

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

PRINTED: 04/03/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185229	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/20/2012
NAME OF PROVIDER OR SUPPLIER BARREN COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 WESTWOOD ST. GLASGOW, KY, 42141		
(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 On 03/20/12, an onsite revisit to the annual survey (03/06/12 -03/15/12), was conducted which determined Immediate Jeopardy (IJ) had been removed at: 42 CFR 483.10 Resident Rights, F-157; 42 CFR 483.20 Resident Assessment, F-280 and F-282; 42 CFR 483.25 Quality of Care, F-309; and 483.75 Administration, F-490 and F-520, on 03/16/12, as alleged in the acceptable Allegation of Compliance (AOC), received 03/16/12. While the IJ was removed at F-157, F-280, F-282, F-309, F-490 and F-520, continued non-compliance remained as follows: F-157, F-280, F-282, F-309, F-490 and F520 at the S/S of a "D." The facility's Quality Assessment and Assurance Committee had not completed the bowel protocol and care plan monitoring and analysis of information, to ensure correction of the deficient practice to prevent recurrence. The non-IJ deficiencies, F-315, F-371, and F441, cited during the annual survey were not reviewed for compliance as the facility had not had an opportunity to submit a Plan of Correction (POC). Therefore, the deficiencies detailed on this statement of deficiencies for the revisit on 03/20/12 include the F-315, F-371, and F-441 deficiencies identified on the annual survey, dated 03/15/12.	{F 000}	Preparation and execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This POC is prepared and executed solely because it is required by federal and state law.		
{F 157} SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in	{F 157}	F 157 Notify of Changes Criteria 1: The attending physician for resident #2 was made aware of the circumstances pertaining to the fecal impaction, and the periods of time between the bowel movements during his		

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

Steve Brown

TITLE

N.H.A.

(X6) DATE

4-26-12

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 157}	<p>Continued From page 1</p> <p>injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and Allegation of Compliance (AoC) review, it was determined the Immediate Jeopardy (IJ) identified during the annual survey, concluded on 03/15/12, had been removed related to physician notification; however, non-compliance continued to exist at a S/S of a "D" as the facility had not completed the Quality Assessment and Assurance (QAA) initiative related to staff implementation of the</p>	{F 157}	<p>Continued from page 1 F 157</p> <p>discussion with the DON on 3/9/12</p> <p>Criteria 2: The attending physician will be notified by the Charge nurse or Unit Manager of the following information when a resident has gone 3 days with no bowel movement:</p> <ul style="list-style-type: none"> -The presence of any identified abnormal assessment findings associated with no bowel movement in 3 days (e.g., abnormal bowel sounds, abdominal distention, nausea, vomiting, abdominal pain, etc.) -The lack of effectiveness and need for further orders if the resident has not had a bowel movement following administration of the ordered laxatives as per the Bowel Elimination Protocol. <p>Criteria 3: Facility licensed nurses and CMT staff have received inservice education on the facility Bowel Elimination Protocol including but not limited to: identification of residents with no BM in 3 consecutive days; resident constipation assessment criteria; constipation interventions (prn laxative/suppository administration in accordance with Physician orders); and follow up procedures (including MD notification) when there are no results after the administration of the prn laxative/suppository as provided by the Staff Development Coordinator/DON on 3-12-12 and 3-13-12, with post test administration.</p>	

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{F 157}	<p>Continued From page 2</p> <p>Bowel Elimination Protocol, analysis of results of audits, and the development and implementation of the Plan of Correction (POC), as related to the notification of the physician of a change in a resident's physical condition.</p> <p>Findings include:</p> <p>Review of the Acceptable Allegation of Compliance (AOC), dated 03/16/12, revealed the Nurse Consultant and the Director of Nursing (DON) revised the Bowel Elimination Protocol to include the appropriate resident assessment criteria, constipation interventions, and follow up interventions to include physician notification to address residents with signs/symptoms of constipation. Facility licensed nurses and certified medication technicians received inservice education by the Staff Development Coordinator and the DON on the facility's revised Bowel Elimination Protocol to include physician notification. The Unit Managers/Director of Nursing will review the lists of residents with no BM in three consecutive days during the week and the Weekend Nurse Supervisor for each day of the weekend to determine that the Bowel Elimination Protocol related to physician notification had been consistently implemented for the residents identified on these lists.</p> <p>An interview with the Administrator, on 03/20/12 at 10:55 AM, revealed while the Quality Assurance Committee (QAC) had met and would continue to monitor the Bowel Elimination Protocol CQI indicator results, in the quarterly CQI meetings, they had not had the opportunity to determine that Protocol interventions were being implemented consistently, to include physician</p>	{F 157}	<p>Continued from page 2 F 157</p> <p>Criteria 4: -The CQI indicator for the monitoring of the components of Bowel Elimination Protocol (Identification of residents with no BM in 3 consecutive days; assessment of the resident by the licensed nurse; administration of prn laxatives/suppositories as per Physician order; follow up interventions (including MD notification) if no BM results after the administration of the prn laxative/suppository; and addressing the Bowel Elimination Protocol interventions on the careplan) will be utilized monthly X 2 months, and then quarterly thereafter under the supervision of the DON.</p> <p>-The Bowel Elimination Protocol CQI indicator results will be reviewed by the Administrator and CQI committee in the quarterly CQI meetings to determine that Protocol interventions and MD notification are being implemented consistently, beginning with the 3-14-12 CQI meeting. An action plan will be developed by the committee for any review that determines failure to meet the CQI indicator established threshold of 100%</p> <p>Criteria 5: March 31, 2012</p>		

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{F 157}	Continued From page 3 notification.	{F 157}			
{F 280} SS=D	<p>As of 03/15/12, the facility had not had the opportunity to submit an acceptable Plan of Correction (PoC).</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and Allegation of Compliance (AoC) review, it was determined the Immediate Jeopardy (IJ) identified during the annual survey, concluded on 03/15/12, had been removed related to care plan review and revision; however, non-compliance continued to exist at a</p>	{F 280}	<p>F 280</p> <p>Revise the Care Plan</p> <p>Criteria 1: -The care plan for resident #2 has been reviewed/revised by DON/ADON on 3-12-12 to reflect the Bowel Elimination Protocol interventions to address his constipation risk.</p> <p>Criteria 2: -All residents have been identified as being at risk for developing constipation as determined by the Unit Managers and DON on 3-9-12. -The care plans for all residents have been reviewed/revised by the Unit Managers and DON on 3-12-12 to address the Bowel Elimination Protocol interventions for constipation risk.</p> <p>Criteria 3: -Facility Unit Managers have received inservice education by the Staff Development Coordinator/DON on 3-12-12 on the identification of all residents as at risk for constipation, and the need to reflect the Bowel Elimination Protocol interventions on each resident care plan.</p> <p>Criteria 4: -5 alternating resident care plans will be audited weekly X 2 weeks, then monthly X 2 months, and then quarterly thereafter by the Unit</p>		

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{F 280}	<p>Continued From page 4</p> <p>S/S of a "D" as the facility had not completed the Quality Assessment and Assurance (QAA) initiative related to Constipation care plan review and revision, analysis of results of audits, and the development and implementation of the Plan of Correction (POC), related to the review and revision of care plans.</p> <p>Findings include:</p> <p>Review of the Acceptable Allegation of Compliance (AOC), dated 03/16/12, revealed the Director of Nursing (DON) and Assistant Director of Nursing (ADON) revised Resident #2's care plan to include diagnoses of Bowel Obstruction and Fecal Impaction and the Bowel Elimination Protocol interventions to include the appropriate resident assessment criteria, constipation interventions, and follow up interventions. All residents were assessed by the Unit Managers and DON and determined to be at risk for constipation and all care plans were reviewed and revised to address the Bowel Elimination Protocol interventions for constipation risk. All residents who return from the hospital with a diagnosis of fecal impaction will be reviewed by Unit Managers/DON to discuss the resident with the attending physician to determine if any further interventions are indicated. The facility's Bowel Elimination Protocol was reviewed and revised by the DON and Nurse Consultant to determined that it reflects the appropriate resident assessment criteria, constipation interventions, and follow up interventions to address residents with signs/symptoms of constipation. Facility licensed nurses and certified medication technicians received inservice education on the facility's revised Bowel Elimination Protocol</p>	{F 280}	<p>Continued from page 4 F280 Managers/DON to determine that the Bowel Elimination Protocols have been addressed.</p> <p>-The CQI indicator for the monitoring of the components of Bowel Elimination Protocol (Identification of residents with no BM in 3 consecutive days; assessment of the resident by the licensed nurse; administration of prn laxatives/suppositories as per Physician order; follow up interventions if no BM results after the initial administration of the prn laxative/suppository; and addressing the Bowel Elimination Protocol interventions on the careplan) will be utilized monthly X 2 months, and then quarterly thereafter under the supervision of the DON.</p> <p>-The Bowel Elimination Protocol CQI indicator results will be reviewed by the Administrator and CQI committee in the quarterly CQI meetings to determine that Protocol interventions are being implemented consistently, beginning with the 3-14-12 CQI meeting. An action plan will be developed by the committee for any review that determines failure to meet the CQI indicator established threshold of 100%.</p> <p>Criteria 5: March 31, 2012</p>	

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{F 280}	Continued From page 5 interventions by the Staff Development Coordinator and DON. Facility Unit Managers have received inservice education by the Staff development Coordinator/DON on the identification of all residents at risk for constipation, and the need to reflect the Bowel Elimination Protocol interventions on each residents care plans. Five alternating resident care plans will be audited weekly times two weeks, then monthly time two months, and then quarterly, thereafter, by the Unit Managers/DON to determine that the Bowel Elimination Protocol interventions have been addressed. An interview with the Administrator, on 03/20/12 at 10:55 AM, revealed while the Quality Assurance Committee (QAC) had met and would continue to monitor the care plan CQI indicator results, in the quarterly CQI meetings, they had not had the opportunity to ensure that the care plans were reviewed and revised. As of 03/15/12, the facility had not had the opportunity to submit an acceptable Plan of Correction (PoC).	{F 280}		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and Allegation of Compliance (AoC) review, it was determined	{F 282}	F 282 Services Provided Per Care Plan Criteria 1: The "3 days with no BM" report is run and reviewed daily by the Unit Managers/Weekend Nurse Supervisor for resident #2 and 13 to determine when the Bowel Elimination Protocol interventions must be implemented as per their care plans.	

