

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

PRINTED: 12/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185309</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>12/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>SPRING VIEW HEALTH &amp; REHAB CENTER, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>718 GOODWIN LANE</b> <b>LEITCHFIELD, KY 42754</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS  Based upon implementation of the acceptable POC, the facility was deemed to be in compliance 12/09/13 as alleged.	{F 000}			

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

TITLE

(X6) DATE

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  SPRING VIEW HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754
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F 000	INITIAL COMMENTS  A standard recertification survey was conducted 11/13/13 through 11/15/13 and a Life Safety Survey was conducted 11/13/13. Deficiencies were cited with the facility having the opportunity to correct deficiencies before remedies would be recommended.	F 000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.	
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 and interview it was determined the facility failed to ensure housekeeping and maintenance services to maintain a sanitary and comfortable interior related to observation of urinals, bed pans and bath basins observed improperly stored in resident bathrooms.  The findings include:  Interview with the Director of Nursing (DON), on 11/15/13 at 11:30 AM, revealed the facility based their standard of practice for care of resident equipment on Mosby's Textbook for Long Term Care Nursing Assistants. Review of section: OBRA and CMS requirements for resident rooms section; revealed "Personal supplies and items are labeled and stored appropriately".  Observation during the initial tour on 11/13/13 at 12:30 PM and 3:35 PM revealed three unlabeled	F 253	F 253  <u>Corrective Measures for Resident Identified in the deficiency:</u>  The three unlabeled wash basins in the bathroom of room 104 were removed by the DON on 11/15/13. The two urinals and two specimen collection containers in the bathroom of room 207 were removed by the DON on 11/15/13. The unlabeled and uncovered bedpan on commode tank lid in room 209 bathroom was removed by the DON on 11/15/13. The unlabeled uncovered specimen container on shelf in the bathroom of room 213 was removed by the DON on 11/15/13  <u>How other residents who may have been affected by this practice were identified:</u>  All resident's have the potential to be affected by utilization of unlabeled and improperly stored bedpans, urinals, and wash basins at the resident bedside and bathrooms.  <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u>  The nursing staff was re-educated on procedure of properly storing bedpans, urinals, and wash	12/09/13

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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 60 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  SPRING VIEW HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 716 GOODWIN LANE LEITCHFIELD, KY 42754		
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F 253	<p>Continued From page 1</p> <p>washbasins stacked together in the bathroom of room #104. Observallon at 12:50 PM and 3:30 PM of room #207 revealed two urinals and two specimen collection containers sitting on a shelf over the commode in the bathroom. The urinals and specimen containers were touching, and were not labeled or covered. Observallons on 11/13/13 at 12:55 PM revealed a specimen container not labeled and uncovered on top of commode tank lid in room #208 bathroom. At 1:10 PM, a bedpan not labeled and uncovered on top of commode tank lid in room #209 bathroom and at 1:20 PM a specimen container not labeled and uncovered on the shelf in the bathroom of room #213.</p> <p>Interview with the DON, on 11/18/13 at 11:30 AM, revealed she expected resident bath basins, urinals and specimen containers to be stored labeled and covered.</p> <p>Interviews with Certified Nursing Assistants (CNA) #1, #2, #3 and #4 on 11/15/13 at 11:20 AM, 11:26 AM and 11:30 AM revealed they had no explanation why the bath basins, urinals and specimen collection containers were stored without being labeled and bagged. They stated it was everyone's responsibility to ensure the resident equipment was stored appropriately. The CNAs said bath basins, urinals and specimen collection containers should always be labeled and bagged.</p>	F 253	<p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>basins by the DON on 11/22/13. Resident equipment stored in resident bathrooms will be QI monitored by DON or designee daily 5x per week x 4 weeks then 3x weekly x 4 weeks then 2x weekly x 4 weeks then weekly x 6 months. Any negative findings will be addressed immediately through re-education.</p> <p><u>Monitoring for Ongoing Compliance:</u></p> <p>Director of Nursing will present findings to the Quality Assurance committee meeting monthly x 9 months for review and development of action to ensure sanitary and comfortable interior is maintained by facility.</p>	12/09/13	

