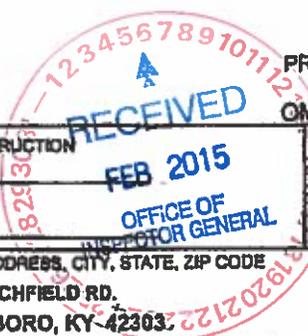


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/23/2015
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2015
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NAME OF PROVIDER OR SUPPLIER OWENSBORO CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD. OWENSBORO, KY 42303
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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	F 000	"This Plan of Correction Is prepared and submitted as required by law. By submitting this Plan of Correction, Owensboro Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 274 SS=D	<p>483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the Minimum Data Set (MDS) Schedule and review of the Resident Assessment Instrument (RAI) Guidelines, it was determined the facility failed to conduct a comprehensive assessment within fourteen (14) days of, or after one (1) of twenty-four (24) sampled residents (Resident #5). Resident #5 developed a Stage II pressure ulcer and experienced a decline in her Activities of Daily Living (ADLs); however, the facility failed to complete a Significant Change Minimum Data Set (MDS) assessment.</p>	F 274	<p>F274</p> <ol style="list-style-type: none"> 1. Resident # 5 was re-assessed by the IDT team consisting of the Director of Nursing, Assistant Director of Nursing, Social Service Director, Recreation Director, and Unit Managers, and a significant change in condition MDS was completed on 1/10/15 to reflect the current status of the resident. 2. The facility shift report, resident change in condition assessments and skin integrity reports were reviewed for the past 30 days by the IDT team consisting of the Director of Nursing, Assistant Director of Nursing, Social Service Director, Recreation Director and Unit Managers on 1/14/15 to determine if any other resident had experienced a decline that would warrant a significant change in condition assessment with one resident identified and a significant change assessment was completed on 1/15/15. 3. Re-education will be provided to IDT members, including the Director of Nursing, Assistant Director of Nursing, Social Service Director, Recreation Director, and Unit Managers on 2/4/15 by 	2/20/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rexdell Smith</i>	TITLE <i>Administrator</i>	(X6) DATE <i>2/5/15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 274	<p>Continued From page 1</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON), on 01/09/15 at 3:25 PM, revealed the facility does not have a policy and procedure related to completing the Significant Change Assessment; however, it follows the Resident Assessment Instrument (RAI) Manual Guidelines.</p> <p>Review of the RAI Guidelines (Chapter 2: Assessments for the RAI), dated 04/2012, revealed a Significant Change Assessment was required to be performed when there was a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline which had occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessment and the resident's condition was not expected to return to baseline within two (2) weeks. In addition, the MDS completion date must be no later than fourteen (14) days after the determination the criteria for a Significant Change Assessment was met.</p> <p>Record review revealed the facility re-admitted Resident #5 on 04/16/14 with diagnoses which included Dysphagia, Chronic Airway Obstruction, Anxiety, and Chronic Pain.</p> <p>Review of a quarterly MDS Assessment, dated 10/16/14, revealed the facility had assessed Resident #5's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of "4" indicating Resident #5 was not interviewable. Further review revealed Resident #5's Range of Motion (ROM) was assessed as no</p>	F 274	<p>the Clinical Reimbursement Manager and will include Chapter 2 of the RAI guidelines significant change assessment. A post-test will be given by the Clinical Reimbursement Manager on 2/4/15 to determine competency.</p> <p>4. The IDT team consisting of the Director of Nursing, Assistant Director of Nursing, Social Service Director, Recreation Director and Unit Managers will review 5 MDS assessments a week times 1 month, BI-weekly times one month, monthly times 4 months to determine assessments reflect resident's current condition. Any areas of concern will be corrected when identified.</p> <p>The Director of Nursing and or Assistant Director of Nursing will submit a summary of the findings to the Performance Improvement Committee consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Social Service Director, Clinical Reimbursement Manager, Admissions Director, Business Office Manager, Human Resource Assistant, Health Information Manager, Dietary Manager, Maintenance Director, and Recreation Director, monthly x 6 months for further review and recommendations.</p>		

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F 274	Continued From page 2 upper or lower extremity impairment and there were no pressure ulcers. Review of the facility's Change in Condition-Skin Assessment, dated 12/02/14, revealed Resident #5 was noted to have a pressure ulcer to left buttock which measured 1.6 centimeters (cm) x 2.0 cm. Review of the facility's Skin Integrity Report, dated 12/02/14, revealed Resident #5 was assessed to have a new pressure ulcer, Stage II. Review of a the facility's Change in Condition assessment, dated 12/05/14, revealed Resident #5 was assessed by the facility to have right shoulder pain with decreased mobility and ROM. Interview with the Registered Nurse, MDS Coordinator, on 01/09/14 at 3:00 PM, revealed a resident with a decline in two (2) or more areas should have a Significant Change MDS assessment completed. She stated that she was aware of the new Stage II pressure ulcer and decrease in ROM; however, she stated she failed to complete the assessment. Interview with the Director of Nursing (DON), on 01/09/14 at 3:25 PM, revealed she expected the MDS assessments to be completed per the guidelines. She stated the facility had always been excellent in this area but Resident #5 had so much going on that he/she was missed.	F 274			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278	F278 1. A significant change in condition MDS assessment was completed on resident #2 on 1/15/15 by the MDS department consisting of the Clinical Reimbursement	2/20/15	

