

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

PRINTED: 08/04/2011
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2011
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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025
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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 An annual survey and abbreviated surveys (KY #16627 and KY #16457) were conducted on 07/19/11 through 07/21/11 and a Life Safety Code survey was conducted on 07/19/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S of an "F." KY #16627 and KY #16457 were substantiated with deficiencies cited. F 225 SS=E 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must	F 000	<u>RESPONSE PREFACE</u> Lake Way acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The Plan of Correction is submitted as a written allegation of compliance. Lake Way's response the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Lake Way reserves the right to submit documentation to refute any of the stated deficiencies of this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any administrative or legal proceeding. 1. Resident number 22 no longer a resident in the facility, therefore no corrective action could be accomplished for him/her. Resident	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Helen Buxton</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/2/2011</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 225	<p>Continued From page 1</p> <p>prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined, the facility failed to ensure alleged violations which involved abuse and the misappropriation of resident property for two residents (#3 & #6), in the selected sample of 17, and for one resident (#22), not in the selected sample, were reported immediately to the Administrator of the facility and other officials in accordance with State law through established procedures. In September 2010, Resident #3 was identified to be missing 54 Lortab pain pills and Resident #22 was identified to be missing 30 Lortab pain pills. The facility failed to implement the policy in regards to the misappropriation of the residents' property related to the missing Lortabs. Additionally, State Registered Nurse Aide (SRNA) #3 observed SRNA #5 handle Resident #6 roughly and use profanity during provision of morning care. SRNA #3 failed to report the incident immediately to her supervisor and the nurse failed to report the incident to the Administrator until three days later. The facility failed to implement the policy in regards to</p>	F 225	<p>number 3's Lortab order DC'd 9/9/2010 due to non-use. Resident number 6 assessed by DON on 5/18/2011 for injuries related to allegation; no injuries noted.</p> <p>2. All residents have the potential to be affected by this deficient practice. Concerns have been corrected and will monitor as stated below.</p> <p>3. In-services initiated 7/22/2011 and will be continued through 8/19/2011 on policy and procedure for reporting abuse, neglect and misappropriation of resident property. Any staff not attending scheduled in-service will not be allowed to work until they have been in-serviced. All new hires will be trained during orientation.</p> <p>4. Weekly QA audits of Incident Reports and 24 Nursing Report will be performed to ensure that all allegations of abuse, neglect, misappropriation of resident property are reported per policy and procedure, to include post-fall skin assessments. Concerns/issues will be reported to the Administrator immediately. Findings will be reviewed in the Executive QA Committee meeting quarterly.</p>	09/02/11	

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F 225	<p>Continued From page 2 reporting abuse to the appropriate agencies at the time of the incident.</p> <p>Findings include:</p> <p>A review of the facility's policy, "Abuse, Neglect, or Misappropriation of Resident Property," dated 02/09, revealed "the Administrator shall ensure the Division of Licensure and Regulation and the Department of Social Services, Adult Protective Services will be notified immediately of all complaints of abuse, neglect, including injuries of unknown origin, or misappropriation of property. Employees shall immediately report such allegations to the Administrator who will ensure the Cabinet is notified in accordance with KRS 209.030, as amended. All such allegations will be investigated and action taken as necessary to prevent further potential abuse while the investigation is in progress."</p> <p>1. A record review revealed Resident #3 was admitted to the facility on 11/11/03 with diagnoses to include History of Traumatic Fracture Left Femur, Constipation and Dysphagia.</p> <p>A review of the physician's orders, dated 09/01/10 through 09/30/10, revealed "Lortab 10/500 milligrams (mg) by mouth (po) two times a day as needed (PRN) for pain."</p> <p>2. A record review revealed Resident #22 was admitted to the facility on 08/17/05 with diagnoses to include Peripheral Vascular Disease, Anxiety, Depressive Disorder and Cerebrovascular Disease.</p> <p>A review of the physician's orders, dated 09/01/10</p>	F 225		

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F 225	<p>Continued From page 3</p> <p>through 09/30/10, revealed "Lortab 10/500 mg one tablet po every six hours PRN for pain."</p> <p>An interview with the Assistant Director of Nursing (ADON), on 07/21/11 at 12:50 PM, revealed there was a question about the number of Lortabs available for Resident #3. After he was made aware, he informed the Director of Nursing (DON). He revealed the DON and Administrator investigated the incident, but he was unaware of the outcome.</p> <p>An interview with the DON, on 07/21/11 at 9:08 AM, revealed, during the holiday weekend, the ADON reported there were Lortab pain pills missing from two different residents (#3 and #22). The ADON informed her a Kentucky Medication Aide (KMA) (no longer employed at the facility) thought it was a paper work issue related to discontinued Lortabs and the removal of the medications from the medication cart. The DON revealed she sent the former Administrator a text message regarding the issue of the missing Lortabs. She stated the former Administrator responded in a text message "if they do not show up, then we will start an investigation". The DON stated she returned to work on 09/07/10, and the Lortabs were not accounted for and the staff could not locate them. She interviewed staff who worked the day the Lortabs were identified to be missing on the West wing. She stated Resident #3 had 54 Lortabs missing and Resident #22 had 30 Lortabs missing. She contacted the two suppliers of medication for the facility and determined the local pharmacy delivered the Lortabs to the facility. She stated she reviewed packing slips from the local pharmacy and determined they delivered Lortabs to the facility</p>	F 225		