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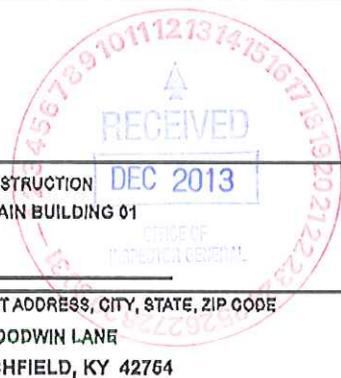
{K 000}	INITIAL COMMENTS  Based upon implementation of the acceptable POC, the facility was deemed to be in compliance 12/18/13 as alleged.	{K 000}		
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1092.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1992, with 6 smoke detectors and 0 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1992 and added onto in 2008.</p> <p>GENERATOR: Type II generator installed in 2007. Fuel source is Propane.</p> <p>A standard Life Safety Code survey was conducted on 11/13/13. Spring View Health &amp; Rehab Center was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Seventy-One (71) beds with a census of Sixty-Two (62) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000	<p>Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.</p>	12/12/13
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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Seventy-One (71) beds with a census of Sixty-Two (62) on the day of the survey. The facility failed to ensure two (2) smoke barriers had a ½ hour rating.  The findings include:  Observation, on 11/13/13 at 12:18 PM with the Plant Services Manager, revealed the smoke	K 025	K025 NFPA 101 Life Safety Code  It is the normal practice of Spring View Health and Rehab to maintain all smoke barriers  <u>Corrective Measures for Resident Identified in the deficiency:</u>  No residents were identified in this deficiency.  <u>How other residents who may have been affected by this practice were identified:</u>  Identified per observation and interview, residents the 3 of 4 smoke compartments and all residents had the potential to be affected.  <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u>  The environmental service director was re-educated on 11/13/13 on the rating requirement for smoke partitions/the ½ hour rating requirement for smoke barriers. The environmental service director audited all remaining smoke barriers on 11/13/13 and no other issues were identified. The identified smoke partitions, extending above the ceiling will be reconstructed to meet the ½ hour rating requirement for a smoke barrier by 12/9/13 by the environmental service director.  <u>Monitoring for Ongoing Compliance:</u>  The environmental service director will conduct a monthly audit of smoke barriers for 6 months	12/12/13

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NAME OF PROVIDER OR SUPPLIER  SPRING VIEW HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754	
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K 025	<p>Continued From page 2</p> <p>partitions, extending above the ceiling located above room# 201 and 204 were not properly rated. The barriers were constructed with one sheet of 1/2" drywall on one side of the barrier and the framing studs exposed on the interior side of the barrier.</p> <p>Interview, on 11/13/13 at 12:18 PM with the Plant Services Manager, revealed he was not aware the barrier was not properly constructed to meet the 1/2 hour rating for a smoke barrier.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(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</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> <li>1. Be made on either side of the smoke barrier, or</li> <li>2. Be made by an approved device designed for the specific purpose.</li> </ol>	K 025	<p><u>Monitoring for Ongoing Compliance:</u></p> <p>and quarterly to validate ongoing compliance that no areas will of penetration are present. The results of the audits will be reported to the Administrator and the Quality Assessment and Assurance committee on a monthly basis for a year.</p>	12/12/13