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F 278	<p>Continued From page 3</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the Minimum Data Set (MDS) manual (CMS's RAI Version 3.0 Manual, 10/2013 update), it was determined the facility failed to code the Minimum Data Set (MDS) correctly related to functional limitation in range of motion (Section G0400) for one (1) of twenty-four (24) sampled residents (Resident #2).</p> <p>The findings include:</p>	F 278	<p>Manager and MDS Coordinators to reflect resident's current status.</p> <ol style="list-style-type: none"> All residents' Range of Motion will be assessed by the Therapy Department, MDS Department and Charges Nurses to determine if limitations are present, and MDS assessments will be corrected to reflect accuracy for each resident by 2/28/15. Re-education will be provided by Clinical Reimbursement Manager to the IDT team consisting of the Director of Nursing, Assistant Director of Nursing, Social Service Director, Recreation Director and Unit Managers regarding completing MDS assessment section G0400 Functional Limitation of Range of Motion on 2/4/15. A post-test will be administered by the Clinical Reimbursement Manager on 2/4/15 to determine competency. The IDT team consisting of the Director of Nursing, Assistant Director of Nursing, Social Service Director, Recreation Director and Unit Managers will audit 5 MDS assessments per week times 1 month, bi-weekly times 1 month then monthly times 4 months to determine accuracy of the assessment to include limitations in range of motion and the need for significant change assessment. Any areas of concern will be corrected when identified. <p>The Director of Nursing and or the Assistant Director of Nursing will submit a summary of findings to the Performance Improvement Committee consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Social Service Director, Clinical Reimbursement Manager, Admissions Director, Business Office Manager, Human</p>	

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F 278	<p>Continued From page 4</p> <p>Interview with the Director of Nursing (DON), on 01/09/15 at 3:25 PM, revealed the facility does not have a policy and procedure related to MDS coding; however, it follows the Resident Assessment Instrument (RAI) Manual Guidelines.</p> <p>Review of the (MDS) manual (CMS's RAI Version 3.0 Manual, 10/2013 update) for G0400 Functional Limitation of Range of Motion, revealed if a resident is noted to have a limitation in upper and/or lower ROM and the limitation interferes with function or places the resident at risk for injury, the MDS assessment should be coded a one (1) or (2) for functional Limitation in range in motion. A code of one is used if impairment on one side and two if the impairment is on both sides.</p> <p>Record review revealed the facility admitted Resident #2 on 05/24/12 with diagnoses which included Malignant Neoplasm of Ovary, Difficulty in walking, Congestive Heart Failure, and Muscle Weakness.</p> <p>Review of Resident #2's quarterly MDS assessment, dated 11/19/14, revealed section G0400 functional limitations, was inaccurately coded related to lower extremity functional limitation being coded as 0, indicating the resident has no impairment to the lower extremities (knee,hip, ankle, foot).</p> <p>Observation of Resident #2's skin assessment, on 01/07/15 at 2:30 PM, revealed Resident #2 had bilateral contractures to both lower extremities with the extremities extending straight out with no ability noted to bend the knees on either side giving the appearance of a scissored effect. Further observation revealed the resident</p>	F 278	Resource Assistant, Health Information Manager, Dietary Manager, Maintenance Director, and Recreation Director, monthly x 6 months for further review and recommendations.		

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F 278	<p>Continued From page 5</p> <p>was able to move his/her lower extremities and raise his/her hips when prompted by the nurse providing care. In addition, the resident was able to uncross his/her lower extremities when prompted but when repositioned would cross back into the scissored position. The resident was noted to have a Stage II pressure sore to the inside of both knees.</p> <p>Review of a Skin Integrity Report, dated 12/29/14, revealed the resident was identified to have a Stage II pressure ulcer to the inside of both knees.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 01/07/15 at 3:00 PM, revealed the resident can raise his/her legs but cannot bend them. She stated the resident has functional limitations in the lower extremities and they had recently started using the lift to transfer the resident due to anxiety when the resident attempts to stand. She revealed they try to get the resident up out of bed at least once a week and sit him/her in a reclined chair due to the fact the resident's legs stick straight out.</p> <p>Interview with the MDS Clinical Care Coordinator, on 01/07/15 at 3:25 PM, revealed that she coded the residents lower extremity functional limitation as 0, indicating the resident has no impairment to the lower extremities (knee, hip, ankle, foot). She stated she coded no impairment because staff provided all care for the resident and the resident was not ambulating. She stated that she has been trained to code the assessment as 0, no functional impairment, if the resident was unable to ambulate.</p> <p>Interview with the Director of Nursing (DON), on</p>	F 278			

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F 278	Continued From page 6 01/09/15 at 2:20 PM, revealed she did not think the MDS was miscoded purposefully. She stated she thought it was just how the MDS Clinical Care Coordinator interpreted it. She revealed this functional limitation does place the resident at risk for injury.	F 278			
F 431 SS=D	483.80(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	F 431	F431 1. The narcotic box in A wing's medication room refrigerator containing narcotics for unsampled residents A, B and C was double locked on 1/9/15 by unit's RN Charge Nurse. RN #1 was re-educated on the policy for securing narcotics by the Director of Nursing on 1/9/15. 2. The Director of Nursing checked all other medication room refrigerators to determine narcotics were double locked and secured on 1/9/15. No other areas of concern were identified. 3. The Licensed Nurses were re-educated to the facility policy for Management of Controlled Drugs by the Assistant Director of Nursing and Unit Managers on 1/9/15. A post- test was given on 1/9/15 by the Assistant Director of Nursing and Unit Managers to determine competency. 4. The Director of Nursing, Assist Director of Nursing and or Unit Managers will audit medication carts and medication rooms refrigerators weekly times 1 month, bi-weekly times 1 month then monthly times 4 months to determine narcotics are double locked. Areas of concern will be corrected when identified. The Director of Nursing and or the Assistant Director of Nursing will submit a summary of findings to the Performance	2/20/15	

