <th>4</th> </tr> </thead> <tbody> <tr> <td>I(443)</td> <td>X</td> <td>X</td> <td>X</td> <td>X</td> </tr> <tr> <td>I(332)</td> <td>X</td> <td>X</td> <td>X</td> <td>X</td> </tr> <tr> <td>II(222)</td> <td>X</td> <td>X</td> <td>X</td> <td>X</td> </tr> <tr> <td>II(111)</td> <td>X</td> <td>X*</td> <td>X*</td> <td>NP</td> </tr> <tr> <td>II(000)</td> <td>X*</td> <td>X*</td> <td>NP</td> <td>NP</td> </tr> <tr> <td>III(211)</td> <td>X*</td> <td>X*</td> <td>NP</td> <td>NP</td> </tr> <tr> <td>III(200)</td> <td>X*</td> <td>NP</td> <td>NP</td> <td>NP</td> </tr> <tr> <td>IV(2HH)</td> <td>X*</td> <td>X*</td> <td>NP</td> <td>NP</td> </tr> <tr> <td>V(111)</td> <td>X*</td> <td>X*</td> <td>NP</td> <td>NP</td> </tr> <tr> <td>V(000)</td> <td>X*</td> <td>NP</td> <td>NP</td> <td>NP</td> </tr> </tbody> </table> <p>X: Permitted type of construction. NP: Not permitted. *Building requires automatic sprinkler protection. (See 19.3.5.1.)</p>	Construction Type	Stories				1	2	3	4	I(443)	X	X	X	X	I(332)	X	X	X	X	II(222)	X	X	X	X	II(111)	X	X*	X*	NP	II(000)	X*	X*	NP	NP	III(211)	X*	X*	NP	NP	III(200)	X*	NP	NP	NP	IV(2HH)	X*	X*	NP	NP	V(111)	X*	X*	NP	NP	V(000)	X*	NP	NP	NP	K 056		
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NAME OF PROVIDER OR SUPPLIER <b>WINDSOR CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE 125 STERLING WAY MOUNT STERLING, KY 40353
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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  Building: 01  Plan Approval: 1976, 1995, 2002, 2008  Survey under: 2000 Existing  Facility type: SNF/NF  Type of structure: One story Type V000 with partial basement.  Smoke Compartments: 5  Fire Alarm: Complete fire alarm system new panel upgrade in 2008  Sprinkler System: Complete automatic (dry and wet) sprinkler system.  Generator: Type II 60 KW Natural gas generator installed in 1976, Type II 150 KW diesel generator installed in 2002.  A Life Safety Code survey was conducted on 09/19/12. Windsor Care Center (Bluegrass Suites Wing) was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was 135 residents. The facility is licensed for 144 residents.  The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000	The following constitutes the facility's response to the findings of the Department for Health Services and does not constitute an admission of the facts alleged or conclusions set forth on the summary statement of deficiencies.  This plan of correction is prepared as required by the provisions of the Health Safety code, 42 CFR and constitutes the facility's written credible allegation of compliance.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rebecca Cooley</i>	TITLE Administrator	(X6) DATE 10/25/12
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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 038 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain exits according to NFPA standards. The deficiency had the potential to affect two smoke compartments, eight residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 09/19/12 at 12:59 PM, revealed the exterior exit for Physical Therapy did not have a hard surface leading to the public way. The observation was confirmed with the Director of Housekeeping.</p> <p>Interview on 09/19/12 at 12:59 PM, with the Director of Housekeeping revealed the facility was not aware the exterior exit leading from Physical Therapy needed a hard surface to the public way.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open</p>	K 038	<p>K038</p> <p>Contact was made with C. W. Cornett, Fire Marshall on 9/20/12 concerning the exterior exit for Physical Therapy room identified during survey process not meeting the regulations to be considered an exit. Mr. Cornett advised our Maintenance Director the door in question should not be an exit and it would be appropriate for the facility to remove the (Exit) sign and place a (Not an Exit) sign on the door.</p> <p>This was completed on 9/21/12. All other doors have been checked and not other doors identified that would result in a deficient practice.</p> <p>Exit doors have been added to monthly maintenance check list.</p> <p>Exit doors will be monitored monthly by Environmental Services Director or maintenance and reviewed through the QA processes quarterly.</p>	9/22/12

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K 038	Continued From page 2 spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way.  7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.  CMS Ref: S&C-05-38	K 038			