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{F 282}	Continued From page 6 the Immediate Jeopardy (IJ) identified during the annual survey, concluded on 03/15/12, had been removed related to implementation of the constipation care plan; however, non-compliance continued to exist at a S/S of a "D" as the facility had not completed the Quality and Assurance (QAA) initiative related to the implementation of the constipation care plan, analysis of results of audits, and the development and implementation of the Plan of Correction (POC), as related to the implementation of the constipation care plan. Findings include: Review of the Acceptable Allegation of Compliance (AOC), dated 03/16/12, revealed the Director of Nursing (DON) and Assistant Director of Nursing (ADON) revised Resident #2's care plan to include diagnoses of Bowel Obstruction and Fecal Impaction and the Bowel Elimination Protocol interventions to include the appropriate resident assessment criteria, constipation interventions, and follow up interventions. All residents were assessed and determined to be at risk for constipation and all care plans were reviewed and revised to address the Bowel Elimination Protocol interventions for constipation risk by the Unit Managers and DON. All residents who return from the hospital with a diagnosis of fecal impaction will be reviewed by Unit Managers/DON to discuss the resident with the attending physician to determine if any further interventions are indicated. The facility's Bowel Elimination Protocol was reviewed and revised by the DON and Nurse Consultant to determined that it reflects the appropriate resident assessment criteria, constipation interventions, and follow up interventions to address residents	{F 282}	Continued from page 6 F 282 Criteria 2: The "3 days with no BM" report is run and reviewed daily by the Unit Managers/Weekend Nurse Supervisor for all residents to determine when the Bowel Elimination Protocol interventions must be implemented as per their care plans. Criteria 3: Facility licensed nurses and CMT staff have received inservice education on the facility Bowel Elimination Protocol including but not limited to: implementation of resident care plans for bowel elimination including identification of residents with no BM in 3 consecutive days; resident constipation assessment criteria; constipation interventions (prn laxative/suppository administration in accordance with Physician orders); and follow up procedures when there are no results after the initial administration of the prn laxative/suppository as provided by the Staff Development Coordinator/DON on 3-12-12 and 3-13-12, with post test administration. Criteria 4: -The Unit Managers/DON will review the lists of residents with no BM in 3 consecutive days daily during the week, and by the Weekend Nurse Supervisor for each day of the weekend to determine that the care plans for Bowel Elimination Protocol interventions have been implemented consistently for the residents identified on these lists.		

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{F 282}	Continued From page 7 with signs/symptoms of constipation. Facility licensed nurses and certified medication technicians received inservice education on the facility's revised Bowel Elimination Protocol interventions by the Staff Development Coordinator and DON. Facility Unit Managers have received inservice education by the Staff development Coordinator/DON on the identification of all residents at risk for constipation, and the need to reflect the Bowel Elimination Protocol interventions on each residents care plans. Five alternating resident care plans will be audited weekly times two weeks, then monthly time two months, and then quarterly thereafter by the Unit Managers/DON to determine that the Bowel Elimination Protocols have been addressed. An interview with the Administrator, on 03/20/12 at 10:55 AM, revealed while the Quality Assurance Committee (QAC) had met and would continue to monitor the Bowel Elimination Protocol CQI indicator results, in the quarterly CQI meetings, they had not had the opportunity to determine that Protocol and care plan interventions were being implemented consistently.	{F 282}	Continued from page 7 F 282 -The CQI indicator for the monitoring of the implementation of the components of Bowel Elimination Protocol as per the care plans (Identification of residents with no BM in 3 consecutive days; assessment of the resident by the licensed nurse; administration of prn laxatives/suppositories as per Physician order; follow up interventions if no BM results after the initial administration of the prn laxative/suppository; and addressing the Bowel Elimination Protocol interventions on the careplan) will be utilized monthly X 2 months, and then quarterly thereafter under the supervision of the DON. Criteria 5: March 31, 2012		
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	{F 309}	F 309 Provide Care/Services for Highest Well Being Criteria 1: -The "3 days with no BM" report is run and reviewed daily by the Unit Managers/Weekend Nurse Supervisor for resident #2 and #13 to determine when the Bowel Elimination		

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{F 309}	Continued From page 8 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and Allegation of Compliance (AoC) review, it was determined the Immediate Jeopardy (IJ) identified during the annual survey, concluded on 03/15/12, had been removed related to the implementation of the Bowel Elimination Protocol and care plan to include nursing assessments, administration of as needed (PRN) laxatives, follow-up and documentation of results of the laxatives, and/or physician notification and review and revision of the constipation care plan; however, non-compliance continued to exist at a S/S of a "D" as the facility had not completed the Quality Assessment and Assurance (QAA) initiative related to staff implementation of the facility's Bowel Elimination Protocol and care plan, revision of the care plan, and/or physician notification, analysis of results of audits, and the development and implementation of the Plan of Correction (POC), as related to staff implementation of the facility's Bowel Elimination Protocol and care plan, revision of the care plan, and/or physician notification. Findings include: Review of the Acceptable Allegation of Compliance (AOC), dated 03/16/12, revealed the Director of Nursing (DON)/Assistant Director of Nursing revised Resident #2's care plan to include diagnoses of Bowel Obstruction and	{F 309}	Continued from page 8 F309 Protocol interventions must be implemented. Criteria 2: -All residents have been identified as being at risk for developing constipation as determined by the Unit Managers and DON on 3-9-12. -The "3 days with no BM" report is run and reviewed daily by the Unit Managers/Weekend Nurse Supervisor for all residents to determine when the Bowel Elimination Protocol interventions must be implemented. -Any resident who returns from the hospital with a diagnosis of fecal impaction will be reviewed by the Unit Managers/DON to determine that the Bowel Elimination Protocol was followed prior to the hospital admission, and to discuss the resident with the attending physician to determine if any further interventions are indicated. Criteria 3: -The facility Bowel Elimination Protocol has be reviewed/ revised by the DON and Nurse Consultant on 3-12-12 to determine that it reflects the appropriate resident assessment criteria, constipation interventions, and follow up interventions to address residents with signs/symptoms of constipation. -Facility licensed nurses and CMT staff have received inservice education on the facility Bowel Elimination Protocol including but not		

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{F 309}	Continued From page 9 Fecal Impaction and the Bowel Elimination Protocol interventions to include the appropriate resident assessment criteria, constipation interventions, and follow up interventions. The Unit Managers and DON assessed all residents and determined they were at risk for constipation and the care plans were reviewed and revised to address the Bowel Elimination Protocol interventions for constipation risk. All residents who return from the hospital with a diagnosis of fecal impaction will be reviewed by Unit Managers/DON to discuss the resident with the attending physician to determine if any further interventions, are indicated. The facility's Bowel Elimination Protocol was reviewed and revised by the DON and Nurse Consultant to determine that it reflects the appropriate resident assessment criteria, constipation interventions, and follow up interventions to address residents with signs/symptoms of constipation. Facility licensed nurses and certified medication technicians received inservice education on the facility's revised Bowel Elimination Protocol. The Unit Managers/Director of Nursing will review the lists of residents with no BM in three consecutive days during the week and the Weekend Nurse Supervisor for each day of the weekend to determine that the Bowel Elimination Protocol had been consistently implemented for the residents identified on these lists. Facility licensed nurses and certified medication technicians received inservice education on the facility's revised Bowel Elimination Protocol interventions. The Bowel Elimination Protocol will be reviewed with all licensed nurses and Certified Medication Technicians in orientation upon hire, as provided by the Staff Development Coordinator. This was included on the orientation	{F 309}	Continued from page 9 F 309 limited to: identification of residents with no BM in 3 consecutive days; resident constipation assessment criteria; constipation interventions (prn laxative/suppository administration in accordance with Physician orders); and follow up procedures when there are no results after the initial administration of the prn laxative/suppository as provided by the Staff Development Coordinator/DON on 3-12-12 and 3-13-12, with post test administration. -The Bowel Elimination Protocol will be reviewed with all licensed nurses and CMTs in orientation upon hire, as provided by the Staff Development Coordinator. This has been included on the facility orientation check list for completion. Criteria 4: -The Unit Managers/DON will review the lists of residents with no BM in 3 consecutive days daily during the week, and by the Weekend Nurse Supervisor for each day of the weekend to determine that the Bowel Elimination Protocol interventions have been implemented consistently for the residents identified on these lists. -The CQI indicator for the monitoring of the components of Bowel Elimination Protocol (Identification of residents with no BM in 3 consecutive days; assessment of the resident by the licensed nurse; administration of prn laxatives/		