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K 025	Continued From page 3	K 025		
K 027 SS=E	<p>19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, thirty-six (36) residents, staff and visitors. The facility is certified for Seventy-One (71) beds with a census of Sixty-Two (62) on the day of the survey. The facility failed to ensure the two (2) sets of cross corridors doors would close properly with the installed door coordinators.</p> <p>The findings include:</p> <p>Observation, on 11/13/13 at 2:06 PM with the</p>	K 027	<p>K 027 NFPA 101 Life Safety</p> <p>It is the normal practice for Spring View Health and Rehab to ensure cross corridor doors will resist the passage of smoke in accordance with NFPA standards.</p> <p><u>Corrective Measures for Resident Identified in the deficiency:</u></p> <p>No residents were identified in this deficiency.</p> <p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>Per observation and interview, this deficiency had the potential to affect residents in 3 of 4 smoke compartments, and 40 residents.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>The environmental service director was re-educated on the NFPA 101 Life safety code relating to door openings in smoke barriers on 11/13/13 by the Administrator.</p> <p>The environmental service director audited all remaining door openings in smoke barriers on 11/13/13 and no other issues were identified.</p>	12/28/13

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K 027	Continued From page 4 Plant Services Manager, revealed the cross-corridor doors located at room # 201 and at the office hallway would not close completely when tested. This was due to coordinators installed on the doors were not properly operating the doors.  Interview, on 11/13/13 at 2:06 PM with the Plant Services Manager, revealed the coordinators were recently installed and he was unaware of how they worked properly.  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.  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.	K 027	<u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u>  The cross-corridor doors located at room 201 will be repaired, coordinators removed, and brushes installed on edging of doors to assure proper operating and to resist the passage of smoke by 12/28/13 by the environmental service director.  <u>Monitoring for Ongoing Compliance:</u>  The environmental service director will conduct a monthly audit of door openings in smoke barriers for 6 months and quarterly to validate ongoing compliance that no areas of penetrations are present. The results of the audits will be reported to the Administrator and the Quality Assessment and Assurance committee on a monthly basis for one year.	12/28/13
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 062	K 062 NFPA Life Safety Code	12/12/13

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K 082	Continued From page 6  Sprinkler report review, on 11/13/13 at 1:39 PM with the Plant Services Manager, revealed the facility failed to provide documentation that the interior of the sprinkler piping had been inspected since October 2008.  Interview, on 11/13/13 at 1:39 PM with the Plant Services Manager, revealed he was unaware the work had not been completed since he depended on the sprinkler company to keep the facility in compliance with all NFPA standards.  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. Exception: Valves and fire department 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	K 082	<u>Monitoring for Ongoing Compliance:</u>  system has been inspected. The environmental service director will conduct a quarterly audit to ensure the sprinkler piping has been inspected. The audits will continue for 24 months with results reported to the Administrator and the Quality Assessment and Assurance Committee on a quarterly basis for 24 months.  The environmental services director will implement a log on 12/9/13 to internally track the timeliness of the fire sprinkler inspections and internal pipe inspections.	12/12/13	

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K 062	Continued From page 7 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 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	K 062		

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K 062	Continued From page 8 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 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	K 062		

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K 062	Continued From page 9 Control Valves Position Test Annually 8-3.4.1 Operation Test Annually 9-3.4.1 Supervisory Test Semiannually 9-3.4.3 Praction/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 9-5.6.1.2 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 Praction/Deluge Valves Maintenance Annually 9-4.3.3.2 Dry Pipe Valves/Quick-Opening Devices Maintenance Annually 9-4.4.3.2	K 062		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Smoking regulations are adopted and include no less than the following provisions:  (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such	K 066	K066 NFPA Life Safety Code  It is the normal practice of Spring View Health and Rehab to ensure use of approved ashtrays at an entrance in accordance with NFPA standards.  <u>Corrective Measures for Resident Identified in the deficiency:</u>  No residents were identified in this deficiency.	12/12/13

