

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

PRINTED: 04/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185310	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/18/2013
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NAME OF PROVIDER OR SUPPLIER EPISCOPAL CHURCH HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 7504 WESTPORT ROAD LOUISVILLE, KY 40222
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F 000	INITIAL COMMENTS A recertification survey was initiated on 04/16/13 and concluded on 04/18/13 and the Life Safety Code survey was conducted on 04/16/13 with deficiencies cited at the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be imposed.	F 000	The following information is provided as the Episcopal Church Home's credible allegation of compliance for the recertification survey of 4/16/2013 - 4/18/2013	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to maintain a clean and sanitary environment for one (1) of three (3) showers rooms. The shower floor on C Unit appeared soiled and unsanitary. In addition, there were seven (7) of eleven (11) wheelchairs on the C Unit that were soiled. The findings include: 1. Review of the facility's policy regarding cleaning the shower rooms was requested; however, the facility did not provide a policy. Interview with the Director of Nursing, on 04/18/13 at 3:05 PM, revealed there was not a policy for the cleaning of wheelchairs. Observation of wheelchairs during the breakfast meal service, on 04/16/13 at 12:24 PM, revealed	F 253	F 253 Additional Information: The DON was misquoted in Finding #1. The interview revealed that a policy for cleaning equipment did exist. Since wheelchairs are equipment, the policy for cleaning equipment did apply. Also, the surveyor was given a copy of the cleaning tasks list on the Nurse Aide Assignment list for Clingman which included the schedule for the cleaning of wheelchairs. Additional Information: P.3/29 Line 4: The Director stated the nurse managers were responsible for tracking the cleaning schedule. The DON observed the state of wheelchairs while doing routine rounding and reported issues to the nurse manager for correction/action. Additional Information: p.3/29 Interview with CNA #3: The CNA states she said that the residents did not walk on the floor with bare feet and that she did not walk on it with bare feet since both wore shoes. Wheel Chairs: Corrective Action Taken: Nurse aides and nurses were reeducated on their roles in cleaning and observing the appearance of wheelchairs,	

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

TITLE

(X6) DATE

X Anne H. Veno RN, CNHA

X Adm/CEO

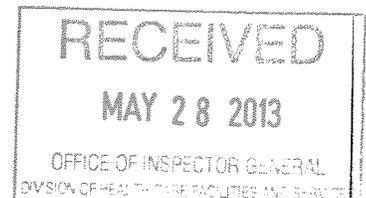
X 5/23/13

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

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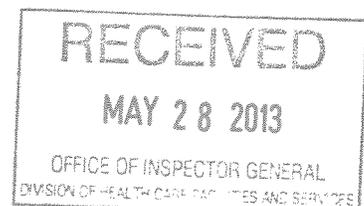
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F 253	<p>Continued From page 1</p> <p>seven (7) of eleven (11) wheelchair support cross bars and wheelchair spokes were soiled with loose tan particles and dried food substances.</p> <p>Observation of wheelchairs during the lunch meal service, on 04/17/13 at 8:30 AM, revealed five (5) of eleven (11) wheelchairs support cross bars and wheelchair spokes were soiled with loose tan particles and dried food substances.</p> <p>Observation of one of two wheelchairs in resident room C 8 and interview with Unsampled Resident E, on 04/18/13 at 2:30 PM, revealed an alcohol wipe with a brown center was stuck to the right support bar under the wheelchair.</p> <p>Interview with the Unit Manager, Licensed Practical Nurse (LPN) #4, on 04/18/13 at 1:00 PM, revealed that was a dried alcohol wipe with blood on it. She reported that should have been put in the trash. She stated the loose tan particles were dust on the wheel chair support bars. She reported the wheelchairs are on a schedule for the night shift to clean. She reviewed the scheduled cleaning and reported the wheelchairs were not cleaned as scheduled on the previous nights this week. She reported she had developed the wheelchair cleaning schedule. She reviewed the wheelchair cleaning schedule as she observed the wheelchairs on the unit and stated the wheelchairs on the schedule earlier this week were not cleaned by their appearance.</p> <p>Interview with the Director of Nursing, on 04/18/13 at 3:05 PM, revealed there was not a policy for the cleaning of wheelchairs. She stated it was the responsibility of the Unit Manager to</p>	F 253	<p>reasons for cleaning wheelchairs, how to do and consequences to them that would occur if not cleaned or monitored. All the residents' wheelchairs listed were cleaned before the end of the day 4/17/13. The Nurse Manager of each neighborhood (Clingman, Marmion, Morton) and shift supervisors (3-11 & 11-7) conducted the instruction using the guide provided for instruction.</p> <p>Other residents having the potential to be affected:</p> <p>All wheelchairs in the facility were Inspected and any needing cleaning were cleaned</p> <p>Measures put in place:</p> <p>Root cause of the issue seemed to be a lack of follow up by the charge nurse and nurse manager to make sure the chairs were being cleaned as assigned or a reassignment done if staffing adjustments were made. A systematic schedule was in place to clean all wheelchairs. A checking report is now to be completed by the night nurse, or if he/she is unable, by another night shift nurse and given to the Nurse Manager. The Nurse Manager is responsible for ensuring the wheelchair checks are completed timely via spot checks while rounding and for educating all staff to maintain clean wheelchairs at all times. Wheelchair inspections for cleanliness have been added to the Environmental Rounds QA tool.</p> <p>Monitoring:</p> <p>The nurse manager will check the work while conducting an environmental inspection with the report submitted for review and problem solving</p>		