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F 225	<p>Continued From page 4</p> <p>on one day. Two to three days later, the pharmacy sent another set of Lortabs to the facility. The DON stated Registered Nurse (RN) #2 reordered the Lortabs from the local pharmacy related to facility staff who reported the residents' medication was not available. She was unable to identify who took the Lortabs. The DON stated she did not report the incident of the missing Lortabs to the appropriate agencies when the incident happened in 09/10.</p> <p>An interview with the former Administrator, on 07/21/11 at 1:16 PM, revealed there were no Lortabs missing in September. She stated a former employee alleged she and the DON did not report missing Lortabs to the corporation. She stated she was off for two months while the DON conducted an investigation. She was informed the packing slips matched what was on the count sheets. She stated, "I did not feel or deem it necessary to call in missing Lortabs. There were not any pills missing. That's how I saw it and how I called it". Additionally, the facility did not conduct drug testing at that time for the staff because there were no missing Lortabs.</p> <p>An interview with the Regional Vice President, on 07/21/11 at 11:15 AM, revealed he received a call from the Corporate Nurse in regards to the missing Lortabs. He stated when he returned to the facility, an investigator from the North Carolina office was in the facility to investigate the incident. He stated the facility should report the incident to the appropriate agencies and the former Administrator was responsible to report at the time of the incident in September.</p> <p>3. A record review revealed Resident #6 was</p>	F 225		

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F 225	<p>Continued From page 5</p> <p>admitted to the facility on 03/11/05 with diagnoses to include Senile Dementia, Dysphagia, Anxiety, Chronic Renal Disease and Psychosis.</p> <p>A review of Resident #6's annual MDS, dated 05/13/11, revealed the resident's cognitive skills to be moderately impaired and required extensive assistance with dressing and transfers. Verbal and physical behaviors toward others were exhibited.</p> <p>A review of the facility's final investigation report, dated 05/18/11, revealed that on 05/15/11, SRNA #3 witnessed SRNA #5 to be "rough" while assisting to dress Resident #6 prior to the breakfast meal. He/she jerked Resident #6's arm and used profanity. SRNA #3 reported the allegation to Licensed Practical Nurse (LPN) #13, who failed to report the allegation to the Administrator until three days later, on 05/18/11. Witness statements were obtained from the staff who worked the area the day the allegation was made.</p> <p>An interview with SRNA #3, on 07/20/11 at 1:42 PM, revealed Resident #6 was often resistive to care. On 05/15/11, she witnessed SRNA #5 jerk Resident #6's arm away during care and SRNA #5 voiced profanity. SRNA #3 reported the allegation to LPN #13 two hours later, after she finished with resident care, which she stated should be reported as soon as the incident occurred.</p> <p>A review of SRNA #5's personnel file revealed termination on 05/18/11, due to inappropriate language and being unnecessarily rough with a resident. A review of LPN #13's personnel file,</p>	F 225		

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F 225	Continued From page 6 revealed, on 05/18/11, she was suspended for three days for failure to report an allegation of abuse in a timely manner. On 05/23/11, she was terminated due to the failure to follow policy and procedure in regard to reporting allegations. An interview with SRNA #5, on 07/21/11 at 10:33 AM, revealed he was terminated from the facility in regards to an allegation of abuse, but denied any verbal inappropriateness or "roughness" with Resident #6. An interview with the DON, on 07/21/11 at 5:28 PM, revealed she expected the nursing assistants to report allegations of abuse to the Charge Nurse, and expected the nurse to report an allegation of abuse immediately to her and other responsible parties. An interview with the Administrator, on 07/21/11 at 5:55 PM, revealed she expected the Charge Nurse to report an allegation of abuse immediately to her and other responsible parties.	F 225			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure policies/procedures were implemented related to bruising of unknown origin for one resident (#10),	F 226	1. A new fall risk assessment completed on 7/20/2011 after 7/19/2011 fall on resident number 10; incident report completed 7/21/2011 regarding bruising, due to area of body affected by fall on 7/19/2011. Bruising not suspicious in nature. Resident was DC'd from physical therapy on 7/13/2011. Resident is currently on a Restorative Nursing Program seven days a week for AROM to both		

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F 226	<p>Continued From page 7 in the selected sample of 17.</p> <p>Findings include:</p> <p>A record review revealed Resident #10 was admitted to the facility on 5/18/2011 with diagnoses to include Alzheimer's Disease, Dementia, Hypertension, Chronic Airway Obstruction and History of Falls.</p> <p>A review of the comprehensive care plan, dated 06/16/11, revealed staff were to provide one person constant guidance and physical assistance with transfers.</p> <p>A review of the nurses' notes, dated 07/19/11 at 7:36 AM, revealed there was evidence of a faded bruise on the resident's left lower buttock. There was no evidence in the nurses' notes related to a bruise on the left side of the mid-back or elbow.</p> <p>An observation of a skin assessment, on 07/20/11 at 1:35 PM, with Licensed Practical Nurse (LPN) #9, revealed a large deep purple bruise on the left side of the mid-back, a faded bruise on the left lower buttock, and a deep purple nickel-sized bruise on the left inner elbow. LPN #9 revealed the bruising was from a previous fall, but could not indicate a date of the fall. There was no evidence of an investigation related to the bruises on the elbow or the mid-back.</p> <p>An interview with LPN #4, on 07/21/11 at 8:43 AM, revealed she was unaware how Resident #10 sustained a bruise to the left side mid-back, but stated he/she got up and down on his/her own.</p>	F 226	<p>lower extremities and is ambulated with 1 assist.</p> <p>2. All residents have the potential to be affected by deficient practice concern has been corrected and will monitor as stated below; 100% skin assessment was completed by charge nurses on 8/11/2011 to identify any bruising that has not been reported/investigated. No new areas found.</p> <p>3. In-service initiated 8/5/2011 and continues through 8/19/2011 for all nursing staff by DON and SDC on performing skin inspections during daily care, reporting, treatment as applicable. Licensed nurses have been in-serviced on completion of Incident Reports and post-incident follow-up assessments and documentation. Any staff not attending scheduled in-service will not be allowed to work until they have been in-serviced. All new hires will be trained during orientation.</p> <p>4. QA Nurse to perform 10 random audits a week X 4 on Incident Reports and 24 hour Nursing Report to ensure follow-up assessments and documentation are complete; then weekly X 4 weeks; then monthly X 3 months. Corrections will be made as</p>		