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{F 309}	Continued From page 10 check list for completion. Facility Unit Managers have received inservice education by the Staff development Coordinator/DON on the identification of all residents at risk for constipation, and the need to reflect the Bowel Elimination Protocol interventions on each residents care plans. Five alternating resident care plans will be audited weekly times two weeks, then monthly time two months, and then quarterly thereafter by the Unit Managers/DON to determine that the Bowel Elimination Protocols have been addressed. An interview with the Administrator, on 03/20/12 at 10:55 AM, revealed while the Quality Assurance Committee (QAC) had met and would continue to monitor the Bowel Elimination Protocol CQI indicators results, in the quarterly CQI meetings, they had not had the opportunity to determine that the Protocol and Constipation care plan interventions were being implemented consistently, to include physician notification and care plan revisions.	{F 309}	Continued from page 10 F 309 suppositories as per Physician order; follow up interventions if no BM results after the initial administration of the prn laxative/suppository; and addressing the Bowel Elimination Protocol interventions on the careplan) will be utilized monthly X 2 months, and then quarterly thereafter under the supervision of the DON. -The Bowel Elimination Protocol CQI indicator results will be reviewed by the Administrator and CQI committee in the quarterly CQI meetings to determine that Protocol interventions are being implemented consistently, beginning with the 3-14-12 CQI meeting. An action plan will be developed by the committee for any review that determines failure to meet the CQI indicator established threshold of 100%. Criteria 5: March 31, 2012		
{F 315} SS=D	As of 03/15/12, the facility had not had the opportunity to submit an acceptable Plan of Correction (PoC). 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	{F 315}	F 315 Prevent UTI Criteria 1: Resident # 8 is provided peri-care and catheter care in accordance with infection control standards of care, which includes changing of gloves between peri-care and cath care and washing of hands between glove changes, as determined by care observations performed by the DON/		

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{F 315}	<p>Continued From page 11</p> <p>infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure one resident (#8), in the selected sample of nineteen residents, received appropriate treatment and services to prevent a urinary tract infection (UTI). During observation of catheter care, on 03/06/12, Nurse Technician (NT) (#4) completed perineal care on Resident #8, and then proceeded to provide catheter care without changing her gloves or washing her hands.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Catheter Care," undated, revealed, "Clean the perineal area at least twice a day. Wash hands before and after caring for any catheter."</p> <p>A record review revealed Resident #8 was admitted to the facility on 12/28/11 with diagnoses to include Spinal Stenosis, Hypertension, and Diabetes Mellitus. A review of the admission Minimum Data Set (MDS), dated 01/06/12, revealed Resident #8 required assistance with activities of daily living (ADLs) and had an indwelling catheter.</p> <p>An observation of catheter care, on 03/06/12 at 2:53 PM, revealed NT #4 proceeded to remove a bedpan from under Resident #8, and provided perineal care, with noted stool to the wipe after</p>	{F 315}	<p>Continued from page 11 F 315</p> <p>Staff Development Coordinator/Unit Managers/MDS Coordinator on 3/29/12 and 3/30/12.</p> <p>Criteria 2: Residents are provided peri-care and catheter care in accordance with infection control standards of care, which includes changing of gloves between peri-care and cath care and washing of hands between glove changes, as determined by care observations performed by the DON/ Staff Development Coordinator/Unit Managers/MDS Coordinator on 3/28/12, 3/29/12 and 3/30/12.</p> <p>Criteria 3: Facility nursing assistants have received inservice education on the provision of peri-care and catheter care in accordance with infection control standards of care which included but was not limited to: changing of gloves between peri-care and catheter care and washing of hands between glove changes, as provided by the DON/ Staff Development Coordinator/Unit Managers/ MDS Coordinator on 3/28/12, 3/29/12 and 3/30/12.</p> <p>Criteria 4: -Peri-care/catheter care observations were performed for facility nursing assistants by the DON/Staff Development Coordinator/Unit Managers/ MDS Coordinator to determine that they are providing this in accordance with infection control standards of care. -The CQI indicator for the monitoring of compliance with infection control standards during</p>	

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{F 315}	Continued From page 12 the wipe was used. Catheter care was immediately performed, spreading the labia area and cleaning the catheter tubing with the same gloves used for perineal care. An interview with NT #4, on 03/06/12 at 2:53 PM, revealed she should have changed her gloves and washed her hands in between the provision of perineal care and catheter care. An interview with Licensed Practical Nurse (LPN) #5, on 03/06/12 at 5:36 PM, revealed she expected the staff to wash their hands and change their gloves between the provision of perineal care and catheter care. An interview with the Director of Nursing (DON), on 03/08/12 at 11:50 AM, revealed she expected the staff to wash their hands and put on new gloves if the gloves were soiled with stool.	{F 315}	Continued from page 12 F 315 peri-care/catheter care will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the DON. Criteria 5: March 31, 2012		
{F 371} SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy and procedure, it was	{F 371}	F 371 Food Procure, Store/Prepare/Serve - Sanitary Criteria 1 and 2: Dietary staff utilize alcohol pads to clean the thermometer after each check of food temperatures as determined by observations completed by the Dietary Manger/RD on 3/14/12. Criteria 3: Dietary staff have received inservice education on cleaning of the thermometer with alcohol pads after each check of food temperatures as provided by the Dietary Manger on 3/12/12.		

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{F 371}	<p>Continued From page 13</p> <p>determined the facility failed to prepare food under sanitary conditions. The facility failed to ensure staff cleaned the food thermometer with alcohol swabs after each use of the thermometer to obtain a food temperature on the tray line.</p> <p>Findings include:</p> <p>A review of the Census and Condition, dated 03/06/12, revealed there were 92 residents in the building and three (3) residents received tube feedings.</p> <p>A review of the facility's "Tray Line and Meal Service Temperature" policy and procedure, undated, revealed the thermometer should be sanitized between obtaining each food's temperature by washing it in the pot sink with hot soapy water, then rinsing the thermometer and dipping it in a sanitizing solution or cleansing it with alcohol swabs.</p> <p>Observation, on 03/06/12 at 11:15 AM, revealed the Dietary Cook obtained the temperature of each food item on the steam table, and then wiped the thermometer off with a napkin before obtaining the next food item's temperature.</p> <p>An interview with the Dietary Cook, on 03/07/12 at 8:35 AM, revealed she usually wiped the thermometer off with a napkin in between obtaining temperatures of each food item, and then, after obtaining the last food temperature she wiped the thermometer off with an alcohol swab.</p> <p>An interview with the Dietary Manager, on 03/07/12 at 8:40 AM, revealed the staff should</p>	{F 371}	<p>Continued from page 13 F 371</p> <p>Criteria 4: Cleaning of the thermometer with alcohol pads after each check of food temps will be monitored with dietary sanitation audits conducted by the RD/Dietary Manager monthly.</p> <p>Criteria 5: March 31, 2012.</p>	

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{F 371}	Continued From page 14 obtain each food temperature and wipe down the thermometer with an alcohol swab before taking the next food temperature.	{F 371}			
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions 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	{F 441}	F 441 Infection Control Criteria 1: Resident # 8 is provided peri-care and catheter care in accordance with infection control standards of care, which includes changing of gloves between peri-care and cath care and washing of hands between glove changes, as determined by care observations performed by the DON/Staff Development Coordinator/Unit Managers/MDS Coordinator on 3/29/12 and 3/30/12. Criteria 2: Residents are provided peri-care and catheter care in accordance with infection control standards of care, which includes changing of gloves between peri-care and cath care and washing of hands between glove changes, as determined by care observations performed by the DON/Staff Development Coordinator/Unit Managers/MDS Coordinator on 3/28/12, 3/29/12 and 3/30/12. Criteria 3: Facility nursing assistants have received inservice education on the provision of peri-care and catheter care in accordance with infection control standards of care which included but was not limited to: changing of gloves between peri-care and catheter care and washing of hands between glove changes, as provided by the DON/Staff Development		

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{F 441}	<p>Continued From page 15</p> <p>transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to provide a sanitary environment to help prevent the development and transmission of infection for one resident (#8), in the selected sample of nineteen residents. During observation of catheter care, on 03/06/12, Nurse Technician (NT) (#4) completed perineal care on Resident #8, and then proceeded to provide catheter care without changing her gloves or washing her hands.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Catheter Care," undated, revealed "reduce urinary infections from entering urethra and to maintain proper drainage." Further review revealed, "Clean the perineal area at least twice a day. Wash hands before and after caring for any catheter."</p> <p>A record review revealed Resident #8 was admitted to the facility on 12/28/11 with diagnoses to include Spinal Stenosis, Hypertension, and Diabetes Mellitus. A review of the admission Minimum Data Set (MDS), dated 01/06/12, revealed Resident #8 required assistance with activities of daily living (ADLs) and had an</p>	{F 441}	<p>Continued from page 15 F 441</p> <p>Coordinator/Unit Managers/MDS Coordinator on 3/28/12, 3/29/12 and 3/30/12.</p> <p>Criteria 4: -Peri-care/catheter care observations were performed for facility nursing assistants by the DON/Staff Development Coordinator/Unit Managers/MDS Coordinator to determine that they are providing this in accordance with infection control standards of care.</p> <p>-The CQI indicator for the monitoring of compliance with infection control standards during peri-care/catheter care will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the DON.</p> <p>Criteria 5: March 31, 2012</p>		

