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

Second SOD

PRINTED: 04/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185200		03/01/2012

RECEIVED MAY 2 2012 Division of Health Care Southern Enforcement Branch

NAME OF PROVIDER OR SUPPLIER: LETCHER MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE: 73 PIEDMONT DRIVE, P O BOX 747, WHITESBURG, KY 41858

(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 A standard health survey was conducted on 02/28-03/01/12. Deficient practice was identified with the highest scope and severity being at "D" level.	F 000	Letcher Manor does not believe nor does the facility admit that any deficiencies exist. Letcher Manor reserves all rights to contest the survey findings through informal dispute resolution, appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard of care, contract, obligation or position. Letcher Manor reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Letcher Manor does not waive, and reserves the right to assert in any administrative, civil, or criminal claim, action or proceeding. Letcher Manor offers its responses credible allegations of compliance and plan of correction as part of its on-going effort to provide quality care to residents. Letcher Manor strives to provide the highest quality of care while ensuring the rights and safety of all residents.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced	F 164	F164 483.10(e), 483.75(l)(4) PRIVACY/CONFIDENTIALITY OF RECORDS Letcher Manor strives to provide a dignified and private environment while providing care and medical treatment for our residents. It is the policy of this facility that all residents be treated with dignity. Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carla E. Dishuni — TITLE: Administrator — (X6) DATE: 5-2-12

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 164	Continued From page 1 by: Based on observation, interview, and review of the facility policy, the facility failed to provide personal privacy for one of twenty-four sampled residents (Resident #3). Observation on 02/28/12, at 6:30 PM, revealed Registered Nurse (RN) #1 failed to pull the privacy curtain during gastrostomy tube medication administration. Resident #3's abdomen was visible/exposed to anyone that passed by or entered the resident's room. The findings include: Review of the facility's policy titled Resident Dignity and Respect (dated 01/09/03) revealed residents should be examined and treated in a manner that maintained the privacy of the resident's body. The policy directed staff to close the resident's door or draw the privacy curtain to shield the resident from passersby. Observation on 02/28/12, at 6:30 PM, revealed Resident #3's abdomen and gastrostomy tube (G-tube) were visible from the hallway while RN #1 was administering medication to the resident via the G-tube. Upon entering the resident's room, RN #1 stated she had administered Phenobarbital (a medication to prevent seizures) to Resident #3 and would provide the water flush as ordered. Interview on 03/01/12, at 1:00 PM, with RN #1 revealed the RN was knowledgeable of the facility's policy to provide privacy during any treatment. RN #1 stated she was a new employee and didn't realize the curtain was not pulled around Resident #3's bed. RN #1 stated	F 164	door or drawn curtain shields the resident. Staff is provided education to this policy upon orientation and annually. This is evidenced as follows: 1. Resident #3 did not reveal signs or symptoms of concern, dissatisfaction or other adverse affects regarding privacy. The RN was aware of the facility policy to provide privacy. The RN stated the privacy curtain was pulled half way around the bed to provide privacy for the resident. The RN was not aware that the curtain had moved, or was not in proper position at the time of medication administration. Resident #3 is not verbal, and has severe cognitive impairment. The RN was re-educated by the Director of Nursing on the privacy policy on March 1, 2012. 2. To identify other residents who may have the potential to be affected, a survey and observation was conducted on March 2, 2012 for all residents. The survey was conducted with all alert and oriented residents; which included observations of privacy for their roommates who were non-verbal, cognitively impaired or dependent. Family members were also surveyed in regards to observation of privacy for non-verbal, cognitively impaired and dependent residents. No privacy issues were observed or reported. No other residents were found to have been affected by privacy issues. Other residents are not expected to be affected due to the implementation of #4 below. 3. To ensure the practice will not recur, educational in-services were held, by the Director of Nursing and Staff Coordinator, on March 13th and 16th, 2012 with all	