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F 431	<p>Continued From page 7 quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure controlled medications, on one (1) out of five (5) wings (Wings A, B, C, D and E,) were kept under double lock. Three (3) unsampled residents' (Residents A, B, and C), controlled medications were not stored under double lock, in the A Wing Medication Room.</p> <p>The findings include:</p> <p>Review of the facility policy for "Management of Controlled Drugs", dated 05/15/14, revealed the emergency supply of controlled drugs must be maintained in a sealed kit, separate from other emergency kits/drugs and must be double locked.</p> <p>Observation of the A Wing Medication Room, on 01/09/15 at 8:53 AM, revealed the narcotic storage box was stored inside a refrigerator on the A Wing that was unlocked. The storage box had three (3), thirty (30) milligram (mg) bottles of Ativan (anti-anxiety), for three residents (#25, #26 and #27,) who were on comfort measures.</p> <p>Interview with Registered Nurse (RN) #1, on 01/09/15 at 8:15 AM, revealed the narcotic drawer was not locked due to the Ativan bottles being in large boxes and they did not fit properly in the drawer. She stated the staff were unable to close and lock the drawer.</p>	F 431	<p>Improvement Committee consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Social Service Director, Clinical Reimbursement Manager, Admissions Director, Business Office Manager, Human Resource Assistant, Health Information Manager, Dietary Manager, Maintenance Director, and Recreation Director, monthly x 6 months for further review and recommendations.</p>		

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F 431	Continued From page 8 Interview with the Charge Nurse for A Wing, RN #2, on 01/09/14 at 8:40 AM, revealed she was unaware the narcotics in the refrigerator were not under double lock and stated this should have been done. Interview with Director of Nursing (DON), on 01/09/15 at 9:20 AM, revealed she was not aware of the unlocked narcotics in the refrigerator and would have expected the staff to have notified her to make other storage arrangements to ensure the medications were under double lock.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	F441 1. Resident #9 room was deep cleaned on 1/9/15 by Housekeeping staff. Resident #9 has been monitored for signs and symptoms of infection by charge nurses from 1/9/15 through 1/12/15. No infection has been identified. Re-education was completed with CNA #1 regarding infection control policies to include glove and hand washing procedures while performing peri-care on residents by the Director of Nursing on 1/9/15. A post-test was given on to determine competency. 2. Shift reports were reviewed for documented signs and symptoms of infection on 1/9/15 by the Unit Managers and Charge Nurses to determine if any resident had experienced symptoms of infection with corrective action if indicated. Observation of nursing assistants performing peri-care was observed on 1/9/15 by Assistant of Nursing with corrective action provided at the point of discovery. 3. Re-education was completed by the Assistant Director of Nursing on 1/27/15 with all nursing staff regarding infection	2/20/15

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F 441	<p>Continued From page 9</p> <p>from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for one (1) of twenty-four sampled residents (Resident #9). Certified Nurse Aide (CNA) #1 failed to remove the contaminated gloves and wash her hands after providing incontinent care for Resident #9. CNA # 1 touched the resident's bedside table, storage bin and a container of ointment with the contaminated gloves, then continued to rub the ointment on the resident's buttocks while wearing the contaminated gloves.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Standard Precautions", dated 09/01/04, with revision date of 10/01/13, revealed all blood and body fluids are considered potentially infectious and, therefore,</p>	F 441	<p>control policies to include glove and hand washing procedures before, during, and after performing peri-care on residents. A post-test was given on to determine competency.</p> <p>4. Audits will be completed weekly on 6 residents for 4 weeks, then monthly times 4 months, utilizing the facility audit tool, for proper peri-care and infection control practices before, during, and after the procedure by the Director of Nursing, Assistant Director of Nursing and/or Unit Managers.</p> <p>The Director of Nursing and or the Assistant Director of Nursing will submit a summary of findings to the Performance Improvement Committee consisting of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Social Service Director, Clinical Reimbursement Manager, Admissions Director, Business Office Manager, Human Resource Assistant, Health Information Manager, Dietary Manager, Maintenance Director, and Recreation Director, monthly x 6 months for further review and recommendations.</p>		

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F 441	<p>Continued From page 10</p> <p>Standard Precautions are always used when providing patient care. Wear gloves whenever exposure to any of the following is planned or anticipated: Blood, blood products, all body fluids (including excretions: urine, feces, saliva). Change gloves between tasks and procedures on the same individual and after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use before touching non-contaminated items and environmental surfaces, and before going to another individual.</p> <p>Record review revealed the facility admitted Resident #9 on 01/09/12, with diagnoses which included Multiple Sclerosis, Unspecified Quadriplegia, and Neurogenic Bladder.</p> <p>Review of the residents Minimum Data Set (MDS) Kardex Report, dated January 2015, revealed the facility identified Resident # 9 as always incontinent of bowel with indwelling catheter in place in bladder. Review of the Comprehensive Care Plan for incontinence of bowel, dated 06/12/14, revealed a goal for the resident to have incontinence care needs met by staff to maintain dignity and comfort and to prevent incontinence related complications.</p> <p>Observation, on 01/07/15 at 10:00 AM, revealed CNA #1 provided incontinent care for Resident #9 after the resident was incontinent of bowel. After providing incontinent care, CNA #1 did not remove the contaminated gloves and wash her hands. Additional observation revealed CNA #1 touched the resident's bedside table, storage bin and a container of ointment with the contaminated gloves, then continued to rub the ointment on the resident's buttocks while wearing</p>	F 441			