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{F 441}	Continued From page 16 indwelling catheter. A catheter care observation, on 03/06/12 at 2:53 PM, revealed NT #4 proceeded to remove a bedpan from under Resident #8, and provided perineal care, stool was noted on the wipe after the wipe was used. The NT was observed immediately performing catheter care, spreading the labia area and cleaning the catheter tubing with the same gloves used for perineal care. On 03/06/12 at 2:53 PM, interview with NT #4 revealed she should have changed her gloves and washed her hands in between the provision of perineal care and catheter care. Licensed Practical Nurse (LPN) #5, on 03/06/12 at 5:36 PM, stated she expected the staff to wash their hands and change their gloves between the provision of perineal care and catheter care. The Director of Nursing (DON), on 03/08/12 at 11:50 AM, revealed she expected the staff to wash their hands and put on new gloves if the gloves were soiled with stool.	{F 441}			
{F 490} SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	{F 490}	F 490 Administration Criteria 1: -The bowel log for the last 6 days for resident #2 has been reviewed by the Nurse Consultant and DON/ADON on 3-14-12 to determine that he is being provided prn laxatives/suppositories in accordance with the Bowel Elimination Protocol and Physician orders. The resident has been reviewed by the attending MD with order updates for his Bowel related medications and that the Bowel Protocol has been utilized		

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{F 490}	<p>Continued From page 17</p> <p>Based on interview, record review, and Allegation of Compliance (AoC) review, it was determined the Immediate Jeopardy (IJ) identified during the annual survey, concluded on 03/15/12, had been removed related to the facility failed to be administered in a manner to ensure an effective system was in place to ensure the implementation of policy and procedures related to bowel management, care plans and physician notification; however, non-compliance continued to exist at a S/S of a "D" as the facility had not completed the Quality Assessment and Assurance (QAA) initiative related to staff implementation of the facility's Bowel Elimination Protocol and care plan, revision of the care plan, and/or physician notifications, analysis of results of audits, and the development and implementation of the Plan of Correction (POC), as related to staff implementation of the facility's Bowel Elimination Protocol and care plan, revision of the care plan, and/or physician notification.</p> <p>Findings include:</p> <p>The Bowel Elimination Protocol Committee Quality Indicator results will be reviewed by the Administrator and CQI Committee in the quarterly CQI meetings to determine that the Protocol interventions are being implemented consistently, beginning 03/14/12. An action plan will be developed by the Administrator and the committee for any review that determines failure to meet the CQI indicator established threshold of 90%. The Nurse Consultant will review the CQI indicators monthly on resident hospital returns/admissions to determine that these audits have been accurately completed and that issues</p>	{F 490}	<p>Continued from page 17 F 490 consistently as indicated by his bowel log.</p> <p>-The care plan for resident #2 has been reviewed/ revised by DON/ADON on 3-12-12 to reflect the Bowel Elimination Protocol interventions to address his constipation risk.</p> <p>-The "3 days with no BM" report is run and reviewed daily by the Unit Managers/Weekend Nurse Supervisor for resident #2 to determine when the Bowel Elimination Protocol interventions must be implemented.</p> <p>Criteria 2: -All residents have been identified as being at risk for developing constipation as determined by the Unit Managers and DON on 3-9-12.</p> <p>-The care plans for all residents have been reviewed/ revised by the Unit Managers and DON on 3-12-12 to address the Bowel Elimination Protocol interventions for constipation risk.</p> <p>-The "3 days with no BM" report is run and reviewed daily by the Unit Managers/Weekend Nurse Supervisor for all residents to determine when the Bowel Elimination Protocol interventions must be implemented.</p> <p>-Any resident who returns from the hospital with a diagnosis of fecal impaction will be reviewed by the Unit Managers/DON to determine that the Bowel Elimination Protocol was followed prior to the hospital admission, and to discuss the resident with the attending</p>		

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Added addendum

Continued from page 19 F 490 Criteria 3

-Facility licensed nurses and CMT staff have received inservice education on the facility Bowel Elimination Protocol including but not limited to: identification of residents with no BM in 3 consecutive days; resident constipation assessment criteria; constipation interventions (prn laxative/suppository administration in accordance with Physician orders); and follow up procedures when there are no results after the initial administration of the prn laxative/suppository as provided by the Staff Development Coordinator/DON on 3-12-12 and 3-13-12, with post test administration.

-Facility Unit Managers have received inservice education by the Staff Development Coordinator/DON on 3-12-12 on the identification of all residents as at risk for constipation, and the need to reflect the Bowel Elimination Protocol interventions on each resident care plan.

-The Bowel Elimination Protocol will be reviewed with all licensed nurses and CMTs in orientation upon hire, as provided by the Staff Development Coordinator. This has been included on the facility orientation check list for completion.

Criteria 4: -The Unit Managers/DON will review the lists of residents with no BM in 3 consecutive days daily during the week, and by the Weekend Nurse Supervisor for each day of the weekend to determine that the Bowel Elimination Protocol interventions have been implemented consistently for the residents identified on these lists.

-5 alternating resident care plans will be audited weekly X 2 weeks, then monthly X 2 months, and then quarterly thereafter by the Unit Managers/DON to determine that the Bowel Elimination Protocols have been addressed.

-The CQI indicator for the monitoring of the components of Bowel Elimination Protocol (Identification of residents with no BM in 3 consecutive days; assessment of the resident by the licensed nurse; administration of prn laxatives/suppositories as per Physician order; follow up interventions if no BM results after the initial administration of the prn laxative/suppository; and addressing the Bowel Elimination Protocol interventions on the careplan) will be utilized monthly X 2 months, and then quarterly thereafter under the supervision of the DON.

-The Bowel Elimination Protocol CQI indicator results will be reviewed by the Administrator and CQI committee in the quarterly CQI meetings to determine that Protocol interventions are being implemented consistently, beginning with the 3-14-12 CQI meeting.. An action plan will be developed by the committee for any review that determines failure to meet the CQI indicator established threshold of 100%.

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Added Addendum

Continued from page 19 F 490 Criteria 4

-The CQI indicator for the monitoring of hospitalizations will be utilized monthly X 2 months and then quarterly under the supervision of the DON to determine compliance with pre and post hospital transfer assessments and documentation and follow up, and any need for staff education.

-The Nurse Consultant will review the CQI Indicators reviewed by the NHA/DON/ADON monthly on resident hospital returns/re-admissions to determine that these audits have been accurately completed and that issues identified have been appropriately addressed.

-The Nurse Consultant will review the BM Daily Records Completed with each monthly visit to determine compliance with the Bowel Elimination Protocol and appropriate follow up and staff education for any issues identified.

Criteria 5: March 31, 2012

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186229	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/20/2012
NAME OF PROVIDER OR SUPPLIER BARREN COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 WESTWOOD ST. GLASGOW, KY 42141		
(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 490}	Continued From page 18 identified have been appropriately addressed. The Nurse Consultant will review the BM Daily Records monthly to determine compliance with the Bowel Elimination Protocol and appropriate follow up and staff education for any issues identified. An interview with the Administrator, on 03/20/12 at 10:55 AM, revealed while the Quality Assurance Committee (QAC) had met and would continue to monitor the Bowel Elimination and Care Plan Protocol CQI indicator results in the quarterly CQI meetings, they had not had the opportunity to determine that the Protocol interventions were being implemented consistently. As of 03/15/12, the facility had not had the opportunity to submit an acceptable Plan of Correction (PoC).	{F 490}	Continued from page 18 F 490 physician to determine if any further interventions are indicated. Criteria 3: -The facility Bowel Elimination Protocol has be reviewed/ revised by the DON and Nurse Consultant on 3-12-12 to determine that it reflects the appropriate resident assessment criteria, constipation interventions, and follow up interventions to address residents with signs/symptoms of constipation. (See added addendum)		
{F 520} SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	{F 520}	F 520 Quality Assurance Criteria 1: -The bowel log for the last 6 days for resident #2 has been reviewed by the Nurse Consultant and DON/ADON on 3-14-12 to determine that he is being provided prn laxatives/suppositories in accordance with the Bowel Elimination Protocol and Physician orders. -The care plan for resident #2 has been reviewed/revised byDON/ADON on 3-12-12 to reflect the Bowel Elimination Protocol interventions to address his constipation risk.		

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

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{F 520}	<p>Continued From page 19</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and Allegation of Compliance (AoC) review, it was determined the Immediate Jeopardy (IJ) identified during the annual survey, concluded on 03/15/12, had been removed. However, non-compliance continued to exist as the facility's Quality Assessment and Assurance Committee (QAAC) had not fully implemented its Committee Quality Indicators to analyze and gather the information to ensure the recurrence of the deficient practice related to the failure to ensure the quality assessment and assurance committee was effective in identifying and correcting quality deficiencies related to bowel management.</p> <p>Findings include:</p> <p>The CQI indicator for monitoring of the components of the Bowel Elimination Protocol will be utilized monthly times two months and then quarterly thereafter under the supervision of the DON. The Bowel Elimination Protocol CQI indicator results will be reviewed by the Administrator and CQI Committee in the quarterly CQI meetings to determine that Protocol</p>	{F 520}	<p>Continued from page 19 F 520</p> <p>The "3 days with no BM" report is run and reviewed daily by the Unit Managers/Weekend Nurse Supervisor for resident #2 to determine when the Bowel Elimination Protocol interventions must be implemented.</p> <p>Criteria 2: -All residents have been identified as being at risk for developing constipation as determined by the Unit Managers and DON on 3-9-12.</p> <p>-The care plans for all residents have been reviewed/ revised by the Unit Managers and DON on 3-12-12 to address the Bowel Elimination Protocol interventions for constipation risk.</p> <p>-The "3 days with no BM" report is run and reviewed daily by the Unit Managers/Weekend Nurse Supervisor for all residents to determine when the Bowel Elimination Protocol interventions must be implemented.</p> <p>-Any resident who returns from the hospital with a diagnosis of fecal impaction will be reviewed by the Unit Managers/DON to determine that the Bowel Elimination Protocol was followed prior to the hospital admission, and to discuss the resident with the attending physician to determine if any further interventions are indicated.</p>		

