

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

PRINTED: 06/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/11/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728
---	--

(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	F 000	<i>This Plan of Correction is the center's credible allegation of compliance</i>	
F 156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services,</p>	F 156	<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F-156 The Medicare Non-Coverage letter that was not issued was found in a closed resident record therefore could not be corrected. Resident #3 died at home after discharge from the facility.</p> <p>The records of all residents who have been discharged from Medicare services in the past 6 months has been audited by the Social Services Director, Medical Records person and/or the Administrator to ensure all ABN notices were issued timely. No other concerns were found.</p> <p>The Social Services Director was reeducated regarding the regulation pertaining to the issuance of Medicare Non-Coverage notices by the Administrator on 7/1/15.</p> <p>When a resident is discharged from Medicare services, the issuance of their Medicare Non-Coverage notice (ABN) will be verified by the Administrator until it is apparent that there are no remaining problems with this process, for a period of at least 3 months. The Administrator will be looking for timely issuance of the notice and proper notification. This will be tracked monthly and reported to</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Marcella Hodges</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7/2/15</i>
---	-------------------------------	----------------------------

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
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2015
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 156	<p>Continued From page 1 including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility</p>	F 156	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>the monthly Quality Assurance meeting by the Administrator for a period of at least 3 months.</p> <p>Date of Correction: 7/15/15</p>		

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

PRINTED: 06/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/11/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728
--	--

(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 156	<p>Continued From page 2</p> <p>written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and closed record review it was determined the facility failed to ensure the resident and/or resident's responsible party was issued a Medicare Non-Coverage letter with information regarding appeal rights for one (1) of three (3) closed resident records reviewed (Resident #18).</p> <p>The findings include:</p> <p>Interview with the Administrator on 06/11/15 at 6:10 PM, revealed the facility did not have a policy and procedure regarding the Advance Beneficiary Notice (ABN).</p> <p>Record review revealed the facility admitted Resident #18 on 12/09/14 with diagnoses which included Congestive Heart Failure, Anemia, and Depression. Further review revealed Resident #18 requested an early discharge and was discharged on 12/22/14. Additional review revealed no documented evidence an ABN was provided to Resident #18 or his/her responsible party.</p> <p>Interview with the Social Services Director on 06/11/15 at 6:05 PM, revealed she was</p>	F 156		
-------	---	-------	--	--

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

PRINTED: 06/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2015
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 156	Continued From page 3 responsible for providing the ABN to residents. She stated she did not provide the ABN to Resident #18 because he/she was discharged home early. The Social Services Director further stated she was not aware that all residents had to receive information regarding their appeal rights or how to file an appeal.	F 156	<i>This Plan of Correction is the center's credible allegation of compliance.</i>		
F 514 SS=E	Interview with the Administrator on 06/11/15 at 6:10 PM, revealed she was aware that all residents were to receive the ABN; however, she was not aware it was not being done. 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to maintain accurate immunization records for five (5) of twenty (20) sampled residents (Residents #3, #8,	F 514	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> F514 The immunization record for Residents #3, #8, #9, #11 and #12 cannot be corrected. The form, History and Record of Immunization, used to document the result of tuberculin skin tests did not provide an area to document the date the results were read. This form was replaced on 6/12/15 with the form, TB SCREENING AND IMMUNIZATION RECORD, that includes an area for "Date Read" as well as "Read By Signature". Education for licensed staff began on 6/11/15 and will be completed by 7/6/15 by the ADON on the requirement to provide the date the results of the tuberculin skin test is read. The DON will audit the TB SCREENING AND IMMUNIZATION RECORDS monthly to ensure proper documentation of the result with date read for a period of 3 months. Any concern noted will be corrected at that time.		