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F 164	Continued From page 2 maintaining residents' privacy was stressed in her recent orientation. Interview on 03/01/12, at 5:15 PM, with the Director of Nursing revealed staff should always provide privacy during care, G-tube medication administration, or during any treatment.	F 164	nursing staff regarding facility policy and procedure for providing privacy. Nursing staff included licensed and registered nurses and SRNAs, as well as nurse aides in training. RN #1 was re-educated on March 1, 2012 to the privacy policy. All new hires shall be oriented to the privacy policy and acknowledge this education was provided upon new hire orientation; and the policy shall be reviewed with staff if a concern is identified. In-services shall be conducted annually with all nursing staff in regards to resident rights. 4. To ensure solutions are sustained in regards to the adherence to the privacy policy, the Director of Nursing shall implement Quality Assurance measures, by the method of survey and observation. A ten (10) percent sample selection of all residents shall be conducted. This shall include survey of alert and oriented residents, survey of family members and/or observation of non-verbal, cognitively impaired and dependent residents. The QA Coordinator shall oversee reviews and compliance on a quarterly basis, and shall evaluate annually for on-going review. Evaluation reports will be distributed by the QA Coordinator to the Director of Nursing for review and appropriate action to be taken as necessary. If solutions are not maintained, dependent upon the cause, corrective action shall be implemented, including, but not limited to: #3 as mentioned above shall be initiated again, and/or sampling increased, and/or increase in periodic monitoring. 5. F164 March 16, 2012	3/16/12
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two of twenty-four sampled residents (Residents #4 and #7). The facility failed to provide nail care for Residents #4 and #7. Observations on 02/29/12, revealed Residents #4 and #7 had excessively long toenails. The findings include: The Director of Nursing (DON) confirmed the facility required staff to follow nail and foot care as outlined in the Sixth Edition of the Mosby's Textbook for Long-Term Care Nursing Assistants.	F 312		

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F 312	Continued From page 3 Review of the textbook revealed Certified Nursing Assistants (CNAs) were not permitted to cut or trim toenails of residents who had a diagnosis of diabetes or poor circulation, required a medication to thin the blood, or if the resident had very thick or ingrown toenails. The facility failed to provide a policy to direct staff related to providing diabetic foot/toenail care. 1. Review of the medical record revealed Resident #7 was readmitted to the facility on 10/24/09, with diagnoses of Diabetes Mellitus, Mental Retardation, and Schizophrenia. Review of the monthly physician's orders for February 2012 revealed Resident #7 would receive dental, eye, and podiatry consultations as needed. Further review revealed the last podiatry consultation was conducted on 05/12/09. Review of the annual Minimum Data Set (MDS) assessment completed on 10/06/11, revealed Resident #7 was dependent on staff for personal hygiene needs. Review of the comprehensive care plan for activities of daily living (ADL) revealed Resident #7 would receive nail care as needed. Review of the CNA care plan revealed Resident #7's nurse was to trim the resident's nails as needed. Review of the weekly skin assessment revealed no documentation of the condition of Resident #7's toenails. Observation during a bed bath provided by CNA #4 on 02/29/12, at 9:25 AM, revealed Resident #7's toenails were very long and thick. Interview with CNA #4 during the bed bath revealed the nurses were responsible for trimming Resident #7's toenails because the resident was diabetic. CNA #4 stated staff was required to communicate to the nurses any change found during bathing of	F 312	F312 483.25 (a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS Letcher Manor maintains that ADL care is provided for all dependent residents. Protocol for ADL nail and foot care is followed by utilizing the Sixth Edition of the Mosby's Textbook for Long-Term Care Nursing Assistants. The protocol outlines both the Nurse Aide and the RN or podiatrist duties for nail and foot care, as well as promoting safety and comfort. This is evidenced as follows: 1. Resident #4 nails were cut by the podiatrist on March 14, 2012. The responsible party had previously refused outside appointments, since 2009. Resident #7 nails were cut March 1, 2012. 2. Nursing Supervisors checked all resident's nails on February 29, 2012. No other residents were identified to have issues with nail care. 3. To ensure the practice will not recur, an educational in-service was held, by the Director of Nursing and Staff Coordinator, on March 13th and 16th, 2012 with all nursing staff regarding facility protocol for nail care. Nursing staff included licensed and registered nurses and SRNAs, as well as nurse aides in training. All new hires shall be oriented to the nail care protocol upon new hire orientation; and the protocol shall be reviewed with staff if a concern is identified. To ensure this issue does not recur, each resident will be scheduled for a weekly review of nail care needs. This review shall be performed by the Charge Nurse of each hall. New patients admitted or readmitted shall be assessed for proper nail care	