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{F 520}	<p>Continued From page 20</p> <p>interventions are being implemented consistently, beginning with the 03/14/12 meeting. An action plan will be developed by the committee for any review that determines failure to meet the CQI established threshold of 90%. The CQI indicator for the monitoring of hospitalizations will be utilized monthly times two months and then quarterly under the supervision of the DON to determine compliance with pre and post hospital transfer assessments and documentation and follow up, and any need for staff education.</p> <p>An interview with the Administrator, on 03/20/12 at 10:55 AM, revealed while the Quality Assurance Committee (QAC) had met and would continue to monitor the Bowel Elimination Protocol CQI indicator results in the quarterly CQI meetings, they had not had the opportunity to determine that the Protocol interventions were being implemented consistently.</p> <p>As of 03/15/12, the facility had not had the opportunity to submit an acceptable Plan of Correction (PoC).</p>	{F 520}	<p>Continued from page 20 F 520</p> <p>Criteria 3: -The facility Bowel Elimination Protocol has been reviewed/ revised by the DON and Nurse Consultant on 3-12-12 to determine that it reflects the appropriate resident assessment criteria, constipation interventions, and follow up interventions to address residents with signs/symptoms of constipation.</p> <p>-Facility licensed nurses and CMT staff have received inservice education on the facility Bowel Elimination Protocol including but not limited to: identification of residents with no BM in 3 consecutive days; resident constipation assessment criteria; constipation interventions (prn laxative/suppository administration in accordance with Physician orders); and follow up procedures when there are no results after the initial administration of the prn laxative/suppository as provided by the Staff Development Coordinator/DON on 3-12-12 and 3-13-12, with post test administration.</p> <p>-Facility Unit Managers have received inservice education by the Staff Development Coordinator/DON on 3-12-12 on the identification of all residents as at risk for constipation, and the need to reflect the Bowel Elimination Protocol interventions on each resident care plan. (See added addendum)</p>		

Barren County Health Care Center

Quality Care – Superior Service – Affordable Price
300 Westwood Street – Glasgow, Ky. 42141

Added Addendum

Continued from page 21 F 520 Criteria 3

The Bowel Elimination Protocol will be reviewed with all licensed nurses and CMTs in orientation upon hire, as provided by the Staff Development Coordinator. This has been included on the facility orientation check list for completion.

Criteria 4: -The Unit Managers/DON will review the lists of residents with no BM in 3 consecutive days daily during the week, and by the Weekend Nurse Supervisor for each day of the weekend to determine that the Bowel Elimination Protocol interventions have been implemented consistently for the residents identified on these lists.

-5 alternating resident care plans will be audited weekly X 2 weeks, then monthly X 2 months, and then quarterly thereafter by the Unit Managers/DON to determine that the Bowel Elimination Protocols have been addressed.

-The CQI indicator for the monitoring of the components of Bowel Elimination Protocol (Identification of residents with no BM in 3 consecutive days; assessment of the resident by the licensed nurse; administration of prn laxatives/suppositories as per Physician order; follow up interventions if no BM results after the initial administration of the prn laxative/suppository; and addressing the Bowel Elimination Protocol interventions on the careplan) will be utilized monthly X 2 months, and then quarterly thereafter under the supervision of the DON.

-The Bowel Elimination Protocol CQI indicator results will be reviewed by the Administrator and CQI committee in the quarterly CQI meetings to determine that Protocol interventions are being implemented consistently, beginning with the 3-14-12 CQI meeting. An action plan will be developed by the committee for any review that determines failure to meet the CQI indicator established threshold of 100%.

-The CQI indicator for the monitoring of hospitalizations will be utilized monthly X 2 months and then quarterly under the supervision of the DON to determine compliance with pre and post hospital transfer assessments and documentation and follow up, and any need for staff education.

-The Nurse Consultant will review the CQI Indicators completed by the NHA/DON/ADON on resident hospital returns/re-admissions to determine that these audits have been accurately completed and that issues identified have been appropriately addressed.

-The Nurse Consultant will review the BM Daily Records Completed with each monthly visit to determine compliance with the Bowel Elimination Protocol and appropriate follow up and staff education for any issues identified.

Criteria 5: March 31, 2012

Your POC must:

- Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to ensure that solutions are sustained; and
- **Include dates when corrective action will be completed. In the right column with the heading 'completion date', include only one date for each corresponding deficiency with the heading 'ID Prefix Tag' listed in the left column.**

You are required to record your plan of correction in the appropriate column on the enclosed forms CMS-2567. **Sign, date, and indicate your title in the blocks provided at the bottom of page one.**

Recommended Remedies

Per CMS Imposition Notice, dated March 27, 2012, after CMS review of the survey findings, the following mandatory and discretionary enforcement remedies have been or will be imposed on the dates indicated::

- A Civil Money Penalty of \$4,200.00 per day effective November 20, 2011, to continue at this daily rate until the jeopardy is removed or your provider agreement is terminated; and
- Denial of payment for new admissions effective March 29, 2012, if the facility is still out of compliance on that date.
- Termination of your provider agreement effective April 7, 2012, if the immediate jeopardy has not been removed by that date;

A change in the seriousness of the noncompliance at the time of a revisit may result in a change in the remedies. If this occurs, you will be notified.

Your provider agreement must be terminated if substantial compliance is not achieved **within six (6) months** from the last day of the survey identifying noncompliance.

Please note that this letter does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other sanction is warranted, it will provide you with a separate formal notification of that determination.

Your facility's noncompliance with 42 CFR 483.25 has been determined to constitute Substandard Quality of Care as defined at 488.301. Sections 1819(g)(5)(c) and 1919(g)(5)(c) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the Nursing Home Administrator's Board of Licensure, be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 488.325(g), you are required to provide the following information to this agency **within ten (10) working days of your receipt of this letter:**

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

List of affected residents: **#2**

Please note that, in accordance with 488.325(g), your failure to provide this information timely will result in termination of participation or imposition of alternative remedies.

Also, as a result of the determination of Substandard Quality of Care pursuant to 42 CFR 488.325, your facility is prohibited from providing a Nurse Aide Training and Competency Evaluation Program effective **March 15, 2012**, and continuing for the next two (2) years.

Loss of Nurse Aide Training Program (NATCEP)

Please note that Federal law, as specified in the Social Security Act at sections 1819 (f)(2)(B) and 1919 (f)(2)(B), prohibit approval of nurse aide training and competency evaluation programs offered by or in your facility which within the previous two years has operated under a section 1819 (b)(4)(c)(ii)(II) or section 1919 (b)(4)(ii) waiver; has been subject to an extended or partial extended survey; or has been assessed a civil money penalty of not less than \$5,000; or, has been subject to denial of payment, the appointment of a temporary manager, termination or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities. As a result of the extended survey and the immediate jeopardy, this provision may be applicable to your facility and you may receive further notification from the State.

Informal Dispute Resolution

In accordance with 42 CFR 488.331 and 906 KAR 1:120, a provider shall have one informal opportunity to dispute a cited deficiency, or scope and severity assessment that constitutes Substandard Quality of Care or Immediate Jeopardy. You are required to **send your request in writing to IDR Coordinator, Office of Inspector General, Division of Health Care, 275 East Main Street, 5E-A, Frankfort, Kentucky 40621.** Your request shall specify the format for the informal dispute resolution, specify the deficiency in dispute, explain the dispute, and provide a detailed basis for the dispute. Documentation in support of the dispute shall be attached to the request. The request and attachments shall be delivered **on or before the tenth calendar day after receipt of the Statement of Deficiencies.** A request for informal dispute resolution shall not delay an enforcement action.

Independent Informal Dispute Resolution

Please note that the Centers for Medicare & Medicaid Services (CMS) will offer a provider an opportunity for an Independent IDR either in its initial Notice of Imposition of a CMP letter to the facility or within 30 calendar days of the letter. Your request for an Independent IDR, along with attachments, shall be delivered **in writing** to the Independent IDR Coordinator, Office of Inspector General, Division of Health Care, 275 East Main Street, 5E-A, Frankfort, KY 40621 **on or before the tenth calendar day after receipt of the offer for Independent IDR by CMS.** A request for an Independent IDR shall not delay an enforcement action.

If you should have questions regarding this information, please contact our office.

Sincerely,

Cheryl White, RN, HSSSV

for Samantha Higginbotham
Assistant Director
Division of Health Care

SH/DAH:lef

c: CMS Regional Office

L&R 10

MEMORANDUM

TO FILES:

FROM: Deborah Henderson RN. NC/I

Name and Title

SUBJECT: Barren County Health Care Center, 300 Westwood, Glasgow, Ky 42141
Facility and Address

TYPE OF FACILITY OR SERVICE: SNF/NF

DATE OF VISIT: 03/06/12-03/09/12 Extended Survey 03/15/12

PURPOSE OF VISIT:	Initial Certification Visit	<input type="checkbox"/>	Initial Licensure Visit	<input type="checkbox"/>
	Recertification Visit	<input checked="" type="checkbox"/>	Relicensure Visit	<input checked="" type="checkbox"/>
	Non-compliance Certification FU	<input type="checkbox"/>	Non-compliance Licensure FU	<input type="checkbox"/>
	Certification Consultation	<input type="checkbox"/>	Licensure Consultation	<input type="checkbox"/>
	Post Certification Revisit	<input type="checkbox"/>	Other (Specify)	<input type="checkbox"/>
	Life Safety Code	<input checked="" type="checkbox"/>		

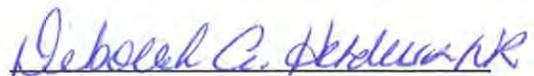
PRESENT AT FACILITY ON THIS DATE:

<u>Facility Staff</u>		<u>DLTC Staff</u>	
Name	Title	Name	Title
Steve Brown	Adminstrator	Deborah Henderson	NC/I
		Leah Norman	NC/I
		Denice Tyler	NC/I
		Lori Rogers	NC/I
		Jeremy Taylor	LSC/I
		Glenn Martin	LSC/I

COMMENTS

A standard survey was conducted at this facility on 03/06/12-03/09/12 and a life safety code survey was conducted on 03/06/12. An extended survey was conducted on 03/15/12. The facility was found not to be in substantial compliance with federal regulations with substandard quality of care and to not meet the minimum State licensure requirements. The highest scope and severity was cited at "J". A Statement of Deficiencies was issued on and an acceptable Plan of Correction was received on . A revisit was conducted on and found this facility to be in substantial compliance with Federal regulations and to meet minimum State licensure requirements. A Resident Rights survey was also conducted and the facility was found to substantially meet the minimum requirements of House Bill #217, Resident Rights. The facility appeared to be in substantial compliance with the Civil Rights Act, Title VI. Therefore, this Office recommends that this facility be recertified for 94 Skilled Nursing Facility/Nursing Facility beds.