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F 441	Continued From page 11 the contaminated gloves. Interview with CNA #1, on 01/08/15 at 4:00 PM, revealed she did not know why she did not remove her gloves. She stated she was nervous and normally she changes her gloves, and she knew better than to do that. She revealed that she keeps extra gloves in her pocket in case she needs them. Interview with Registered Nurse (RN) #1, on 01/09/15 at 2:10 PM, revealed she was concerned the CNA did not use proper technique. She stated the facility had quarterly training on infection control issues and proper hand washing. She also revealed she expected the CNA to have changed her gloves prior to touching anything else. Interview with Director of Nursing (DON), on 01/09/15 at 2:20 PM, revealed she expected the CNA to prepare everything she needed to have in advance and she should have removed her gloves and washed her hands before she proceeded on to do anything else.	F 441			
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 490	F 490 1. The contractor returned and completed the work, sealing the smoke barrier near E14 and D North over the Dietary Office, on January 23, 2015. The work was inspected at that time by the Maintenance Supervisor.	2/20/15	

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F 490	Continued From page 12 Based on observation and interview, it was determined the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. During the Life Safety Code (LSC) survey, conducted 01/08/15, there was a deficiency cited which was cited on the previous annual survey (10/30/13) because it had not been corrected. (Refer to K-0025).	F 490	<ol style="list-style-type: none"> 2. An audit of all smoke barriers in the center was performed by the Maintenance Supervisor on 1/30/15. No penetrations or missing sheet rock were identified in any other areas. No other residents or areas were affected. 3. The Administrator received re-education, including post-test, by the Regional Vice President, on January 21, 2015. The Maintenance Supervisor received re-education, including post-test, by the Administrator on January 28, 2015. The essential responsibilities of each position were part of the re-education. All work performed by an outside vendor in the attic will be inspected by Maintenance staff to assure the integrity of smoke walls prior to acceptance of the work. 4. Monthly inspections will be completed and reported to the Safety Committee, made up of the Administrator, Maintenance Director, Food Service, Housekeeping/Laundry Supervisor, Director of Nursing, Assistant Director of Nursing, and a Unit Manager, for 3 months. After 90 days, quarterly inspections, in addition to the inspections following a vendor, will be performed and reported to the Administrator and Safety Committee. Subsequent plans of correction will be implemented when necessary. 		

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K 000	INITIAL COMMENTS Building: 01 Plan Approval: 1966, 1999 Survey under: NFPA 101 (2000 edition) Chapter 19 Facility type: SNF/NF Type of structure: Type III (211) Smoke Compartment: 9 Fire Alarm: Complete fire alarm installed in 1966. Panel upgraded in 2001 Sprinkler System: Complete automatic dry sprinkler system installed in 1966 and upgraded in 2012. Generator: Type II, Natural Gas, installed in 1983. A standard Life Safety Code survey was initiated on 01/07/15 and concluded on 01/08/15. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred forty-five (145) beds with a census of one-hundred thirty-four (134) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Owensboro Place Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
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	K 025	K 025 1. The contractor returned and completed the work, sealing the smoke barrier near E14 and D North over the Dietary Office, on January 23, 2015. The work was inspected at that time by the Maintenance Supervisor. The penetrations of the smoke barrier extending above the ceiling located over the Kitchen Dry Storage were corrected by Maintenance staff on January 29, 2015.	2/20/15



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wendell Smith TITLE: Administrator (X6) DATE: 2/5/15

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 025	<p>Continued From page 1</p> <p>panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect four (4) of six (6) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred forty-five (145) beds and at the time of the survey, the census was one-hundred thirty-four (134).</p> <p>The findings include:</p> <p>Observation, on 01/07/15 at 1:30 PM, with the Maintenance Supervisor revealed the smoke barrier, extending above the ceiling located by room #E14 did not have drywall installed on both sides of the wall near the eve.</p> <p>Interview, on 01/07/15 at 1:31 PM, with the Maintenance Supervisor revealed he was not aware the contractor had not completed the work of installing the drywall to the smoke barrier in the attic.</p> <p>Observation, on 01/07/15 at 1:40 PM, with the Maintenance Supervisor revealed the smoke</p>	K 025	<p>2. An audit of all smoke barriers in the center was performed by the Maintenance Supervisor on 1/30/15. No penetrations or missing sheet rock were identified in any other areas. No other residents or areas were affected.</p> <p>3. The Maintenance Supervisor received re-education, including post-test, from the Administrator on January 28, 2015. All work performed by an outside vendor in the attic will be inspected by Maintenance staff to assure the integrity of smoke walls prior to acceptance of the work.</p> <p>4. Monthly inspections will be completed and reported to the Safety Committee, made up of the Administrator, Maintenance Director, Food Service, Housekeeping/Laundry Supervisor, Director of Nursing, Assistant Director of Nursing, and a Unit Manager, for 3 months. After 90 days, quarterly inspections, in addition to the inspections following a vendor, will be performed and reported to the Administrator and Safety Committee. Subsequent plans of correction will be implemented when necessary.</p>	

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K 025	<p>Continued From page 2</p> <p>barrier, extending above the ceiling located over the Kitchen Dry Storage had penetrations around two (2) conduits and a bundle of category five (5) phone cables.</p> <p>Interview, on 01/07/15 at 1:41 PM, with the Maintenance Supervisor revealed he was not aware of the penetrations.</p> <p>Observation, on 01/07/15 at 1:48 PM, with the Maintenance Supervisor revealed the smoke barrier, extending above the ceiling located in D North over the Dietary Office did not have drywall installed on both sides of the wall near the eve.</p> <p>Interview, on 01/07/15 at 1:49 PM, with the Maintenance Supervisor revealed he was not aware the contractor had not completed the work of installing the drywall to the smoke barrier in the attic.</p> <p>This is a repeat deficiency from an annual survey conducted on 10/30/13. (refer to N-0316)</p> <p>The census of one-hundred thirty-four (134) was verified by the Administrator on 01/08/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 01/08/15.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p>	K 025			

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K 025	Continued From page 3 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025			
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1½-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted.	K 027	K 027 1. A new door with a 20-minute fire rating has been ordered by the Maintenance Supervisor for the Dietary Office. Delivery is scheduled for February 4, 2015. The door will be installed, including a self-closing device, by February 6, 2015.	2/20/15	