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F 226	Continued From page 8 An interview with Registered Nurse (RN) #2, on 07/21/11 at 8:55 AM, revealed at the time of the fall on 07/19/11, she did not observe a bruise on the resident's left side mid-back. An interview with State Registered Nurse Aide (SRNA) #6, on 07/21/11 at 1:44 PM, revealed the bruise on the resident's left side mid-back was present for several days. An interview with SRNA #14, on 07/21/11 at 2:50 PM, revealed there was a bruise on Resident #10's mid-back for several days, but was unable to state the exact date the bruise occurred. SRNA #14 revealed she was expected to report bruising and skin tears to the Charge Nurse. An interview with LPN #6, on 07/21/11 at 2:45 PM, revealed weekly skin assessments were not completed as scheduled. She stated findings were reported by the staff during daily care. The nurse assigned to the hall was to look at the skin and make a note of the findings. If an area was identified, an incident report was to be filled out. An interview with the Director of Nursing (DON), on 07/21/11 at 5:20 PM, revealed charting was done by exception and there was not a specific policy on completion of skin assessments. She verbalized her expectation was for staff to report findings to the Charge Nurse and an incident report was to be completed. If a cause was not determined, an investigation was to be conducted. The DON verbalized there should be documentation in the chart once a bruise was identified. She was unable to provide any documentation or assessment of the bruise on	F 226	applicable. Findings will be reviewed monthly by DON and reports reviewed by Executive QA Committee quarterly.	9/02/11	

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F 226	Continued From page 9 the resident's left side mid-back, or an investigation which indicated the cause of the bruising.	F 226		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the environment was free from accident hazards as is possible, for two residents (#4 and #7), in the selected sample of 17, and for three residents (#20, #21 and #23), not in the selected sample. Unsupervised medications were observed in Resident #4's possession and Resident #20's possession, a cigarette lighter for Resident #7 was not safely secured, three razors for Resident #21 were not safely secured, and the staff failed to respond to Resident #23's chair alarm in a timely manner. Findings include: 1. A record review revealed Resident #4 was admitted to the facility on 05/02/11 with diagnoses to include Malaise/Fatigue, Lack of Coordination, Senile Dementia, Depression and History of Falls.	F 323	1. All hazardous devices have been removed from resident number 4, 20, and 21 rooms. Resident number 7 no longer a resident of facility therefore no corrective action is needed. Resident number 23 screened for therapy services – 8/8/2011, physical therapy to treat X 30 days to include gait training etc. due to multiple falls. 2. All residents have the potential to be affected by deficient practice. All resident rooms searched for unsafe items such as sharps, medications, lighters, inappropriate liquids such as peroxide, alcohol etc by Admissions Coordinator/LPN on 7/21/2011. Concern has been corrected and will be monitored as stated below. 3. In-services initiated to all nursing on 8/5/2011 and continues through 8/19/2011 by QA Nurse and SDC on responding to all alarms promptly; on monitoring residents environment to be as free of accident hazards as possible, and by providing adequate supervision and assistive devices to prevent accidents. Resident's	

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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
F 323	<p>Continued From page 10</p> <p>An observation, on 07/19/11 at 4:15 PM, revealed Resident #4 was sitting in his/her room with a bottle of hydrogen peroxide up to his/her mouth. The resident was observed to swish the liquid around in his/her mouth and spit the liquid in the sink. Resident #4 returned the bottle of hydrogen peroxide to the right side of the drawer beneath the sink. The bottle had the resident's name on it, but no opened date. The expiration date was 06/13.</p> <p>An interview with Nurse Aide (NA) #2, on 07/19/11 at 4:20 PM, revealed the hydrogen peroxide was not something the resident should store in his/her room.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 07/19/11 at 4:40 PM, revealed hydrogen peroxide was not kept in the building and stated "I have no idea how the resident got it."</p> <p>2. A record review revealed Resident #20 was admitted to the facility on 07/19/11 with diagnoses to include Cardiac Dysrhythmias, Dementia, Hypertension, Chronic Kidney Disease, Alzheimer's Disease, Hypothyroidism and Sleep Apnea.</p> <p>An observation of a medication pass, on 07/20/11 at 8:20 AM, with Kentucky Medication Aide (KMA) #4 revealed Resident #20 was scheduled to take Cozaar 25 milligrams (mg) by mouth (po), Lopid 600 mg po, Pepcid 20 mg po, Aggrenox 200 mg/Aspirin 25 mg po, Exelon 4.6 mg/24 hour patch, Imdur 30 mg po, and Sectral 200 mg po. When KMA #4 took the medications to administer to the resident, he/she revealed, "I got my own</p>	F 323	<p>cigarettes/lighters will be kept in locked box and signed "in" and "out" when used by resident. Charge nurses will account for each lighter/cigarettes at shift change. Admission Coordinator will review this with residents and families during the admission process. Any staff not attending scheduled in-service will not be allowed to work until they have been in-serviced. All new hires will be trained during orientation.</p> <p>4. Weekly audits to be performed on response time on alarms X 4 weeks per QA nurse; then monthly X 4 months. Results of audits will be reviewed by Administrator and DON monthly. Outcomes will be reviewed by Executive QA Committee, quarterly.</p>	09/02/11