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

PRINTED: 06/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2015
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 514	<p>Continued From page 4 #9, #11, and #12). Review of the immunization records for Residents #3, #8, #9, #11, and #12 revealed the facility failed to document the date the tuberculin skin test results were determined by facility staff.</p> <p>The findings include:</p> <p>Review of the Clinical Record Documentation Guideline policy (dated 02/20/12) revealed the facility would maintain a complete, accurately documented, accessible, and organized clinical record for each resident.</p> <p>Review of the Tuberculin testing policy (dated 04/01/13) revealed the tuberculin skin test results must be documented through recording of the date and millimeters of induration of the most recent skin test in the medical record.</p> <p>1. Review of the facility's tuberculin (TB) History and Record of Immunization for Resident #3 revealed the annual TB skin test was administered on 04/08/15. Further review revealed the result was recorded as zero (0) millimeters (mm). Additional review revealed no documented evidence of the date the results were obtained by the facility.</p> <p>2. Review of the facility's TB History and Record of Immunization for Resident #8 revealed the annual TB skin test was administered on 03/11/15. Further review revealed the result was recorded as zero (0) mm. Further review revealed no documented evidence of the date the results were obtained by the facility.</p> <p>3. Review of Resident #9's TB History and Record of Immunization revealed on 08/13/14</p>	F 514	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>The result of these audits will be taken to the monthly Quality Assurance meeting for review by the IDT for a period of 3 months.</p> <p>Date of correction: 7/15/15.</p>		

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

PRINTED: 06/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2015
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 514	<p>Continued From page 5</p> <p>Resident #9 was given a Purified Protein Derivative (PPD) skin test in the right forearm. Although Resident #9 had a reading of zero (0) mm, there was no date provided as to when the PPD skin test was read by the nurse.</p> <p>4. Review of Resident #11's TB History and Record of Immunization revealed on 03/01/15 Resident #11 was given a PPD skin test in the left forearm. Although Resident #11 had a reading of zero (0) mm, there was no date provided as to when the PPD skin test was read by the nurse.</p> <p>5. Review of the immunization record for Resident #5 revealed the annual tuberculin skin test was administered on 03/12/15. The test result was recorded as zero (0) mm; however, there was no date recorded to reflect the date the test results were obtained by facility staff.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 06/10/15 at 8:17 AM, revealed she does all of the annual TB skin tests at the facility. She stated the facility's TB History and Record of Immunization form did not have room to record the date the TB skin test was read (assessed for a positive or negative result).</p> <p>Interview with the Director of Nursing (DON) on 06/11/15 at 3:20 PM, revealed it was her expectation for staff to document the date the TB skin test was read. She stated this was important because the test must be read within 48-72 hours after administration for accurate results. The DON stated she was not aware the facility's form did not have room to record the date.</p>	F 514			

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

PRINTED: 06/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. 2015	(X3) DATE SURVEY COMPLETED 06/10/2015
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728	
(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	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1985 SURVEY UNDER: 2000 Existing (Short Form) FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: Two story, Type 11(000) SMOKE COMPARTMENTS: 6 FIRE ALARM: Complete fire alarm system with heat and smoke detection SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system GENERATOR: Type II diesel generator A life safety code survey using a 2786S (short form) was initiated and concluded on 06/10/15, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility to not be in compliance with NFPA 101 Life Safety Code, 2000 Edition. The census for the facility was ninety-eight (98) with a capacity of one hundred four (104) residents, staff, and visitors. Deficiencies were identified during this survey with the highest deficiency at "F" level.	K 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than	K 018	K-018 Furniture in rooms 112, 114, 116, 120,137, 201 and 214 has been rearranged to allow the doors to the hallway to be closed. An audit of all resident rooms in the facility was conducted by the Maintenance Director to ensure there were no other impediments to closing the doors to the corridors of the facility. Any concerns that were identified were corrected at that time.	