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K 027	<p>Continued From page 4</p> <p>Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, It was determined the facility failed to ensure cross-corridor doors, located in a smoke barrier, would resist the passage of smoke in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred forty-five (145) beds and the census was one-hundred thirty-four (134) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 01/07/15 at 1:49 PM, with the Maintenance Supervisor, revealed the smoke barrier door located in the Dietary Office did not have a self-closing device installed on the door.</p> <p>Interview, on 01/07/15 at 1:50 PM, with the Maintenance Supervisor, revealed he was not aware the door was not self-closing.</p> <p>The census of one-hundred thirty-four (134) was verified by the Administrator on 01/08/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 01/08/15.</p>	K 027	<p>2. An audit of all cross-corridor doors was completed by Maintenance staff on January 30, 2015 to assure all cross-corridor doors in a smoke wall would resist the passage of smoke per NFPA standards and have self-closing devices. No other areas were identified.</p> <p>3. The Maintenance Supervisor received re-education from the Administrator on January 28, 2015. The maintenance director or designee will verify the operation of the self-closing device added to the dietary office door weekly for 1 month and once bi-weekly for 2 additional months. After three months, the inspections and adjustments will be monthly or as needed.</p> <p>4. The documentation of the inspections and corrections will be presented to the Safety Committee, made up of the Administrator, Maintenance Director, Food Service, Housekeeping/Laundry Supervisor, Director of Nursing, Assistant Director of Nursing, and a Unit Manager, for review. Inspection of the self-closing devices will be added to our electronic preventive maintenance system for a tickler system and documentation. Subsequent plans of correction will be implemented when necessary.</p>	

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K 027	Continued From page 5 Reference: NFPA 101 (2000 Edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18 mm) for wood doors. Reference: NFPA 101 (2000 Edition), 19.3.7.6* Requires doors in smoke barriers to be self-closing and resist the passage of smoke. Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 027			
K 029 SS=D	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	K 029	K 029 1. A self-closing device was installed on the door to the E Wing Whirlpool Room by Maintenance staff on January 14, 2015.	2/20/15	

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K 029	<p>Continued From page 6</p> <p>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 meet the requirements for Protection of Hazards, in accordance with the National Fire Protection Agency (NFPA) standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred forty-five (145) beds and the census was one-hundred thirty-four (134) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 01/07/15 at 3:18 PM, with the Maintenance Supervisor revealed the E Wing Whirlpool Room was being used for hazardous storage and the door was not equipped with a self-closing device.</p> <p>Interview, on 01/07/15 at 3:19 PM, with the Maintenance Supervisor revealed he was not aware the room would have to meet the requirements of protection from hazards.</p> <p>The census of one-hundred thirty-four (134) was verified by the Administrator on 01/08/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the</p>	K 029	<p>2. An audit of other rooms housing combustible materials was conducted by Maintenance staff on January 30, 2015. Two other rooms were identified needing self-closing devices on the doors. These were added on February 2, 2015.</p> <p>3. The Maintenance Supervisor received re-education from the Administrator on January 28, 2015. All self-closing devices in the facility will be inspected and tested for proper operation bi-weekly for three months to assure proper operation and will be adjusted as needed. After three months, the inspections and adjustments will be monthly or as needed.</p> <p>4. The documentation of the inspections and corrections will be presented to the Safety Committee, made up of the Administrator, Maintenance Director, Food Service, Housekeeping/Laundry Supervisor, Director of Nursing, Assistant Director of Nursing, and a Unit Manager, for review. Inspection of the self-closing devices will be added to our electronic preventive maintenance system for a tickler system and documentation. Subsequent plans of correction will be implemented when necessary.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185236	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0101 B. WING _____	(X3) DATE SURVEY COMPLETED 01/08/2015
NAME OF PROVIDER OR SUPPLIER OWENSBORO CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD. OWENSBORO, KY 42303	
(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 029	Continued From page 7 exit interview on 01/08/15. Actual NFPA Standard: Reference: NFPA 101 (2000 Edition) 19.3.2 Protection from Hazards. Reference: NFPA 101 (2000 Edition) 9.3.2.1 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 permitted to have nonrated, factory or field-applied	K 029		

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K 029	Continued From page 8 protective plates extending not more than 48 in. (122 cm) above the bottom of the door. Reference: NFPA 101 (2000 Edition) 7.2.1.8 Self-Closing Devices. Reference: NFPA 101 (2000 Edition) 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2. Reference: NFPA 101 (2000 Edition) 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 029		
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

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K 038 SS=D	<p>Continued From page 9</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, it was determined the facility failed to ensure egress was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect two (2) of six (6) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred forty-five (145) beds and at the time of the survey, the census was one-hundred thirty-four (134).</p> <p>The findings include:</p> <p>1) Observation, on 01/07/15 at 2:00 PM, with the Maintenance Supervisor revealed the door to the Social Services Office opened outward into the path of egress and was not equipped with a self-closing device to ensure the door would not reduce the width of egress below the minimum width.</p> <p>Interview, on 01/07/15 at 2:00 PM with the Maintenance Supervisor, revealed he was not aware of the requirements for egress.</p>	K 038	<p>K 038</p> <p>1. Self-closing devices were installed on both Social Services office doors by Maintenance staff on January 14, 2015. A new light fixture with dual bulbs and an electric eye switch was installed outside the North end of E Wing by an electrical contractor on January 13, 2015. The outside light fixtures at the C Lobby exit and the A Lobby exit were changed on January 13, 2015 by Maintenance staff. New fixtures with dual bulbs and an electric eye switch were installed. These were installed on emergency circuits.</p> <p>2. An audit of lighting for all paths of egress was conducted on January 12, 2015. No other residents or areas were affected. An audit of all doors opening into the hallway was conducted on January 30, 2015. The audit identified one other door needing a self-closing device. The device has been ordered and is scheduled to be installed on February 2, 2015.</p> <p>3. The Maintenance Supervisor received re-education, including post-test, from the Administrator on January 28, 2015. The operation of egress pathway lighting will be inspected weekly for 3 months to assure proper operation. Corrections or repairs will be made immediately. All self-closing devices on doors that open into the path of egress will be inspected and tested for proper operation bi-weekly for three months to assure proper operation and will be adjusted as needed. After three months, the inspections and adjustments will be monthly or as needed. Inspection of egress pathway lighting will be added to our electronic preventive maintenance system for a tickler system and documentation.</p> <p>4. The documentation of both inspections and any corrections will be presented to the Safety</p>	2/20/15