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

PRINTED: 08/04/2011
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 11</p> <p>stash of medicine." The resident had a pill box labeled AM and PM medications. The AM pill box contained ten pills for Monday, ten pills for Tuesday; Wednesday was empty, ten pills for Thursday, ten pills for Friday, and ten pills for Saturday. Resident #20 kept the pills in a cabinet with his/her personal belongings.</p> <p>3. A record review revealed Resident #21 was admitted to the facility on 01/28/11 with diagnoses to include Acute and Chronic Respiratory Failure, Chronic Ischemic Heart Disease, Chronic Pain Syndrome, Anxiety, Chronic Airway Obstruction, Senile Dementia, Depressive Disorder and Hypertension.</p> <p>An observation, on 07/19/11 at 10:10 AM, revealed Resident #21 was noted with three (3) razors in a cup on his/her bedside table. At 4:20 PM, the razors remained on the resident's bedside table.</p> <p>An interview with NA #2, on 07/19/11 at 4:20 PM, revealed razors were not allowed in the residents' rooms unattended and stated they were supposed to be signed out one at a time by staff and were to be properly disposed.</p> <p>4. A record review revealed Resident #23 was admitted to the facility on 04/27/11 with diagnoses to include Senile Dementia with Delirium, Macular Degeneration, Depressive Disorder, Anxiety, Hearing Loss and Aortic Valve Disorders.</p> <p>A review of the comprehensive care plan, dated 05/27/11, for potential for falls related to generalized weakness, unsteady gait, poor vision and rolling walker to ambulate revealed Resident</p>	F 323		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/04/2011
FORM APPROVED
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F 323	<p>Continued From page 12</p> <p>#23 required assistance during transfer and mobility and was to have a bed alarm and a chair alarm.</p> <p>An observation, on 07/21/11 at 1:30 PM, revealed the resident was sitting in his/her bed with a wheel chair nearby, and the chair alarm was sounding. At 1:33 PM, the chair alarm continued to sound and there were no staff in the hall and no one responded to the alarm. At 1:38 PM, Certified Nurse Aide (CNA) #6 came to the room and assisted the resident into the wheelchair and went out of the room.</p> <p>Interviews with Licensed Practical Nurse (LPN) #4 and Registered Nurse (RN) #2, on 07/21/11 at 1:55 PM, revealed they were able to hear chair alarms and bed alarms from the nurses' station. LPN #4 and RN #2 both stated the alarms could be heard adequately at the nurses' station and the alarms were usually kept on high. When the staff were asked about Resident #23's chair alarm sounding for seven minutes without a response, they stated, "it was an all day thing for Resident #23 and he/she got up and down all day long." LPN #4 went to check the resident's chair alarm and reported the alarm was on low. She stated Resident #23 knew how to turn the alarm off.</p> <p>An interview with the Director of Nursing (DON), on 07/21/11 at 6:55 PM, revealed she expected staff members to respond to the resident's alarms as soon as they heard it. When asked if seven minutes was a longer time than expected, she stated she expected the alarms to be answered immediately.</p>	F 323			

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

PRINTED: 08/04/2011
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 13</p> <p>5. A record review revealed Resident #7 was admitted to the facility on 09/28/10 with diagnoses to include Chronic Airway Obstruction, Chronic Obstruction Pulmonary Disease, Emphysema and Hypoxemia.</p> <p>A review of the nurse's note, dated 07/10/11, revealed Resident #7 was agitated because he/she lost his/her lighters. LPN #5 documented, "He/she had several lighters at one time and did not know where he/she put them. He/she wanted the staff's lighters, but when he/she borrowed them, he/she refused to return the lighters. A CNA went out and got the resident a lighter and put his/her name on it. The CNA directed him/her to bring it back to the desk and not to put it in his/her pocket or hide it in his/her room."</p> <p>An interview with LPN #5, on 07/21/11 at 2:15 PM, revealed she recalled the incident with Resident #7 on 07/10/11, when he/she came to the the nurse's desk and did not have a lighter. She stated, "he/she lost his/her cigarettes and lighters. He/she was supposed to bring them back to the desk when he/she came in from smoking. There was no lighter in the drawer at the nurse's station. We searched his/her room and one of the staff went out with him/her and lit the resident's cigarette." She stated the facility did not require the oncoming and off-going shifts to count the cigarette lighters. LPN #5 stated, "I would not know if the resident returned them or not, and I do not know what he/she did with the lighters."</p> <p>An interview with LPN #1, on 07/21/11 at 9:00 AM, revealed Resident #7 did not have designated smoke times. According to LPN #1,</p>	F 323			

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

PRINTED: 08/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/21/2011
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F 323	Continued From page 14 he/she smoked eight to ten times per day and stated his/her cigarettes and lighters should be stored at the nurse's station. She stated none of the residents were supposed to have cigarettes and lighters in the rooms. An interview with KMA #2, on 07/21/11 at 9:15 AM, revealed staff members collected cigarette lighters when the residents returned from smoking. She stated, "Lighters were kept in an unlocked drawer at the nurse's station. There was no assignment sheet to check for accountability of lighters." She was not aware of a facility policy related to smoking.	F 323			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, review of policy/procedure and interview, it was determined the facility failed to ensure oxygen cylinders were stored appropriately. Observations, on 07/19/11 and 07/21/11, revealed oxygen cylinders sat directly on the floor and were not secured in a	F 328	1. Oxygen cylinders have been stored in a designated rack on east wing clean utility room. 2. All residents have the potential to be affected by deficient practice. All oxygen cylinders have been checked for appropriate storage concerns have been corrected and will be monitored as stated below. 3. In-services initiated 8/5/2011 and will continue through 8/19/2011 on proper storage/security of oxygen cylinders by SDC. Any staff not attending scheduled in-service will not be allowed to work until they have been in-serviced. All new hires will be trained during orientation. 4. Oxygen cylinders to be checked every shift on rounds to assure cylinders are in racks, by charge		

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

PRINTED: 08/04/2011
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OMB NO. 0938-0391

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F 328	Continued From page 15 rack. Findings include: A review of a safety policy/procedure, "Compressed Gas Safety," dated 05/00, revealed "In storage, restrain cylinders of all sizes by straps, chains or suitable stand to prevent them from falling". An observation, on 07/19/11 at 11:00 AM, revealed an oxygen cylinder sat directly on the floor in the East Unit clean utility room. The Assistant Director of Nursing (ADON) secured the oxygen cylinder at the time and stated he usually checked the cylinders daily. An observation, on 07/21/11 at 4:45 PM, revealed another oxygen cylinder sat directly on the floor in the East Unit clean utility room. An interview with the Director of Nursing (DON), on 07/21/11 at 4:45 PM, revealed oxygen cylinders were to be secured in a rack and not to be left sitting directly on the floor.	F 328	nurses. Daily rounds sheets will be reviewed weekly by DON and findings reported to Executive QA Committee quarterly.	09/02/11
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure that it was free of medication error rates	F 332	1. Residents number 3, 18 and 19 will receive medications that are in accordance with physician's orders. These services will be provided and meet professional standards of facility. 2. All residents have the potential to be affected by this deficient practice of professional standards.	