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F 312	Continued From page 4 the resident by making a note on the daily CNA assignment sheet or tell the nurse verbally. CNA #4 stated she was not sure if the nurse was aware of Resident #7's long and thick toenails because she had not been assigned to Resident #7 recently. Interview on 03/01/12, at 4:50 PM, with Licensed Practical Nurse (LPN) #1, who was assigned to provide care for Resident #7, revealed licensed staff was to cut the toenails of residents who had a diagnosis of Diabetes or if the resident required blood thinning medication. LPN #1 confirmed staff should provide nail care during the weekly skin assessments. LPN #1 stated she didn't feel staff could manage Resident #7's thick toenails and a podiatric consultation would be required. Interview on 03/01/12, at 5:15 PM, with the DON revealed the CNA assignment sheet directs which staff is responsible for providing nail care to residents. The DON stated if a resident is diabetic the assignment sheet will specify that the nurse is required to provide/cut the resident's nails. The DON stated nail care should be provided by staff as needed. 2. A review of the medical record revealed Resident #4 was admitted to the facility on 02/15/12, with diagnoses of History of Left Hip Fracture, History of Small Cell Cancer, Hypertension, Respiratory Failure, and Weakness. Review of monthly physician's orders for February 2012 revealed Resident #4 would receive dental, eye, and podiatry services. The Minimum Data Set (MDS) assessment and comprehensive care plan were not complete at the time of survey.	F 312	within twenty-four (24) hours of the admission by the admission nurse. 4. To ensure solutions are sustained in regards to the above, the Director of Nursing shall implement Quality Assurance measures, to review quarterly, to ensure the adherence to facility policy for grooming, including nails. Unit Coordinators shall be assigned to review a ten (10) percent sample selection of all residents from each hall, to provide direct observation, and ascertain for appropriate nail care. The QA Coordinator shall oversee reviews and compliance on a quarterly basis, shall report to the Director of Nursing any findings that are not within protocol, and shall evaluate annually for on-going review. If solutions are not maintained, corrective action shall be implemented by the Director of Nursing and the policy shall be reviewed with staff if a concern is identified. 5. F 312 March 16, 2012 F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS It is the policy of Letcher Manor to provide guidelines for the safe handling of foods. The guideline utilized by the facility was distributed by the Public Department of Health. The guideline entitled "Gloves" states that the KY Food Establishment Act and Retail Food Code ***does not require the use of plastic gloves***, and states that "hand washing must be done as often as is necessary ... to keep them clean." It also states, "Food shall be ***prepared*** with the least manual contact, using suitable utensils." The FDA does recommend the use of plastic gloves and for food to not be touched by ***food***	3/16/12

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F 312	Continued From page 5 Review of the CNA care plan revealed Resident #4 required extensive assistance per staff with grooming and would have nails trimmed as needed. Review of the medical record revealed Resident #4 had not been recommended for a podiatric consultation since being admitted to the facility. Further review revealed the weekly skin assessments did not address the condition of Resident #4's toenails. Observation during a skin assessment performed by Registered Nurse (RN) #3 and LPN #1 on 02/29/12, at 2:20 PM, revealed Resident #4's toenails were thick and excessively overgrown over the ends of the resident's toes. Interview with LPN #1 during the skin assessment revealed the CNAs and LPNs were responsible for trimming residents' toenails unless they were diabetic, and then it was the RN's responsibility. Further interview with LPN #1 revealed after observation of Resident #4's toenails during the skin assessment she felt the resident's toenails were in need of trimming and she would do it.	F 312	***service workers*** hands; but, it also makes allowance for contact with ready-to-eat foods with bare hands under certain circumstances as specified in Food Code 3-301.11(D), which includes hand washing. Letcher Manor educates staff to utilize proper hand washing and also safe handling of foods. This is evidenced by: 1. For un-sampled Resident B and Resident C, there have been no signs or symptoms of infectious process or adverse affects from the minimal contact with food. SRNA #2 and SRNA #3 both reported that proper hand washing had been implemented prior to having the least manual contact with the resident's food. Both SRNAs were educated on February 29th regarding facility policy of infection control and proper food handling. 2. To identify other residents who may have the potential to be affected, all alert and oriented residents who receive dining assistance were interviewed, and all non-verbal, non-interviewable residents were observed by the SRNA Preceptors. There were no other incidents reported of staff handling of resident's food with least minimal contact. Other residents are not expected to be affected due to the implementation of #3 and #4 below 3. To ensure infection control is maintained with the least manual contact with resident's food, an educational in-service was held, by the Director of Nursing and the Staff Coordinator, on March 13th and 16th, 2012. The in-service was held with all nursing, activities and dietary staff regarding facility guidelines and policy for	
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;	F 441		