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NAME OF PROVIDER OR SUPPLIER OWENSBORO CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD. OWENSBORO, KY 42303	
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K 038	<p>Continued From page 10</p> <p>2) Observation, on 01/07/15 at 3:16 PM, with the Maintenance Supervisor, revealed the E north exit did not have a light outside to light the egress path.</p> <p>Interview, on 01/07/15 at 3:17 PM with the Maintenance Supervisor revealed he was not aware of the requirements for egress.</p> <p>3) Observation, on 01/07/15 at 4:16 PM, with the Maintenance Supervisor revealed only one light installed outside the C-Lobby Exit to light the path of egress.</p> <p>Interview, on 01/07/15 at 4:17 PM, with the Maintenance Supervisor revealed he was not aware of the requirements for egress.</p> <p>4) Observation, on 01/07/15 at 4:25 PM, with the Maintenance Supervisor revealed the door to the Social Services Office opened outward into the path of egress and was not equipped with a self-closing device to ensure the door would not reduce the width of egress below the minimum width.</p> <p>Interview, on 01/07/15 at 4:26 PM with the Maintenance Supervisor, revealed he was not aware of the requirements for egress.</p> <p>5) Observation, on 01/08/15 at 9:20 AM, with the Maintenance Supervisor revealed only one light installed outside the A-Lobby Exit to light the path of egress.</p> <p>Interview, on 01/08/15 at 9:21 AM, with the Maintenance Supervisor revealed he was not aware of the requirements for egress.</p>	K 038	<p>Committee, made up of the Administrator, Maintenance Director, Food Service, Housekeeping/Laundry Supervisor, Director of Nursing, Assistant Director of Nursing, and a Unit Manager, for review. Subsequent plans of correction will be implemented when necessary.</p>	

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K 038	<p>Continued From page 11</p> <p>The census of one-hundred thirty-four (134) was verified by the Administrator on 01/08/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 01/08/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 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.</p> <p>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.)</p> <p>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.</p> <p>Reference: NFPA 101 (2000 Edition) 7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided</p>	K 038			

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K 038	<p>Continued From page 12</p> <p>in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way.</p> <p>7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units.</p> <p>7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low</p>	K 038			

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K 038	Continued From page 13 fighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area. 7.8.1.5 The equipment or units installed to meet the requirements of Section 7.10 also shall be permitted to serve the function of illumination of means of egress, provided that all requirements of Section 7.8 for such illumination are met. 7.8.2 Sources of illumination. 7.8.2.1* Illumination of means of egress shall be from a source considered reliable by the authority having jurisdiction. 7.8.2.2 Battery-operated electric lights and other types of portable lamps or lanterns shall not be used for primary illumination of means of egress. Battery-operated electric lights shall be permitted to be used as an emergency source to the extent permitted under Section 7.9.	K 038			
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with National Fire	K 047	K 047 1. An illuminated exit sign was installed over the kitchen door where the hood suppression system asul pull station is located on January 27, 2015. The exit sign is on the emergency electrical circuit. 2. All of the exit signs were audited by Maintenance staff on January 5, 2015 to assure proper operation. No other residents or areas were affected.	2/20/15	

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K 047	<p>Continued From page 14</p> <p>Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, staff and visitors. The facility has the capacity for one-hundred forty-five (145) beds and at the time of the survey, the census was one-hundred thirty-four (134).</p> <p>The findings include:</p> <p>Observation, on 01/07/15 at 3:18 PM, with the Maintenance Supervisor revealed the Kitchen did not have an exit sign installed to insure the path of egress was clearly recognizable.</p> <p>Interview, on 01/07/15 at 3:19 PM, with the Maintenance Supervisor revealed he was not aware of the requirements for exit signage.</p> <p>The census of one-hundred thirty-four (134) was verified by the Administrator on 01/08/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 01/08/15.</p> <p>Actual NFPA Standard: Reference: NFPA 101 (2000 Edition)</p> <p>19.2.10 Marking of Means of Egress. 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10. Exception: Where the path of egress travel is obvious, signs shall not be required in one-story buildings with an occupant load of fewer than 30 persons.</p> <p>7.10 MARKING OF MEANS OF EGRESS 7.10.1 General.</p>	K 047	<p>3. The Maintenance Supervisor received re-education, including post-test, from the Administrator on January 28, 2015. The new signage will be added to the regular inspection schedule for all exit signs in the facility.</p> <p>4. The documentation of the inspections and repairs will be presented to the Safety Committee, made up of the Administrator, Maintenance Director, Food Service, Housekeeping/Laundry Supervisor, Director of Nursing, Assistant Director of Nursing, and a Unit Manager, for review each month. Subsequent plans of correction will be implemented when necessary.</p>		