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

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F 332	<p>Continued From page 16</p> <p>of five percent or greater. Observations during the medication pass for one resident (#3), in the selected sample of 17, and for two residents (#18 and #19), not in the selected sample, revealed there were three errors out of 43 opportunities, which resulted in a six per cent medication error rate.</p> <p>Findings include:</p> <p>A review of the policy/procedure, "Routine Hours of Medication Administration," undated, revealed "the times for the medication administration, unless facility staff members requested an alternate schedule, were noted to be twice a day medication dosing before meals (BID ac), at 7:00 AM and 6:00 PM; three times a day (TID) doses were scheduled for 8:00 AM, 12:00 PM and 4:00 PM, or 8:00 AM, 12:00 PM and 8:00 PM. Routine medications may be administered one hour before or after the time indicated on the Medication Administration Record (MAR). The one hour time frame may be exceeded as long as this did not cause the resident discomfort or jeopardize the resident's health and safety."</p> <p>A review of the "Clinical Nursing Skills and Techniques," written by Potter and Perry, revealed the "Five Rights of Drug Administration" were the right drug, the right dose, the right resident, the right route, and the right time. When preparing a medication dosage, always check the label of the drug container with the physician's order or MAR three times as follows: before removal of the medication from the drawers or the shelf; as the amount of the drug was removed from the container; and before returning the container to storage.</p>	F 332	<p>3. In-services initiated 8/5/2011 and continues through 8/19/2011 by DON, SDC and QA for all licensed nurses and KMA's to include professional standard and facility policy of providing medications. Any staff not attending scheduled in-service will not be allowed to work until they have been in-serviced. All new hires will be trained during orientation.</p> <p>4. Administrative nurses will complete 5 med pass audits per week X 4 weeks, then 5 per month X 3 months. Any concerns will be reported to the DON immediately. The result of the audits will be reviewed by the DON monthly. Audit reports will be reviewed quarterly by the executive QA committee.</p>	09/02/11	

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

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F 332	<p>Continued From page 17</p> <p>1. A record review revealed Resident #3 was admitted to the facility on 11/11/03 with diagnoses to include Constipation and Dysphagia.</p> <p>A review of the physician's orders, dated 07/11, revealed "Colace liquid 50 milligrams (mg) in 5 ml to equal 100 mg by mouth (po) twice daily (BID) or 100 mg per dose."</p> <p>An observation of a medication pass, on 07/20/11 at 4:00 PM, revealed Kentucky Medication Aide (KMA) #5 poured five (5) milliliters (ml) from a bottle of Colace liquid to equal 50 mg.</p> <p>An interview with KMA #5, on 07/20/11 at 4:45 PM, revealed she looked at the top line of the MAR for Colace liquid, and this was the mixture of the medication amounts suspended in the liquid or Colace 50 mg in five (5) ml. She stated she administered Colace 50 mg po to the resident "all this week."</p> <p>An interview with Licensed Practical Nurse (LPN) #13, on 07/20/11 at 4:50 PM, revealed the resident should have received Colace 100 mg or 10 ml.</p> <p>2. A record review revealed Resident #18 was admitted on 06/28/11 with diagnoses to include Pneumonia and Altered Mental Status.</p> <p>A review of the physician's orders, dated 07/11, revealed "Buspar 10 mg po three times a day (TID), at 9:00 AM, 3:00 PM and 9:00 PM."</p> <p>An observation of a medication pass, on 07/20/11 at 4:17 PM, revealed KMA #5 administered</p>	F 332		

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

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FORM APPROVED
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F 332	<p>Continued From page 18 Buspar 10 mg po to Resident #18.</p> <p>An interview with KMA #5, on 07/20/11 at 5:15 PM, revealed she should administer Buspar before 4:00 PM, and stated "I just missed it."</p> <p>An interview with LPN #13, on 07/20/11 at 4:50 PM, revealed she expected Buspar to be administered one hour before 3:00 PM or at least before 4:00 PM.</p> <p>3. A record review revealed Resident #19 was admitted to the facility on 12/30/08 with diagnoses to include Spinal Cord Injury, Quadriplegia, Acute Peptic Ulcer and Convulsions.</p> <p>A review of the physician's orders, dated 07/11 revealed "Carafate suspension one gram (gm) by mouth (po) before meals."</p> <p>An observation of a medication pass, on 07/20/11 at 8:10 AM, revealed LPN #4 administered Carafate liquid suspension one (1) gm to Resident #19. Resident #19 just finished the breakfast meal being fed to him/her by a staff member.</p> <p>An interview with LPN #4, on 07/20/11 at 2:00 PM, revealed she could not always administer the</p>	F 332			

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

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FORM APPROVED
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F 332	Continued From page 19 medication prior to meals due to being understaffed and answering call lights. She stated the Carafate should be administered prior to Resident #19's breakfast meal. An interview with the DON, on 07/21/11 at 1:10 PM and 5:40 PM, revealed the KMA should have administered the Colace one hour before or one hour after the scheduled dose, and should have compared the MAR with the physician's orders. Carafate should be administered at least 30 minutes before the meal was served. She also stated "we help when the staff are challenged," and LPN #4 should have communicated, because a Charge Nurse could have assisted with the medication administration.	F 332		
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	F 441	1. SRNA number I0 and 11 involved in resident number 3's care during survey have been re-inserviced on the handwashing policy and procedure which includes directions for when gloves should be changed. Resident number 3 assessed for s/s infection – none noted. 2. All residents have the potential to be affected by the deficient practice. Concern has been corrected and will monitor as stated below. 3. In-services initiated 7/19/2011 and continues through 8/19/2011 for all nursing staff by SDC regarding preventing the spread of infections as related to staff washing their hands and changing gloves after each	