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

TITLE

(X6) DATE

Marcella Hodges

Administrator

7/2/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 06/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2015
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728	
(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 018	<p>Continued From page 1</p> <p>required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure there were no impediments to the closing of doors located in the corridor as required by the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of six (6) smoke compartments, twenty (20) residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observations between 2:08 PM and 2:29 PM on 06/10/15, with the Maintenance Director, revealed the doors of resident rooms 112, 114, 116, 120, 137, 201, 201, and 214 were blocked from</p>	K 018	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <hr/> <p>As a part of their weekly environmental rounds, the Administrator and/or the Maintenance Director will include ensuring that there are no impediments to closing doors to the corridors of the facility. Any concerns found will be addressed at that time.</p> <p>The result of these rounds will be reported to the monthly Quality Assurance meeting by the Maintenance Director or the Administrator for a period of 3 months and quarterly thereafter.</p> <p>Date of Correction: 7/10/15</p>	

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

PRINTED: 06/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2015
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728	
(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 018	<p>Continued From page 2 closing by the use of furniture (resident chairs and beds).</p> <p>Interview with the Maintenance Director during the observations revealed staff should be aware resident room doors were not to be blocked by furniture.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1 3/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.</p>	K 018		

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

PRINTED: 06/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2015
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728	
(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 062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure automatic sprinkler systems were inspected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, one hundred four (104) residents, staff, and visitors.</p> <p>The findings include:</p> <p>Record review of the facility automatic sprinkler inspection records on 06/10/15 at 3:31 PM, with the Maintenance Director, revealed the facility last had an outside contractor conduct an internal pipe inspection on 03/04/10 to check for obstruction. Interview with the Maintenance Director on 06/10/15 at 3:31 PM, revealed the facility had no further documentation of an internal pipe inspection of the automatic sprinkler system.</p> <p>The Administrator acknowledged the findings during the exit conference.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>10-2* Obstruction Investigation and Prevention. 10-2.1* To ensure that piping remains clear of all obstructive foreign matter, an obstruction</p>	K 062	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>K-062 The internal pipe inspection for the automatic sprinkler system has been scheduled for 7/14/15.</p> <p>The tracking system for all inspections has been audited by the new Maintenance Director and the company Regional Maintenance Director to ensure that all other inspections are up to date and current. No other areas of concern were found.</p> <p>The Administrator and/or the Regional Maintenance Director will verify through use of the company tracking system that all inspections that are due have been scheduled timely and that all inspections are current, monthly for a period of 6 months. Any concerns found will be corrected at that time.</p> <p>The Maintenance Director and/or the Administrator will report the finding from the above verification to the IDT at the monthly Quality Assurance meeting for a period of 6 months and quarterly thereafter for a period of one year.</p> <p>Date of Correction: 7/15/15</p>	

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

PRINTED: 06/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2015
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728	
(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 062	<p>Continued From page 4</p> <p>investigation shall be conducted for system or yard main piping wherever any of the following conditions exist:</p> <p>(a) Defective intake for fire pumps taking suction from open bodies of water</p> <p>(b) The discharge of obstructive material during routine water tests</p> <p>(c) Foreign materials in fire pumps, in dry pipe valves, or in check valves</p> <p>(d) Foreign material in water during drain tests or plugging of inspector's test connection(s)</p> <p>(e) Plugged sprinklers</p> <p>(f) Plugged piping in sprinkler systems dismantled during building alterations</p> <p>(g) Failure to flush yard piping or surrounding public mains following new installations or repairs</p> <p>(h) A record of broken public mains in the vicinity</p> <p>(i) Abnormally frequent false tripping of a dry pipe valve(s)</p> <p>(j) A system that is returned to service after an extended shutdown (greater than 1 year)</p> <p>(k) There is reason to believe that the sprinkler system contains sodium silicate or highly corrosive fluxes in copper systems</p> <p>(l) A system has been supplied with raw water via the fire department connection.</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>	K 062		

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

PRINTED: 06/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2015
NAME OF PROVIDER OR SUPPLIER SUMMIT MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 062	Continued From page 5 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.	K 062			