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K 047	<p>Continued From page 15</p> <p>7.10.1.1 Where Required. Means of egress shall be marked in accordance with Section 7.10 where required in Chapters 11 through 42.</p> <p>7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.</p> <p>7.10.1.3 Exit Stair Door Tactile Signage. Tactile signage shall be located at each door into an exit stair enclosure, and such signage shall read as follows: EXIT Signage shall comply with CABO/ANSI A117.1, American National Standard for Accessible and Usable Buildings and Facilities, and shall be installed adjacent to the latch side of the door 60 in. (152 cm) above the finished floor to the centerline of the sign. Exception: This requirement shall not apply to existing buildings, provided that the occupancy classification does not change.</p> <p>7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements.</p> <p>7.10.1.5* Floor Proximity Exit Signs. Where floor proximity exit signs are required in Chapters 11 through 42, signs shall be placed near the floor level in addition to those signs</p>	K 047			

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K 047	Continued From page 16 required for doors or corridors. These signs shall be illuminated in accordance with 7.10.5. Externally illuminated signs shall be sized in accordance with 7.10.6.1. The bottom of the sign shall be not less than 6 in. (15.2 cm) but not more than 8 in. (20.3 cm) above the floor. For exit doors, the sign shall be mounted on the door or adjacent to the door with the nearest edge of the sign within 4 in. (10.2 cm) of the door frame. 7.10.1.6* Floor Proximity Egress Path Marking. Where floor proximity egress path marking is required in Chapters 11 through 42, a listed and approved floor proximity egress path marking system that is internally illuminated shall be installed within 8 in. (20.3 cm) of the floor. The system shall provide a visible delineation of the path of travel along the designated exit access and shall be essentially continuous, except as interrupted by doorways, hallways, corridors, or other such architectural features. The system shall operate continuously or at any time the building fire alarm system is activated. The activation, duration, and continuity of operation of the system shall be in accordance with 7.9.2. 7.10.1.7* Visibility. Every sign required in Section 7.10 shall be located and of such size, distinctive color, and design that it is readily visible and shall provide contrast with decorations, interior finish, or other signs. No decorations, furnishings, or equipment that impairs visibility of a sign shall be permitted. No brightly illuminated sign (for other than exit purposes), display, or object in or near the line of vision of the required exit sign that could detract attention from the exit sign shall be permitted. 7.10.2* Directional Signs. A sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of	K 047		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185238	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0101 B. WING _____	(X3) DATE SURVEY COMPLETED 01/08/2015
NAME OF PROVIDER OR SUPPLIER OWENSBORO CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD. OWENSBORO, KY 42303	
(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 047	Continued From page 17 travel to reach the nearest exit is not apparent. 7.10.3* Sign Legend. Signs required by 7.10.1 and 7.10.2 shall have the word EXIT or other appropriate wording in plainly legible letters. 7.10.4* Power Source. Where emergency lighting facilities are required by the applicable provisions of Chapters 11 through 42 for individual occupancies, the signs, other than approved self-luminous signs, shall be illuminated by the emergency lighting facilities. The level of illumination of the signs shall be in accordance with 7.10.6.3 or 7.10.7 for the required emergency lighting duration as specified in 7.9.2.1. However, the level of illumination shall be permitted to decline to 60 percent at the end of the emergency lighting duration. 7.10.5 Illumination of Signs. 7.10.5.1* General. Every sign required by 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode. 7.10.5.2* Continuous Illumination. Every sign required to be illuminated by 7.10.6.3 and 7.10.7 shall be continuously illuminated as required under the provisions of Section 7.8. Exception: Illumination for signs shall be permitted to flash on and off upon activation of the fire alarm system. 7.10.6 Externally Illuminated Signs. 7.10.6.1* Size of Signs. Externally illuminated signs required by 7.10.1 and 7.10.2, other than approved existing signs, shall have the word EXIT or other appropriate wording in plainly legible letters not less than 6 in. (15.2 cm) high with the principal strokes of letters	K 047		

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K 047	Continued From page 18 not less than 3/4 in. (1.9 cm) wide. The word EXIT shall have letters of a width not less than 2 in. (5 cm), except the letter I, and the minimum spacing between letters shall be not less than 3/8 in. (1 cm). Signs larger than the minimum established in this paragraph shall have letter widths, strokes, and spacing in proportion to their height. Exception No. 1: This requirement shall not apply to existing signs having the required wording in plainly legible letters not less than 4 in. (10.2 cm) high. Exception No. 2: This requirement shall not apply to marking required by 7.10.1.3 and 7.10.1.5. 7.10.6.2* Size and Location of Directional Indicator. The directional indicator shall be located outside of the EXIT legend, not less than 3/8 in. (1 cm) from any letter. The directional indicator shall be of a chevron type, as shown in Figure 7.10.6.2. The directional indicator shall be identifiable as a directional indicator at a distance of 40 ft (12.2 m). A directional indicator larger than the minimum established in this paragraph shall be proportionately increased in height, width and stroke. The directional indicator shall be located at the end of the sign for the direction indicated. Exception: This requirement shall not apply to approved existing signs. Figure 7.10.6.2 Chevron-type indicator. 7.10.6.3* Level of Illumination. Externally illuminated signs shall be illuminated by not less than 5 ft-candles (54 lux) at the illuminated surface and shall have a contrast ratio of not less than 0.5. 7.10.7 Internally Illuminated Signs. 7.10.7.1 Listing. Internally illuminated signs, other than approved existing signs, or existing signs having the	K 047		