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K 068	<p>Continued From page 10 area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays at an entrance, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, thirty (30) residents, staff and visitors. The facility is certified for Seventy-One (71) beds with a census of Sixty-Two (62) on the day of the survey. The facility failed to ensure smoking was only being conducted off the facility property.</p> <p>The findings include:</p> <p>Observation, on 11/13/13 at 12:19 PM with the Plant Services Manager, revealed the area at the time clock exit is being used as a smoking area due to cup full of water with cigarette butts placed</p>	K 068	<p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>Per observation and interview, residents 1 of 4 smoke compartments and 30 residents had the potential to be affected.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>On 11/13/13 the environmental services director was reeducated on the NFPA standard that the facility must ensure the use of approved ashtrays at an entrance.</p> <p>All staff were reeducated on the facility policy the smoking is not allowed on facility premises. Education will be completed by 12/12/13.</p> <p>On 12/10/13 letters were sent to family members outlining the facility policy as it relates to no smoking on facility grounds, by Social Services Director.</p> <p>On 11/13/13 an audit was completed by the environmental service director of all facility entrances to ensure no smoking materials were seen. No further issues were noted.</p> <p>On 11/13/13 the environmental service director ensured approved ashtrays were available to residents who have been grandfathered into the smoking policy.</p> <p><u>Monitoring for Ongoing Compliance:</u></p> <p>The environmental service director will conduct daily audits for 2 weeks, then audits 3 times weekly for 2 weeks, then weekly audits for 2 weeks, to ensure no smoking materials are noted unless in an approved ashtray. Thereafter random audits will be conducted in accordance with findings.</p>	12/12/13

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K 068	<p>Continued From page 11</p> <p>inside. The area did not provide an approved ashtray and is not listed as a smoking area at the facility.</p> <p>Interview, on 11/13/13 at 12:19 PM with the Plant Services Manager, revealed he was unaware smoking was being conducted in the unapproved area.</p> <p>Reference: NFPA 101 (2000 edition)          19.7.4* Smoking, Smoking regulations shall be adopted and shall include not less than the following provisions:          (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the International symbol for no smoking.          Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.          (2) Smoking by patients classified as not responsible shall be prohibited.          Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision.          (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p>	K 068	<p><u>Monitoring for Ongoing Compliance:</u></p> <p>Results of the audits will be reported to the facility Administrator and Quality Assessment and Assurance committee on a monthly basis and on going for one year.</p>	12/12/13

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K 066	Continued From page 12 (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066		
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:  (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;  (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and  (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2  This STANDARD is not met as evidenced by: Based on observation, interview and plan of correction review, it was determined the facility failed to assure the room being used to transfer liquid oxygen was rated per NFPA requirements. The deficiency had the potential to affect two (2) of four (4) smoke compartments, sixty-two (62) residents, staff and visitors. The facility is certified	K 143	K143 NFPA Life Safety Code  It is normal practice of Spring View Health and Rehab to ensure the room being used for transfer of liquid oxygen is rated per NFPA requirements.  <u>Corrective Measures for Resident Identified in the deficiency:</u>  No residents were identified in this deficiency.  <u>How other residents who may have been affected by this practice were identified:</u>  Per observation and interview, residents in 2 of 4 smoke compartments had the potential to be affected and 62 residents.  <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u>  On 11/13/13 the environmental service director was reeducated on the NFPA standard that rooms being used to transfer liquid oxygen must be rated per NFPA guidelines, ensuring rooms have a fire rated door frame that has a 1 hour fire resistive rating and are equipped with proper signage on the doors noting trans-filling is occurring and no smoking for the area.  On 11/13/13 an audit was conducted by the environmental service director of all oxygen transferring rooms to ensure fire rated door frames and proper signage was in place. No further issues noted.	12/17/13