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

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F 441	<p>Continued From page 20</p> <p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions 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, interviews and record reviews, it was determined the facility failed to ensure staff washed their hands and/or changed gloves, after each direct resident contact in which hand washing and/or glove changing was indicated by accepted professional practice, for one resident (#3), in the selected sample of 17.</p> <p>Findings include:</p> <p>A review of the policy/procedure, "Standard Precautions," dated 08/05, revealed "the nurse was to remove gloves promptly, before he/she touched non-contaminated items and environmental surfaces and before going to another resident, and were to wash his/her hands to avoid the transfer of microorganisms to other</p>	F 441	<p>resident contact for which handwashing is indicated by accepted professional practice. Any staff not attending scheduled in-service will not be allowed to work until they have been in-serviced. All new hires will be trained during orientation.</p> <p>4. Administrative Nurses will monitor nursing staff providing incontinent care on 10 residents per week X 4 weeks, then 10 residents monthly X 3 months; to ensure proper handwashing/glove changing is performed after all direct resident contact for which handwashing and/or glove changing is indicated per accepted professional practice. Immediate retraining will be provided by Administrative Nurses if indicated. The result of the audits will be reviewed by the Director of Nursing monthly. Audit reports will be reviewed by Executive QA Committee quarterly.</p>	9/02/11

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2011
NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42026	
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F 441	<p>Continued From page 21 residents or environments."</p> <p>A record review revealed Resident #3 was admitted to the facility on 11/11/03 with diagnoses to include Cerebrovascular Accident and Lack of Coordination.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 06/09/11, revealed the resident was moderately cognitively impaired and dependent on staff members for all of the resident's care needs and was incontinent of bowel and bladder.</p> <p>An observation, on 07/20/11 at 10:30 AM, revealed State Registered Nurse Aide (SRNA) #10 and SRNA #11 provided perineal care for Resident #3, who was incontinent of bowel. After the stool was cleaned off and the soiled brief was disposed of into a plastic bag placed on the bed, the SRNAs proceeded to apply an ointment on the resident's reddened groin, using the same gloves which were used to wash the resident's stool. The SRNAs picked up the disposable wipe dispenser several times, prior to removing their soiled gloves and placed the dispenser on the bed, on the bedside table and in the resident's drawer, prior to removal of the soiled gloves and then washed their hands.</p> <p>Interviews with SRNA #10 and SRNA #11, on 07/20/11 at 10:45 AM, revealed they "did not really think about it" when asked about the transfer of microorganisms during the incontinent care, but stated they should have washed their hands before application of the ointment.</p> <p>An interview with License Practical Nurse (LPN) #1, on 07/20/11 at 10:47 AM, revealed the</p>	F 441		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/04/2011
FORM APPROVED
OMB NO. 0938-0391

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F 441	Continued From page 22 SRNAs should wash their hands prior to application of the ointment and stated the disposable wipes "were not a good design." An interview with the Director of Nursing (DON), on 07/21/11 at 5:40 PM, revealed she expected the SRNAs to dispose of their gloves after incontinent care and wash their hands prior to the application of the ointment.	F 441			

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

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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: 1978</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V Unprotected</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator installed in 1979. Fuel source is liquid propane.</p> <p>A standard Life Safety Code survey was conducted on 07/19/2011. Lakeway Nursing and Rehabilitation was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred ten (110) beds and the census was eighty five (85) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p><u>RESPONSE PREFACE</u></p> <p>Lake Way acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Lake Way's response the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Lake Way reserves the right to submit documentation to refute any of the stated deficiencies of this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any administrative or legal proceeding.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Wanda Buzal

TITLE

Administrators

(X6) DATE

8/25/2011

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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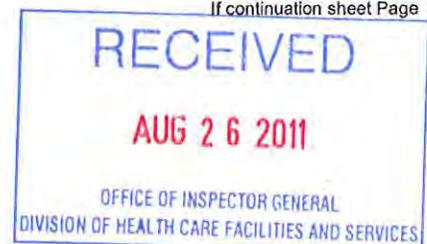
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K 000	Continued From page 1	K 000		
K 027 SS=F	<p>Deficiencies were cited with the highest deficiency identified at F level. CFR: 42 CFR 483.70(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure access doors in smoke barriers were installed to meet NFPA Standard. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred ten (110) beds with a census of eighty five (85) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/19/11 at 1:45 PM, with the Maintenance Supervisor revealed unrated homemade smoke barrier access doors located</p>	K 027	<ol style="list-style-type: none"> Maintenance personnel sealing vertical doors and making fire rated from bottom that extends through ceiling that is fire rated. All residents have the potential to be affected in the event of an emergency or fire. The concern has been corrected and will monitor as stated below. Maintenance staff and Administrator reviewed NFPA Life Safety Code Standards (7.2.1.14, 19.2.2.2.6, 19.3.7.5., 19.3.7.6, 19.3.7.7) on 8/05/2011 regarding installation of access doors in smoke barriers to meet NFPA standard. Current copy of Life Code Safety NFPA 101 2000 edition available for reference. QA audits will be performed per maintenance staff weekly to ensure smoke barriers are effective with corrections made as needed. Findings will be reviewed weekly by Facility Administrator. 	08/18/11