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F 441	Continued From page 6 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe and sanitary environment to prevent the development and transmission of disease and infection for three unsampled residents (unsampled Residents A, B, and C). Observation of Restorative Dining on 02/28/12, at the noon meal, revealed staff	F 441	infection control and proper food handling. Nursing staff included licensed and registered nurses and SRNAs, as well as nurse aides in training. All new hires shall be oriented to the policy during new hire orientation; and the policy shall be reviewed with staff if a concern is identified. 4. To ensure that solutions are sustained, proper food handling will be included in annual in-services for both infection control and hand washing review and education. The Director of Nursing shall implement Quality Assurance measures, to review on a quarterly basis, the adherence to facility policy for proper food handling and infection control protocol. The QA Coordinator shall randomly select ten (10%) of residents who require dining assistance, and interview or observe for proper food handling and infection control adherence to facility policy. The QA Coordinator shall oversee reviews and compliance on a quarterly basis, shall report to the Director of Nursing any findings that are not within protocol, and shall evaluate annually for on-going review. If solutions are not maintained, corrective action shall be implemented by the Director of Nursing and the protocol shall be reviewed with staff if a concern is identified. 5. F 441 March 16, 2012	3/16/12

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F 441	Continued From page 7 handled resident's cornbread and grilled cheese sandwich with bare hands. The findings include: Review of the facility's policy titled Gloves (not dated) revealed the Kentucky Food Establishment Act directed staff that food should be prepared with the least manual contact by using suitable utensils. The policy recommended foods should not be touched by a food service worker's hands. Observation on 02/28/12, at 11:35 AM, revealed staff assisted five residents with the lunch meal in the Restorative Dining room. Further observation revealed Certified Nursing Assistant (CNA) #3 delivered and set up a tray for unsampled Resident A. CNA #3 was observed to pick up the resident's cornbread with bare hands to apply butter/margarine on the cornbread. Continued observation revealed CNA #2 set up a meal tray for unsampled Resident B. CNA #2 lifted the cornbread with her bare hands to apply salt to the resident's macaroni and cheese and greens. CNA #2 then assisted unsampled Resident C who required maximum assistance for feeding. CNA #2 was observed to handle a grilled cheese sandwich and tear the sandwich into bite-size portions and placed the bite-size portions in a bowl of tomato soup. CNA #2 then fed the sandwich and soup to unsampled Resident C. Interview on 02/29/12, at 1:30 PM, with CNA #2 revealed staff should not touch residents' food with bare hands. CNA #2 confirmed she handled	F 441		

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F 441	Continued From page 8 the grilled cheese sandwich but could not remember handling the cornbread. CNA #2 stated she did not follow proper infection control by handling residents' food with her bare hands. Interview on 02/29/12, at 1:30 PM, with CNA #3 confirmed she handled unsampled Resident A's cornbread with her bare hands. CNA #3 stated she was knowledgeable of the requirement to avoid contact with residents' food. CNA #3 had no explanation of why she handled the cornbread with her bare hands. Interview on 02/29/12, at 2:45 PM, with the DON revealed staff had been in-serviced and should not touch residents' food with their bare hands. The DON stated the staff should use silverware to apply butter/margarine or to cut up residents' food.	F 441		

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MAR 20 2012
Division of Health Care
Southern Enforcement Branch

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STREET ADDRESS, CITY, STATE, ZIP CODE: 73 PIEDMONT DRIVE, P O BOX 747, WHITESBURG, KY 41858

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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1992 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type V (111) SMOKE COMPARTMENTS: Four COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Type II diesel generator A life safety code survey was initiated and concluded on 02/29/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	Letcher Manor does not believe nor does the facility admit that any deficiencies exist. Letcher Manor reserves all rights to contest the survey findings through informal dispute resolution, appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard of care, contract, obligation or position. Letcher Manor reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Letcher Manor does not waive, and reserves the right to assert in any administrative, civil, or criminal claim, action or proceeding. Letcher Manor offers its responses, credible allegations of compliance and plan of correction as part of its on-going effort to provide quality care to residents. Letcher Manor strives to provide the highest quality of care while ensuring the rights and safety of all residents.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in	K 025	K025 NFPA 101 LIFE SAFETY CODE STANDARD Letcher Manor has contracted with a Professional Service for which they are responsible for quarterly and annual inspections, and for notifying the facility of any deficient area in need of correction. New fire-rated UL approved attic access doors were installed and in place effective February	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carla Bishop — TITLE: Administrator — (X6) DATE: 3/24/12