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K 047	Continued From page 19 required wording in legible letters not less than 4 in. (10.2 cm) high, shall be listed in accordance with UL 924, Standard for Safety Emergency Lighting and Power Equipment. Exception: This requirement shall not apply to signs that are in accordance with 7.10.1.3 and 7.10.1.5. Reference: NFPA 96 (1998 Edition) 7-5.1 A readily accessible means for manual activation shall be located between 42 in. and 60 in. (1067 mm and 1524 mm) above the floor, located in a path of exit or egress, and clearly identify the hazard protected. The automatic and manual means of system activation external to the control head or releasing device shall be separate and independent of each other so that failure of one will not impair the operation of the other. Exception No. 1: The manual means of system activation shall be permitted to be common with the automatic means if the manual activation device is located between the control head or releasing device and the first fusible link. Exception No. 2: An automatic sprinkler system.	K 047			
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on sprinkler testing record review and interview, it was determined the facility failed to maintain the sprinkler system in accordance with	K 062	K 062 1. The 4 th Quarter sprinkler inspection/test was performed by our sprinkler inspection company on October 10, 2014. 2. All residents have already been identified as being affected by the sprinkler inspection/test being in the wrong quarter. 3. The Maintenance Supervisor received re-education, including post-test, from the Administrator regarding the responsibilities of	2/20/15	

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K 062	<p>Continued From page 20</p> <p>National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, all residents, staff and visitors. The facility has the capacity for one-hundred forty-five (145) beds and at the time of the survey, the census was one-hundred thirty-four (134).</p> <p>The findings include:</p> <p>Sprinkler testing record review, on 01/07/15 at 3:00 PM, with the Maintenance Supervisor revealed the facility failed to conduct the quarterly sprinkler inspection in the third (3rd) quarter of 2014.</p> <p>Interview, on 01/07/15 at 3:01 PM, with the Maintenance Supervisor revealed he relied on his Sprinkler Company to ensure the system was inspected properly and quarterly as required.</p> <p>The census of one-hundred thirty-four (134) was verified by the Administrator on 01/08/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 01/08/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance.</p> <p>Exception: Valves and fire department</p>	K 062	<p>the Maintenance supervisor for compliance with local, state, and Federal regulations on January 28, 2015. If the sprinkler inspection/test has not been performed by the midpoint of each quarter, the Maintenance Supervisor will contact the vendor to assure the inspection/testing is completed before the end of the quarter.</p> <p>4. Results of the sprinkler inspection/tests will be presented to the Safety Committee, made up of the Administrator, Maintenance Director, Food Service, Housekeeping/Laundry Supervisor, Director of Nursing, Assistant Director of Nursing, and a Unit Manager, during the next meeting following the inspection/test, along with any corrective measures that were needed and taken. Subsequent plans of correction will be implemented when necessary.</p>	

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K 062	Continued From page 21 connections shall be inspected, tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test at 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or	K 062		

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K 062	Continued From page 22 as needed Chapter 10 Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Component Activity Frequency Reference Control Valves Sealed Inspection Weekly 9-3.3.1 Locked Inspection Monthly 9-3.3.1 Exception No. 1 Tamper switches Inspection Monthly 9-3.3.1 Exception No. 1 Alarm Valves Exterior Inspection Monthly 9-4.1.1 Interior Inspection 5 years 9-4.1.2 Strainers, filters, orifices Inspection 5 years 9-4.1.2 Check Valves Interior Inspection 5 years 9-4.2.1 Preaction/Deluge Valves Enclosure (during cold weather) Inspection Daily/weekly 9-4.3.1 Exterior Inspection Monthly 9-4.3.1.2 Interior Inspection Annually/5 years 9-4.3.1.3 Strainers, filters, orifices Inspection 5 years 9-4.3.1.4 Dry Pipe Valves/Quick-Opening Devices Enclosure (during cold weather) Inspection Daily/weekly 9-4.4.1.1 Exterior Inspection Monthly 9-4.4.1.3 Interior Inspection Annually 9-4.4.1.4 Strainers, filters, orifices Inspection 5 years 9-4.4.1.5 Pressure Reducing and Relief Valves Sprinkler systems Inspection Quarterly 9-5.1.1 Hose connections Inspection Quarterly 9-5.2.1 Hose racks Inspection Quarterly 9-5.3.1 Fire pumps	K 062		
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K 062	Continued From page 23 Casing relief valves Inspection Weekly 9-5.5.1, 9-5.5.1.1 Pressure relief valves Inspection Weekly 9-5.5.2, 9-5.5.2.1 Backflow Prevention Assemblies Reduced pressure Inspection Weekly/monthly 9-6.1 Reduced pressure detectors Inspection Weekly/monthly 9-6.1 Fire Department Connections Inspection Quarterly 9-7.1 Main Drains Test Annually 9-2.6, 9-3.4.2 Waterflow Alarms Test Quarterly 9-2.7 Control Valves Position Test Annually 9-3.4.1 Operation Test Annually 9-3.4.1 Supervisory Test Semiannually 9-3.4.3 Preaction/Deluge Valves Priming water Test Quarterly 9-4.3.2.1 Low air pressure alarms Test Quarterly 9-4.3.2.10 Full flow Test Annually 9-4.3.2.2 Dry Pipe Valves/Quick-Opening Devices Priming water Test Quarterly 9-4.4.2.1 Low air pressure alarm Test Quarterly 9-4.4.2.6 Quick-opening devices Test Quarterly 9-4.4.2.4 Trip test Test Annually 9-4.4.2.2 Full flow trip test Test 3 years 9-4.4.2.2.1 Pressure Reducing and Relief Valves Sprinkler systems Test 5 years 9-5.1.2 Circulation relief Test Annually 9-5.5.1.2 Pressure relief valves Test Annually 9-5.5.2.2 Hose connections Test 5 years 9-5.2.2 Hose racks Test 5 years 9-5.3.2 Backflow Prevention Assemblies Test Annually 9-6.2 Control Valves Maintenance Annually 9-3.5 Preaction/Deluge Valves Maintenance Annually 9-4.3.3.2	K 062		

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K 062	Continued From page 24 Dry Pipe Valves/Quick-Opening Devices Maintenance Annually 9-4.4.3.2	K 062			