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

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OMB NO. 0938-0391

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K 027	Continued From page 2 in the attic. Interview, on 07/19/11 at 1:45 PM, with the Maintenance Supervisor confirmed the observation and indicated he was unaware that the doors in the attic must be rated for use. Reference: NFPA 101 (2000 Edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Continuity 8.3.2 Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.	K 027		
K 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 other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	1. Bunge cord removed from laundry door 7/19/2011. 2. All residents have the potential to be affected in the event of an emergency/fire. All other doors in the facility have been checked for obstructions. The concern has been corrected and will monitor as stated below. 3. Maintenance staff and Administrator reviewed NFPA Life Safety Code Standards (8.4.1 and/or 19.3.5.4 and 19.3.2.1) on protection	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 029	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to meet the requirements of Protection of Hazards, per NFPA Standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartment, residents, staff and visitors. The facility is licensed for one-hundred ten (110) beds with a census of eighty five (85) on the day of the survey. The findings include: Observation, on 07/19/11 at 11:55 AM, with the Maintenance Supervisor revealed the door to the Laundry Room was held open with a bungee cord. Interview, on 07/19/11 at 11:55 AM, with the Maintenance Supervisor revealed he was unaware that the door was being held open with the bungee cord. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 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	K 029	of hazardous areas 8/5/2011. Life Safety Code NFPA 2000 edition available for reference. 4. QA audits will be performed throughout the facility weekly by Maintenance staff to monitor compliance to assure all fire doors are functioning according to NFPA standard and corrections made as needed. Findings to be reviewed weekly by the Facility Administrator.	08/18/11



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

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K 029	Continued From page 4 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 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	1. Chain link fence gate across sidewalk leading to public unlocked 7/19/2011. 2. All residents have the potential to be affected in the event of an emergency maintenance staff checked all other exits for deficient practice. The concern has been corrected and will monitor as stated below.	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 038	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access was maintained, according to NFPA standards. The deficiency had the potential to affect four (4) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred ten (110) beds with a census of eighty five (85) on the day of the survey. The findings include: Observation, on 07/19/11 at 11:30 AM, with the Maintenance Supervisor revealed a locked chain link fence gate across the sidewalk leading to the public way. Two exit doors had sidewalks that lead to this location, which is located directly out from the exit door next to room 222. Interview on 07/19/11 at 11:30 AM, with the Maintenance Supervisor revealed they kept the gate locked to keep strangers from wandering up to the building. NFPA reference: NFPA 101 (2000 edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in	K 038	3. Maintenance staff and Administrator reviewed NFPA 101 Life Code Standards (7.1, 19.2.1) on exit accessibility 8/5/2011. Current Life Safety Code manual accessible for reference. 4. Maintenance staff to audit all exits weekly on maintenance QI tool report findings to Administrator weekly. Reports will be reviewed by executive QA committee quarterly.	08/18/11



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K 038	Continued From page 6 health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2:* Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. Reference: NFPA 101 (2000 edition) 7.1.10 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	K 038		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure fire drills	K 050	1. Drill times will be changed to alternating times every shift quarterly. 2. All residents have the potential to be affected by the deficient practice. 3. Maintenance staff and Administrator reviewed NFPA Standard (19.7.1.2) on conducting fire drills at unexpected times each shift quarterly 8/5/2011. Current Life Safety Manual accessible for reference.	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 050	Continued From page 7 were conducted at unexpected times under varied conditions. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, staff and residents. The facility is licensed for one hundred ten (110) beds with a census of eighty five (85) residents on the day of the survey. The findings include: Record review, on 07/19/11 at 2:00 PM, with the Maintenance Supervisor revealed the fire drills were not being conducted at unexpected times under varied conditions. Interview, on 07/19/11 at 2:00 PM, with the Maintenance Supervisor revealed he was unaware the fire drills were not conducted as required. Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050	4. Safety QA team to audit fire drills on monthly basis to assure compliance with alternating times. Findings will be reviewed by Safety Committee monthly. Findings reported to Administrator monthly.	08/18/11
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler	K 056	1. Premier Fire Protection, Inc. has been contacted to install sprinklers on porches outside rooms 100 and 125. Scheduled to install 9/2/2011. 2. All residents have potential to be affected by this deficient practice during an emergency/fire. All other exits have been checked to assure required sprinkler systems are equipped with water flow and tamper	



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K 056	Continued From page 8 systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, according to NFPA standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred ten (110) beds with a census of eighty five (85) on the day of the survey. The findings include: Observation, on 07/19/11 at 12:50 PM, with the Maintenance Supervisor revealed two (2) porches located outside exit doors next to room number 100, and 125 to be extend out four (4) foot or greater, made of combustible materials, and were not sprinkler protected. Interview, on 07/19/11 at 12:50 PM, with the Maintenance Supervisor confirmed the observation. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or	K 056	switches which are electronically connected to the building fire alarm system. 3. Maintenance staff and Administrator reviewed Life Safety Code NFPA 13 and 25 (19.3.5) on automatic sprinkler systems 8/5/2011. Current Life Safety Manual accessible for reference. 4. Maintenance to monitor on daily rounds with corrections made as needed. Findings will be reported to Administrator weekly and reviewed by the executive QA Committee quarterly.	09/02/11



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K 056	Continued From page 9 limited combustibile construction.	K 056		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system according to NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred ten (110) beds with a census of eighty five (85) on the day of the survey. The Findings Include: Observation, on 07/19/11 at 12:20 PM, with the Maintenance Supervisor revealed items stored on a shelf within 18 inches of the sprinkler head located in the dry storage area of the Kitchen. Interview, on 07/19/11 at 12:20 PM, with the Maintenance Supervisor revealed they were unaware someone had placed the items within 18 inches of the sprinkler head. Reference: NFPA 13 (1999 Edition)	K 062	1. Items stored on shelf in kitchen have been rearranged on other shelving 07/19/2011. 2. All residents have potential to be affected by deficient practice. Maintenance checked all areas of facility to assure no items stored within 18" of sprinkler head. The concern has been corrected and will monitor as stated below. 3. Maintenance staff and Administrator reviewed Life Safety Code Standard (19.7.6,4.6.12, NFPA 13, NFPA 25, and 9.7.5). Life Safety Code Manual accessible for reference. Inservice initiated for all staff 8/5/2011 and will continue through 8/18/11 regarding storage of items within 18" of sprinkler head. Any staff not attending scheduled inservice will not be allowed to work until they have been inserviced. All new hires will be trained during orientation. 4. Maintenance staff and Administrative staff will monitor on daily rounds and corrections made immediately as needed. Findings	