Also, recommend relicensure for 94 Nursing Facility beds.


Signed

03/15/12

Date

COMPLIANCE REPORT FOR INSTITUTIONAL FACILITIES
(Civil Rights Act Title VI)

IDENTIFYING INFORMATION

Name of Facility: Barren County Health Care Center
 Chief Administrative Officer/Title Steve Brown/Administrator
 Telephone No. 270-651-9131 Medicare Provider No. 18-5229

Licensed Bed Capacity 94
 (number)

Name, Address & Telephone Number of Owner of Facility
Steve Brown 270-651-9131
300 Westwood Street; Glasgow, KY 42141

Name of referring Individual or Institutions	Address	Person actually making the contact with this facility
J.L. Samson Hospital	Glasgow, KY	Denise Billingsley
NHC Health Care	Glasgow, KY	Inogene Stephens
Caverna Hospital	Cave City, KY	Alan Alexander

- Have all of the above referral sources been notified, in writing, of this facility's policy of admitting all patients without regard to race, color, or national origin x yes no
- Do any of the persons who receive referrals in this facility inquire about the race of the person being referred before providing information on space available in the facility?
yes x no
- How many persons are on the waiting list? Total 20
 Asian 1 African American 1 American Indian 1
 Spanish Surnamed American 1
- Has the person responsible for patient placement in this facility been instructed to assign patients to room accommodations without regard to race, color, or national origin? x yes no
- Are patients asked whether they are willing to share a room with a patient of a different race? yes x no
- Are all private rooms available to both white and nonwhite patients? x yes no
- Are patients routinely assigned to 2-bed, 3-bed, and ward rooms without regard to race, color, or national origin? x yes no
- Do you transfer patients because they object to sharing rooms with patients of a different race? yes x no
- Total number of patients in today's census:
92 White African American American Indian Asian Spanish Surnamed American Other

- What is the approximate nonwhite population in the service area? 3.7%
- Have you notified the general public, in writing, that your facility will admit and serve patients equally, without regard to race, color, or national origin x yes no
- If "Yes" check method of communication: Date 6/1/07
x newspaper letter Other (Specify) _____
- Is the use of this facility limited to membership in a defined group? (i.e., fraternal organization, religious denomination, employees of a corporation, etc.) yes no
- If "Yes" explain and define membership requirements under remarks.

Remarks
 (Use bond paper if more space is needed)

- Does this facility admit patients without regard to race, color, or national origin? x yes no
- List the facility's chief referral source (such as doctors, Hospitals, other nursing homes, local welfare departments, etc [next column])

17. Indicate below the number of minority group patients or beneficiaries in today's census by type of room assignment according to the following breakdown: N/A

Type of Room Assignment	African American	American Indian	Asian	Spanish Surnamed American
Number of minority patients or beneficiaries in single rooms or in room alone				
Number of minority patients or beneficiaries in semi-private or ward rooms having only minority persons.				
Number of minority patients or beneficiaries in semi-private or ward rooms with one or more non-minority persons.				
Total				

Indicate the number of patients or beneficiaries in today's census whose charges made by your facility are paid in part or full by Medicare or Public Welfare. N/A

Type of Aid	Total	African American	American Indian	Asian	Spanish Surnamed American
Medicare					
Medicaid					

18. Estimate the number of patients or beneficiaries of the minority groups admitted during the past year:

0 3 1-10 11-20 21-50 Over 50
 patients? x yes no

20. If you have one patient dining room, is it used by persons of different races simultaneously? yes x yes x no

21. If you have more than one patient dining room (give number 2) is one used predominantly by one race? yes x yes x no

22. Are all services and facilities used routinely by all persons without regard to race, color, or national origin (i.e., nursing care, social services, occupational therapy, lounges, barber shops, beauty salons, etc.)? x yes no

23. If "No" specify which are not.

24. Are services rendered in this facility without regard to the race of either the patient or the person rendering the service? x yes no

25. If "No" specify which services are not.

26. Is the use of courtesy title (Mr., Mrs., etc.) uniform throughout this facility on records, news releases, public address systems, name tags, etc., and in addressing patients? x yes no

27. Estimate below the number of physicians and other licensed paramedical personnel not on your payroll that gave patient service in this facility during the last month by race of the physician or person rendering the service.

Physicians and Other Non-salaried Paramedical Personnel	Total	African American	American Indian	Asian	Spanish Surnamed American
	2		1	1	

28. Has the staff been notified, in writing, of the facility's policies as they apply to the Civil Rights Act of 1964? x yes no

29. Are referrals to other facilities and services (e.g., skilled, intermediate, or residential care facilities) made routinely without consideration of the race of the patient? x yes no

30. Are referrals made to other facilities or services which consider race in the acceptance of patients? yes x no

I CERTIFY THAT THE INFORMATION GIVEN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF:

Steve Brown Administrator 03/06/2012
 Signature of Authorized Official Title Date

Deborah A. Hudson NR
 Signature of Reviewer Title of Reviewer

CHECKLIST FOR COMPLIANCE WITH KRS 214.620 (4) HIV/AIDS PATIENT INFORMATION

DISTRIBUTION METHOD

YES NO Agency uses patient information form developed by the Department for Health Services.

YES NO Agency uses their own patient information form.

YES NO Agency distributes patient information in admissions package.

AGENCY FORM INCLUDES THE FOLLOWING INFORMATION

METHODS OF TRANSMISSION:

YES NO sexual contact (anal, oral, or vaginal intercourse) with an infected person when blood, semen or cervical/vaginal secretions are exchanged;

YES NO sharing a syringe/needle with someone who is infected;

YES NO infected mother may pass HIV to unborn child; and

YES NO receiving contaminated blood or blood products, organ/tissue transplants, and artificial insemination (rare now since testing for HIV antibodies began).

METHODS OF PREVENTION:

YES NO no sexual intercourse except with a monogamous partner who is not infected;

YES NO sexual relations with anyone else requires use of latex condom, female condom, or dental dam;

YES NO do not share syringes or needles with anyone;

YES NO should be tested for HIV if pregnant or plan to be pregnant; and

YES NO education of self & others about HIV infection & AIDS.

APPROPRIATE ATTITUDES & BEHAVIORS

YES NO assurances that the agency provides quality services to all patients, regardless of HIV status.

DEPARTMENT FOR MEDICAID SERVICES
PROGRAM VISIT REPORT
NURSING FACILITY

SURVEY DATE:

03/06 - 03/08/12

Facility Name: Barren County Health Care Center

Facility Address: 300 West Wood St. Glasgow, Ky 42141

Nurse Aide Training Provider Number: _____

Program Coordinator: _____
(Can be Director of Nurses)

Program Instructor: _____
(Cannot be Director of Nurses)

MOI: Yes () No () 2 years as R.N.: Yes () No () 1 year long term experience: Yes () No ()

<u>Yes</u>	<u>No</u>		
_____	_____	Course Curriculum - Adapted Mosby's Textbook for LTC Assistants as of July 1, 1997.	
_____	_____	Observed Classroom (i.e. necessary equipment and supplies available).	<u>*6th Edition Book</u>
_____	_____	Observed class in session.	<u>Mandatory 3/1/11.</u>
_____	_____	Observed clinicals performed.	

1. Is the learning environment conducive for adult students: (i.e. well-lighted, well-ventilated, quiet)?

2. What evidence exists that the class is being conducted within submitted plan?

3. Is there sufficient number of faculty to meet ratios for classroom and clinical (maximum is 1:15)?

4. Is there documentation of staff development offered to nurse aides (12 hours/year): Yes () No ()

<u>Yes</u>	<u>No</u>				
_____	_____	5. Are performance records available to nurse aide and employer?			
_____	_____	6. Are performance records maintained for a minimum of five (5) years?			
_____	_____	7. Pass/Fail for last two (2) classes: Date: _____ # Pass: _____ # Fail: _____			
			Date: _____ # Pass: _____ # Fail: _____		
_____	_____	8. Does facility notify Medicaid of <i>all</i> program changes within thirty (30) days? (i.e. new administrator, classroom, coordinator, instructor)			

Signature of Reviewer: Deborah A. Herdusa

Date: 03/06/12

Does not conduct Nurse Aide training.