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K 143	<p>Continued From page 13</p> <p>for Seventy-One (71) beds with a census of Sixty-Two (62) on the day of the survey. The facility failed to ensure one (1) oxygen transferring room had a fire rated door frame that had a 1 hour fire resistive rating and equipped with proper signage on the trans-filling room doors.</p> <p>The findings include:</p> <p>Observation, on 11/13/13 at 1:57 PM with the Plant Services Manager, revealed the oxygen trans-filling room behind the nurses' station on 100 hall did not have a fire rated door and frame installed. The door frame is steel but there is no fire rating tag on the door frame.</p> <p>Interview, on 11/13/13 at 1:57 PM with the Plant Services Manager, revealed he was unaware the door for the trans-filling room had to have a one hour fire rating.</p> <p>Observation, on 11/13/13 between 1:10 PM and 2:30 PM with the Plant Services Manager, revealed there was no signage placed on the two (2) trans-filling rooms to indicate trans-filling was occurring and no smoking for the area.</p> <p>Interview, on 11/13/13 between 1:10 PM and 2:30 PM with the Plant Services Manager, revealed he was unaware of the requirement to have signage on the oxygen trans-filling room.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container</p>	K 143	<p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>ON 12/12/13 a fire rated door frame with a 1 hour fire resistive rating and that was equipped with proper signage on the trans-filling room door, to include a fire rating tag has been ordered by the environmental service director and will be completed by 12/17/13.</p> <p><u>Monitoring for Ongoing Compliance:</u></p> <p>The environmental service director will conduct a monthly audit for 6 months and then quarterly of all liquid oxygen transfer rooms to ensure door frames are fire rated according to NFPA standards and to ensure proper signage is on trans-filling room doors. Results of audit will be reported to the Administrator and the quality assessment and assurance committee on a monthly basis for one year.</p>	12/17/13

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K 143	Continued From page 14 to another shall be accomplished at a location specifically designated for the transferring that is as follows: a. Separated from any portion of a facility where in patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and b. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and c. The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted. Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures. The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.	K 143		
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source.	K 211	K211 NFPA Life Safety Code  It is the normal practice of Spring View Health and Rehab to ensure alcohol based hand rub dispensers are not installed over or adjacent to an ignition source in accordance with NFPA standards.  <u>Corrective Measures for Resident Identified in the deficiency:</u>  No residents were identified in this deficiency.	12/12/13

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K 211	<p>Continued From page 15</p> <p>o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that Alcohol Based Hand Rub dispensers were not installed over or adjacent to an ignition source in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, thirty-six (36) residents, staff and visitors. The facility is certified for Seventy-One (71) beds with a census of Sixty-Two (62) on the day of the survey. The facility failed to ensure eight (8) alcohol dispensers were not installed adjacent to electrical outlets.</p> <p>The findings include:</p> <p>Observation, on 11/13/13 between 1:10 PM and 2:30 PM with the Plant Services Manager, revealed Alcohol Based Hand Rub Dispensers installed adjacent to electrical outlets in rooms# 114, 116, 118, 110, 106, 105, 103, and 117.</p> <p>Interview, on 11/13/13 between 1:10 PM and 2:30 PM with the Plant Services Manager, revealed he was unaware the dispensers were mounted to close to the electrical outlets.</p>	K 211	<p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>Per observation and interview, residents in 1 of 4 smoke compartments and 36 residents had the potential to be affected.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>On 11/13/13 the environmental service director was reeducated that alcohol based hand rub dispensers are not to be installed over or adjacent to an ignition source in accordance with NFPA standards.</p> <p>On 11/13/13 the environmental service director conducted 100% facility audit to ensure no other alcohol based dispensers were over or adjacent to an ignition source. No other issues were noted.</p> <p>On 12/10/13 the environmental service director relocated the alcohol based hand rub dispensers in rooms 103,105,106,110,114,115,116,and 117 to not be adjacent to the electrical outlets and to be in compliance with NFPA standards.</p> <p><u>Monitoring for Ongoing Compliance:</u></p> <p>The environmental service director will conduct a monthly audit of all alcohol based hand rub dispensers for 6 months then quarterly, to ensure they are not installed over or adjacent to ignition sources, in accordance with NFPA standards. Results of the audits will be reported to the Administrator and Quality Assessment and Assurance Committee on a monthly basis for one year.</p>	12/12/13

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NAME OF PROVIDER OR SUPPLIER  SPRING VIEW HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 715 GOODWIN LANE LEITCHFIELD, KY 42754	
(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 211	Continued From page 16 Reference: NFPA 101 (2000 Edition)  Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211		