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K 062	Continued From page 10 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.	K 062	reviewed by the Administrator weekly. Reviewed by QA Safety Committee on a monthly basis.	8/18/11
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access according to NFPA standards. The deficient practice had the potential to affect six (6) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred ten (110) beds with a census of eighty five (85) on the day of the survey. The findings include: Observations, on 07/19/11 at 11:30 AM, revealed that wheelchairs, refreshment carts, linen carts, lifts, and Med carts were being stored in the East and West Wing corridors. An interview, on 07/19/11 at 11:30 AM, with the Maintenance Supervisor confirmed the	K 072	1. All wheelchairs refreshment carts, linen carts, lifts and med carts have been relocated from the corridor to help prevent obstruction in the case of fire or other emergencies (7/24/2011). 2. All residents have the potential to be affected in the event of a facility emergency; the concern has been corrected and will be monitored as stated below. 3. Maintenance Staff and Administrator reviewed NFPA Life Safety Code Book (7.1.10) regarding insuring that all corridors remain free from obstruction 8/5/2011. Current Life Safety Manual accessible for reference. In-services initiated for all staff 8/5/2011 and will continued through 8/18/2011 regarding ensuring that all corridors remain free from obstruction. Any staff member not attending scheduled in-service will not be allowed to work until they have attended scheduled	



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K 072	Continued From page 11 observations. 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.	K 072	in-service. All new hires will be trained during orientation.	
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress. This deficiency had the potential to affect three (3) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred ten (110) beds, with a census of eighty five (85) on the day of the survey. The findings include: Observation, on 07/19/11 between 10:30 AM and 3:30 PM, with the Maintenance Supervisor revealed an unapproved lock (slide bolt type) was installed on the egress side of doors located in the Soiled Utility Room, Activities Office, Nourishment Room, Shower Room, Medical Records Office, Kitchen, Dietary Manager Office, and a hook and loop latch located in Room 100 bathroom, East Hall.	K 130	4. Daily QA audits will be conducted throughout the facility by maintenace staff to monitor the compliance to insure that all corridors remain free from obstruction; with corrections made inmediately as needed. Audits will be reviewed on a weekly basis by facility Administrator to ensure compliance and reported to executive QA Committee quarterly.	8/18/11
		K 130	1. All unapproved locks (slide bolt type and hook & eye latches) located in soiled utility rooms, activities office, nourishment rooms, shower rooms, medical records office, kitchen, dietary managers office; room 100 bathroom on east hall have been removed as of 7/26/2011 to assure that all doors are maintained within a required means of egress. 2. All residents have the potential to be affected in the event of a facility emergency; the concern has been corrected and will be monitored as stated below.	



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K 130	Continued From page 12 Interview, on 07/19/11 between 10:30 AM and 3:30 PM, with the Maintenance Supervisor revealed he was aware of the locks, but not aware they could not be used. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130	3. Maintenance staff and Administrator reviewed NFPA 101; other LSC Deficiency reference NFPA 101 (2000 edition) 19.2.2.2.4 on 8/5/2011 regarding standard for doors within a required means to egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Current Life Safety Code Manual accessible for reference. Daily QA audits will be performed through out the facility by Maintenance staff to monitor for compliance to ensure that all doors are free of unapproved locks with corrections as needed.	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. The deficiency has the potential to affect four (4) of seven (7) smoke compartments, including residents, staff, and visitors. The facility is licensed for one hundred ten (110) beds with a census of eighty five (85) on the day of the survey. The findings include: Observations, on 07/19/11 between 10:30 AM and 3:30 PM, with the Maintenance /supervisor revealed: 1) Storage in front of the electrical panel in the	K 147	4. Findings will be reviewed by facility Administrator monthly to assure compliance. 1. A. Items in storage in front of electrical panels in housekeeping office and the mechanical rooms on east hall has been relocated on 8/8/2011. B. Extension cords in room 204, activities office and dietary office have been removed 8/8/2011.	08/18/11
		K 147		



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K 147	<p>Continued From page 13 Housekeeping Office, and the Mechanical Room located in the East Hall.</p> <p>2) Extension cords being used in rooms; 204, the Activities Office, and the Dietary Managers Office.</p> <p>3) Misuse of power strips; a. Power strips plugged into each other in the Staff development Coordinators Office. b. Medical equipment charger and refrigerator plugged into a power strip, in the Therapy Room. c. Hair dryers, and curling irons plugged into a power strip, in the Beauty Shop.</p> <p>4) Unlocked electrical panels located in the Dining Room Hall.</p> <p>Interview, on 07/19/11 between 10:30 AM and 3:30 PM, with the Maintenance Director confirmed all observations.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>Reference: NFPA 70 (1999 edition)</p>	K 147	<p>C. Power strips in staff development office have been unplugged from one another 8/03/2011.</p> <p>D. Medical equipment charger and refrigerator no longer plugged together into power strips in therapy room 7/21/2011.</p> <p>E. Hair dryer and curling irons now plugged separately in the beauty shop 7/20/2011.</p> <p>F. Electrical panel in dining room hall has lock applied 7/24/2011.</p> <p>2. All residents have the potential to be affected by this deficient practice; the concern has been corrected and will be monitored as stated below.</p> <p>3. Maintenance Staff and Administrator reviewed Life Safety Code Standard NFPA 70, and (9.1.2) on 8/5/11. Current Life Safety Code Manual accessible for reference. In-service initiated 8/5/2011 and will continue through 8/18/201 for all staff to include improper use of extension cords, power cords, electrical panel etc. Any staff member not attending scheduled in-service will not be allowed to work until they have been in-serviced. All new hires will be trained during orientation. QA team will perform inspections on daily rounds to assure</p>	



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K 147	Continued From page 14 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K 147	that no extension cords, power strips or electrical panel are not used improperly, corrections made as needed. Staff instructed not to use power cords, extension cords without approval from Maintenance Staff or Administrator. 4. Findings will be reviewed by the Administrator monthly.	08/18/11	