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

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NAME OF PROVIDER OR SUPPLIER BARREN COUNTY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 WESTWOOD ST. GLASGOW, KY 42141
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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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{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 (111)</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is propane.</p> <p>A standard Life Safety Code survey was conducted on 03/06/12. Barren County Health and Rehab was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for ninety four (94) beds and the census was ninety two (92) 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}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Steve Brown</i>	TITLE <i>Administrator</i>	(X6) DATE <i>5-25-12</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185229	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED R 05/10/2012
NAME OF PROVIDER OR SUPPLIER BARREN COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 WESTWOOD ST. GLASGOW, KY 42141		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	Continued From page 1 Deficiencies were cited with the highest deficiency identified at "F" level. A standard Life Safety Code follow-up survey was conducted on 05/10/12. Barren County Health Care Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid.	{K 000}			
{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 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, during the follow-up survey conducted on 05/10/12, it was determined the facility failed to ensure the deficiency cited on 03/06/12 during the standard survey, was corrected as outlined in the facility's plan of correction. The facility's alleged compliance date was 03/20/12.	{K 025}	K025 #1. The facility smoke barriers identified on 5/10/12 were inspected by the facility's contracted provider and a quote to repair all areas that are in need of material to seal the penetrations was provided on 5/11/12. The smoke barriers are scheduled to be repaired by the contract provider on 5/14/12. #2 The Administrator (or contracted provider) has inspected all smoke barriers to determine that there are no other areas located to have penetrations by wires and pipes that are not properly sealed. #3. The Administrator received in-service education on Regulation K025 from the facility's contracted consultant on 3/14/12 regarding the requirements to have all spaces around the penetrations in smoke barriers sealed. The Administrator shall inform all		

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{K 025}	<p>Continued From page 2</p> <p>The findings include:</p> <p>Observations, on 05/10/12 between 10:00 AM and 11:00 AM, with the Maintenance Director revealed the smoke partitions, extending above the ceiling, located throughout the facility were noted to have penetrations by ducts, wires and pipes. The spaces around the penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke.</p> <p>Interview, on 05/10/12 between 10:00 AM and 11:00 AM, with the Maintenance Director revealed he had not had the time to repair all of the penetrations in the smoke barriers.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.</p> <p>3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 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. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining 	{K 025}	<p>Continued K025 # 3.</p> <p>contractors completing work that involves penetrating smoke barriers to properly seal any areas.</p> <p>#4. The CQI Indicator for the monitoring of the smoke barriers will be utilized monthly X 2 months and then quarterly, as per the established CQI calendar under the supervision of the Administrator.</p> <p># 5. Completed 5/31/12.</p>	

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{K 025}	Continued From page 3 the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	{K 025}			
{K 062} SS=E	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, during the follow-up survey conducted on 05/10/12, it was determined the facility failed to ensure the deficiency cited on 03/06/12 during the standard survey, was corrected as outlined in the facility's plan of correction. The facility's alleged compliance date was 04/30/12. The findings Include: Observation, on 05/10/12 between 10:00 AM and 11:00 AM, with the Maintenance Director revealed the sprinklers in the attic were blocked by falling insulation. Interview, 05/10/12 between 10:00 AM and 11:00 AM, with the Maintenance Director revealed he	{K 062}	K062 #1. The sprinkler heads in the attic that have fallen insulation that is blocking the sprinkler heads will be removed/repared by an insulation contractor. #2. An inspection was performed by the facility's maintenance and Administrator to identify if any sprinkler heads were blocked by fallen insulation after work was completed. No other heads were blocked by fallen insulation. #3. The Administrator received in-service education on Regulation K062 from the facility's contracted consultant on 3/14/12, to assure insulation in the attic is not blocking the sprinkler heads. #4. The CQI Indicator for the monitoring of the sprinkler system will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Administrator. #5 Completed 5/31/12.		

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{K 062}	<p>Continued From page 4</p> <p>was aware the insulation had fallen, blocking the spray pattern of the sprinkler heads, and a contractor was installing netting to hold the insulation in place and prevent it from blocking the sprinklers. However, the contractor has not completed the job as outlined in the facilities plan of correction.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>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.</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system</p>	{K 062}		
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{K 062}	Continued From page 5 (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	{K 062}		
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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 (111)</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is propane.</p> <p>A standard Life Safety Code survey was conducted on 03/06/12. Barren County Health and Rehab was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for ninety four (94) beds and the census was ninety two (92) 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		

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

TITLE

(X6) DATE

Steve Brown

Michael

4-26-12

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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K 000	Continued From page 1	K 000		
K 025 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety four (94) beds and the census was ninety two (92) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 03/06/12 between 2:00 PM and 3:00 PM, with the Administrator revealed the smoke partitions, extending above the ceiling,</p>	K 025	<p>K025</p> <p>#1. The facility smoke barriers identified on 3/6/12 were inspected by the facility's contracted provider and a quote to repair all areas that are in need of material to seal the penetrations was provided on 3/14/12. The smoke barriers are scheduled to be repaired by the contract provider on 3//9-12.</p> <p>#2. The Administrator (or contracted provider) has inspected all smoke barriers to determine that there are no other areas located to have penetrations by wires and pipes that are not properly sealed.</p> <p>#3. The Administrator received in-service education on Regulation K025 from the facility's contracted consultant on 3/14/12 regarding the requirement to have all spaces around the penetrations in smoke barriers sealed. The Administrator shall inform all contractors completing work that involves penetrating smoke barriers to properly seal any areas.</p> <p>#4. The CQI Indicator for the monitoring of the smoke barriers will be utilized monthly X 2 months and then quarterly, as per the established CQI calendar under the supervision of the Administrator.</p> <p>#5. Completed 3/20/12.</p>	

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K 025	<p>Continued From page 2</p> <p>located throughout the facility were noted to have penetrations by wires and pipes. The spaces around the penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke.</p> <p>Interview, on 03/06/12 between 2:00 PM and 3:00 PM, with the Administrator revealed he was not aware of the penetrations in the smoke barriers.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.</p> <p>3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 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. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 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. <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for 	K 025			

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K 025 K 029 SS=E	<p>Continued From page 3 the specific purpose.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect six (6) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety four (94) beds and the census was ninety two (92) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 03/06/12 between 10:10 AM and 3:20 PM, with the Administrator revealed magnets had been installed to keep doors for hazardous area open. The following areas had the magnets; storage room on green hall, biohazard room on</p>	K 025 K 029	<p>K029</p> <p>#1. The magnets that had been installed to keep the doors open to hazardous areas, as identified during the survey on 3/6/12, have been removed. The medical records door has had a closer installed by the contracted provider on 3/30/12.</p> <p>#2 The Administrator (or contracted provider) have inspected all doors to determine that there are no other magnets in use to hold doors open unless the magnets are connected to the fire alarm system. All areas identified as hazardous will have an automatic door closure installed by 4/30/12.</p> <p>#3 The Administrator received in-service education on Regulation K029 from the facility's contracted consultant on 3/14/12 regarding not to use magnets to hold doors open.</p> <p>#4 The CQI Indicator for the monitoring of the smoke doors will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Administrator.</p> <p>#5. Completed 4/30/12.</p>		

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K 029	<p>Continued From page 4</p> <p>green hall, medical storage on beige hall, janitor closet on white hall, janitor closet on orange hall, and housekeeping office. Further observation showed that medical records did not have a door closer for a hazardous room.</p> <p>Interview, on 03/06/12 between 10:10 AM and 3:20 PM, with the Administrator revealed he was unaware that the magnets on the doors were not a proper way to hold doors open. Further interview with the Administrator revealed he was unaware all the paperwork in medical records made the office a hazardous area.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms 	K 029		

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K 029	Continued From page 5 (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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety four (94) beds and the census was ninety two (92) on the day of the survey. The findings include:	K 038	K038 #1. The gate identified on 3/6/12 was inspected by the facility's contracted provider and a quote to install a self release latch was provided on 3/28/12. The gate is scheduled to be /was repaired with a self release latch in accordance with NFPA standards on 4/30/12. #2. There are no other exits that are affected by this practice. #3. The Administrator received in-service education on Regulation K038 from the facility's contracted consultant on 3/14/12 regarding access to the public way. #4 The CQI Indicator for the monitoring of the exits will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Administrator. #5. Completed 4/30/12.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185229	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/06/2012
NAME OF PROVIDER OR SUPPLIER BARREN COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 WESTWOOD ST. GLASGOW, KY 42141	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	<p>Continued From page 6</p> <p>Observation, on 03/06/12 at 12:00 PM, with the Administrator revealed the gate in the exit path was locked with a key. This key was hung on the wall and was not easy accessible in case of emergency. This gate blocked the durable surface to the public way.</p> <p>Interview, on 03/06/12 at 12:00 PM, with the Administrator revealed he was unaware that he could not keep the gate locked at all times. He stated it was locked due to the wander risk of residents on the porch.</p> <p>Reference:</p> <p>NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance</p>	K 038		

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K 038	<p>Continued From page 7</p> <p>with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS</p>	K 038			

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K 038	Continued From page 8 DOOR CAN BE OPENED IN 15 SECONDS 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. 7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an	K 038			

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K 038	Continued From page 9 unobstructed opening in the tent wall of the minimum width required for door openings.	K 038			
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety four (94) beds and the census was ninety two (92) on the day of the survey. The findings include: Observation, on 03/06/12 at 11:17 AM, with the Administrator revealed the exit door for the Kitchen was not identified with exit signage. Interview, on 03/06/12 at 11:17 AM, with the Administrator revealed he was unaware the exit door for the Kitchen was required to have exit signage. Reference: NFPA 101 (2000 edition)	K 047	K047 #1. The dietary exit door identified on 3/6/12 that did not have an exit sign was inspected by the facility's contracted provider and a quote to install an exit sign was provided on 3/20/12. The exit sign (was installed /will be scheduled to be installed) by the contract provider on 3/30/12. #2. There were no other exits identified that did not have exit signage. #3. The Administrator received in-service education on Regulation K047 from the facility's contracted consultant on 3/14/12 regarding the monitoring and inspection of all exterior exits to assure exit signs are installed per NFPA standards. #4. The CQI Indicator for the monitoring of the exit signs will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Administrator. #5. Completed 3/30/12.		