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185200	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/29/2012

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LETCHER MANOR	73 PIEDMONT DRIVE, P O BOX 747 WHITESBURG, KY 41858

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K 025	Continued From page 1 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 observation and interview, the facility failed to maintain fire/smoke barriers with a half-hour fire resistance rating as required. The facility failed to ensure that penetrations at smoke barrier walls were properly sealed. The facility failed to maintain access doors in the smoke barrier walls. This deficient practice affected four of four smoke compartments, staff, and 119 residents. The facility has the capacity for 142 beds with a census of 119 on the day of the survey. The findings include: During the Life Safety Code survey on 02/29/12, at 11:30 AM, with the Director of Maintenance (DOM), the fire/smoke barrier wall in the A Hall attic area was observed to have gaps around piping and wiring that were penetrating this wall. The access door in this wall was left open with the closing mechanism detached from the door. During the survey two other fire/smoke barrier walls were observed with these same types of penetrations with one other access door not	K 025	2010. Telephone/Computer Contractors had been in the attic area the Friday prior to the survey on February 24, 2012. All doors were ensured closed and latched; and all gaps were sealed properly on February 29, 2012. To ensure solutions are maintained, maintenance staff shall conduct inspections after each contractor completes their services, and shall perform safety checks each month via routine inspection of the areas. **K025** February 29, 2012 K147 NFPA 101 LIFE SAFETY CODE STANDARD New hospital grade receptacles have been purchased and shall be installed as replacement of existing non-hospital grade receptacles need replacement. Letcher Manor Director of Maintenance has been educated on using the required circuit-testing device to properly test the Ground Fault Circuit Interrupter (GFCI) receptacles near wet areas. The tester was available at the time of survey, and is currently in use, effective February 29, 2012. To ensure solutions are maintained, maintenance staff shall perform safety checks and inspection of all receptacles periodically, and as required. **K147** March 2, 2012	2/29/12 3/2/12

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K 025	Continued From page 2 closed all the way. Fire/smoke barrier walls must be properly maintained to prevent fire and smoke from spreading to other areas of the facility in a fire situation. An interview with the DOM on 02/29/12, at 11:30 AM, revealed contract work was performed in the attic about a month ago. The DOM stated these walls were not inspected after the work was completed. 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. 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: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or	K 025		

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K 025	Continued From page 3 2. Be made by an approved device designed for the specific purpose.	K 025		
K 147 SS=F	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 interview, the facility failed to ensure that electrical wiring and standards met NFPA requirements. This deficient practice affected four of four smoke compartments, staff, and 119 residents. The facility has the capacity for 142 beds with a census of 119 on the day of the survey. The findings include: During the Life Safety Code survey on 02/29/12, at 11:30 AM, an interview with the Director of Maintenance (DOM) revealed the DOM was not replacing existing receptacles with hospital grade receptacles at resident bed locations as required. The DOM stated he was not aware hospital grade receptacles were required at resident bed locations when the receptacles needed to be replaced. The DOM stated he tested Ground Fault Circuit Interrupter (GFCI) receptacles at resident room sinks with the test buttons located on the receptacles. GFCI receptacles help prevent personnel from accidental shock by receptacles located near wet areas. The DOM was not aware GFCI receptacles required a circuit-testing device to properly test these types	K 147		

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K 147	Continued From page 4 of receptacles. Reference: NFPA 70 (1999 Edition). 517-18. General Care Areas (b) Patient Bed Location Receptacles. Each patient bed location shall be provided with a minimum of four receptacles. They shall be permitted to be of the single or duplex types or a combination of both. All receptacles, whether four or more, shall be listed "hospital grade" and so identified. Each receptacle shall be grounded by means of an insulated copper conductor sized in accordance with Table 250-122. Exception No. 1: Requirements of Section 517-18(b) shall not apply to psychiatric, substance abuse, and rehabilitation hospitals meeting the requirements of Section 517-10(b)(2). Exception No. 2: Psychiatric security rooms shall not be required to have receptacle outlets installed in the room. FPN: It is not intended that there be a total, immediate replacement of existing non-hospital grade receptacles. It is intended, however, that non-hospital grade receptacles be replaced with hospital grade receptacles upon modification of use, renovation, or as existing receptacles need replacement.	K 147		