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K 047	Continued From page 10 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.	K 047			
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 were conducted quarterly on each shift at random times in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety four (94) beds and the census was ninety two (92) on the day of the survey. The findings include: Fire Drill review, on 03/06/12 at 3:00 PM, with the Administrator revealed the fire drills were not	K 050	K050 #1.& #2. Fire Drills are being conducted (monthly) quarterly on each shift and at random times in accordance with NFPA standards. #3. The Administrator received in-service education on Regulation K050 from the facility's contracted consultant on 3/14/12 regarding the requirement to conduct fire drills at random times per NFPA standards. The Administrator provided in-service education on Regulation K050 to the facility's maintenance director on 3/30/12. #4. The CQI Indicator for the monitoring of fire drills will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Administrator. #5. Completed 3/30/12.		

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K 050	Continued From page 11 being conducted at unexpected times under varied conditions. Around the 30th of the month second shift fire drills were being conducted predictably between 3:00 PM and 3:30 PM and third shift between 6:15 AM and 6:50 AM. Interview, on 03/06/12 at 3:00 PM, with the Administrator revealed he was unaware the fire drills were not being 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			
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure smoke detectors were inspected and tested in accordance with NFPA Standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety four (94) beds and the census was ninety two (92) on the day of the survey.	K 054	K054 #1. The facility smoke detectors identified on 3/6/12 are being inspected and tested for sensitivity per NFPA standards. #2. All smoke detectors will be inspected and tested for sensitivity. #3 The Administrator received in-service education on Regulation K054 from the facility's contracted consultant on 3/14/12 the requirement to inspect all smoke detectors every two years per NFPA standards. A quote to inspect and test all smoke detectors by the contracted provider was provided on 3/30/12. #4. The CQI Indicator for the monitoring of smoke detector's will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the		

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K 054	<p>Continued From page 12</p> <p>The findings include:</p> <p>Observation, on 03/06/12 at 3:20 PM, with the Administrator revealed no documentation of a Smoke Detector Sensitivity Test being performed on the fire alarm smoke detectors within the last two years. Smoke detectors must be tested according to NFPA 72 (1999 edition) to ensure their reliability.</p> <p>Interview, on 03/06/12 at 3:20 PM, with the Administrator revealed he was unaware the facility did not have a current sensitivity test on the fire alarm smoke detectors. He is trying to obtain paperwork showing the testing was completed.</p> <p>Reference: NFPA 72 (1999 edition)</p> <p>7-3.2.1* Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms</p>	K 054	<p>Continued from page 12</p> <p>Administrator.</p> <p>#5 Completed 3/30/12.</p>		

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K 054	<p>Continued From page 13</p> <p>and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method (2) Manufacturer ' s calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced.</p> <p>Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced.</p> <p>Exception No. 2: This requirement shall not apply</p>	K 054			

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K 054	Continued From page 14 to single station detectors referenced in 7-3.3 and Table 7-2.2.	K 054			
K 056 SS=D	<p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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 systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>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, in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety four (94) beds and the census was ninety two (92) on the day of the survey.</p>	K 056	<p>K056</p> <p>#1. The sprinkler heads identified in Room 2 and the Green Storage Room(have been/will be) replaced by the facility's designated sprinkler system service company.</p> <p>#2 An inspection was performed by the facility's contracted sprinkler system service company to identify if other sprinkler heads of a different nature are located in the same compartment.</p> <p>#3 The Administrator received in-service education on Regulation K056 from the facility's contracted consultant on 3/14/12 regarding the routine inspection of the sprinkler heads to assure that sprinkler heads of different types are not installed in the same compartments.</p> <p>#4. The CQI Indicator for the monitoring of sprinkler heads will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Administrator.</p> <p>#5. Completed 3/15/12.</p>		

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K 056	<p>Continued From page 15</p> <p>The findings include:</p> <p>Observation, on 03/06/12 at 10:30 AM, with the Administrator revealed a standard response sprinkler head and a quick response sprinkler head in the same compartment located in Room 2. Further observation showed the same in the storage room on Green Hall.</p> <p>Interview, on 03/06/12 at 10:30 AM, with the Administrator revealed he was not aware that the sprinklers had to have the same response time if the sprinkler heads are located in the same compartment.</p> <p>Reference: NFPA 13 (1999 Edition) 5-13 8.1</p> <p>Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.</p> <p>Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:</p>	K 056			

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K 056	Continued From page 16 (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.	K 056			
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety four (94) beds and the census was ninety two (92) on the day of the survey. The findings Include: Observation, on 03/06/12 between 10:00 AM and 3:30 PM, with the Administrator revealed sprinkler heads located throughout the facility to be loaded with lint and dirt. Interview, on 03/06/12 between 10:00 AM and 3:30 PM, with the Administrator revealed he was not aware the sprinkler heads were loaded with	K 062	K062 #1. The sprinkler heads identified on 3/6/12 to have lint and dirt have been cleaned. The gauge on the sprinkler riser (has been/will be) replaced by the facility's designated sprinkler system service company. The fallen insulation that is blocking the sprinkler heads will be removed/ repaired by the sprinkler system service company. #2 An inspection was performed by the facility's contracted sprinkler system service company to identify if other sprinkler heads were in need of cleaning, to check all areas in the attic to assure no other heads were blocked by fallen insulation. No other gauges were found to be in need of calibration. #3 The Administrator received in-service education on Regulation K062 from the facility's contracted consultant on 3/14/12 regarding the routine cleaning of all sprinkler heads, to assure insulation in the attic is not blocking the sprinkler heads and to assure the gauge on the sprinkler riser is calibrated or replaced every five (5) years. #4. The CQI Indicator for the		

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K 062	<p>Continued From page 17 so much debris.</p> <p>Observation, on 03/06/12 between 10:00 AM and 3:30 PM, with the Administrator revealed the facility failed to provide to provide documentation that the gauge on the sprinkler riser had been calibrated within the last 5 years.</p> <p>Interview, 03/06/12 between 10:00 AM and 3:30 PM, with the Administrator revealed he was not aware the gauges on the sprinkler riser had to be calibrated once every 5 years.</p> <p>Observation, on 03/06/12 between 10:00 AM and 3:30 PM, with the Administrator revealed the sprinklers in the attic were blocked by falling insulation.</p> <p>Interview, 03/06/12 between 10:00 AM and 3:30 PM, with the Administrator revealed he was unaware the insulation had fallen, blocking the spray pattern of the sprinkler heads.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>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.</p> <p>2-2.1.1* Sprinklers shall be inspected from the</p>	K 062	<p>Continued from page 17.</p> <p>monitoring of the sprinkler system will be utilized monthly x 2 months and then quarterly as per the established CQI calendar under the supervision of the Administrator.</p> <p>#5 Completed 4/30/12.</p>		

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K 062	<p>Continued From page 18</p> <p>floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied:</p> <p>(1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height</p> <p>The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.</p> <p>Reference: NFPA 25 (1998 Edition).</p>	K 062			

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K 062	<p>Continued From page 19</p> <p>10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance</p>	K 062			

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K 062	Continued From page 20 Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10	K 062			
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised	K 144			

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K 144	<p>Continued From page 21</p> <p>under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the emergency generator was maintained in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety four (94) beds and the census was ninety two (92) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 03/06/12 at 3:20 PM, with the Administrator revealed the generator was not being maintained on a weekly basis as required.</p> <p>Interview, on 03/06/12 at 3:20 PM, with the Administrator revealed he was not aware the generator needed to have a weekly maintenance schedule.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's</p>	K 144	<p>K144</p> <p>#1 & #2 The generator is being visually inspected and tested weekly, and exercised under load for 30 minutes per month and documented. The transfer switch is being tested monthly. A schedule has been set up by the Administrator to record this information.</p> <p>#3 The Administrator received in-service education on Regulation K144 from the facility's contracted consultant on 3/14/12 regarding the routine testing and running of the generator weekly and under load monthly.</p> <p>#4. The CQI Indicator for the monitoring of the generator will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Administrator.</p> <p>#5. Completed 3/30/12.</p>		

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K 144	Continued From page 22 recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction 6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.	K 144		
K 147 SS=D	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 in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility is	K 147		

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K 147	<p>Continued From page 23</p> <p>licensed for ninety four (94) beds and the census was ninety two (92) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 03/06/12 at 11:00 AM, with the Administrator revealed the electrical panels and the Generator Transfer switch were blocked by storage in the Kitchen. There is to be 3 feet of clearance around these panels for they are easily accessible.</p> <p>Interview, on 03/06/12 at 11:00 AM, with the Administrator revealed he was unaware the panels in the Kitchen were required to have 3 feet of clearance around them.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>110-26. Spaces</p> <p>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.</p>	K 147	<p>K147</p> <p>#1. The Electrical panel that was blocked during the survey on 3/6/12 has been corrected.</p> <p>#2. No other electrical panels areas were identified as being blocked.</p> <p>#3 The Administrator received in-service education on Regulation K147 from the facility's contracted consultant on 3/14/12 regarding the requirement to assure that all electrical panels are not blocked. The Administrator provided in-service education of this requirement to the Dietary personnel on 3/15/12.</p> <p>#4. The CQI Indicator for the monitoring of the electrical panels will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Administrator.</p> <p>#5. Completed 3/19/12.</p>		