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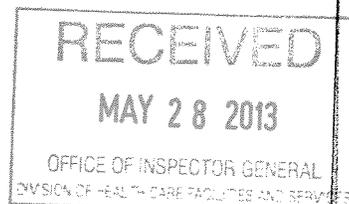
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F 253	<p>Continued From page 2</p> <p>ensure the wheelchairs were kept clean and there was a cleaning schedule. She reported she did not track the cleaning schedule.</p> <p>2 Observation, on 04/16/13 at 2:25 PM, 04/18/13 at 1:30 PM, and 04/18/13 at 2:05 PM, revealed the shower/whirlpool room on the C Unit had a cushioned floor tile with multiple stains.</p> <p>Review of the Life Floor Tile Installation and Maintenance Guide revealed the floor could be installed in showers and bathrooms. The floor should be cleaned and scrubbed using a mop, cloth, sponge, or scrubbing machine. In high traffic areas daily cleaning was recommended.</p> <p>Review of the facility's Environmental Services (EVS) Inspection Sheets, dated 03/18/13 thru 04/15/13, revealed Whirlpool Room floors were swept and mopped daily.</p> <p>Interview with Environmental Services (EVS) Aide #2, on 04/18/13 at 9:55 AM, revealed he did sweep and mop the floor in the C Unit shower room on occasion; however, was not the regular Floor Tech for the C Unit. The EVS Aide stated the floor would come clean after being mopped, and would also smell better.</p> <p>Interview, on 04/18/13 at 1:40 PM, with CNA #3 revealed the housekeeping department was responsible to clean the shower room floor on the C Unit. The CNA stated the floor was soiled and stained and would not walk on the floor herself, nor allow the resident to walk on the floor. The aide stated she did not allow the residents to take</p>	F 253	<p>immediately and during the Neighborhood staff meeting. The problem solving plan would then be submitted to the QAPI Steering Committee monthly. Frequency of submission may decrease in frequency to every other month if perfect compliance existed.</p> <p>Corrective date: 4/19/2013</p> <p>Whirlpool/Shower Room Floor:</p> <p>Corrective Action Taken: Immediate housekeeping services were provided by properly cleaning the floor identified as having stains/soiled.</p> <p>Consultation from the manufacturer of the Life Floor Tile was obtained and a new cleaning technique was applied using chemicals provided by the manufacturer of the floor, that were not disclosed to ECH at the time of purchase/installation or upon inquiry, prior to the May 2013.</p> <p>The Director Of Environmental Services education the EVS Floor Technician & EVS Supervisor on the proper cleaning technique for the Life Floor Tile on May 2, 2013. The EVS Technician was able to demonstrate proper leaning technique using chemicals obtained by Life Floor Tile on May 6, 2013.</p> <p>Other Residents have the potential to be affected:</p> <p>36 of the residents in the Clingman Neighborhood routinely receive services in the shower room.</p> <p>Measures put in place:</p> <p>Include shower rooms on daily rounds for EVS Inspection Checklist. Encourage nursing staff to</p>		



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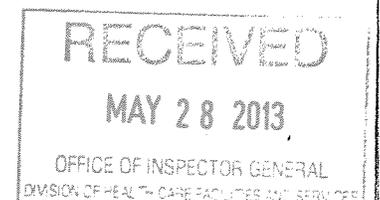
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F 253	Continued From page 3 their shoes off until they were in the whirlpool tub. The CNA stated residents could get contaminated walking on the floor in its condition. On 04/18/13 at 1:45 PM, interview with EVS Aide #1 revealed he mopped the C Unit shower room floor daily; however, the stains would not come out. The EVS Aide stated he used a floor scrubber twice a week to get the stains out. The aide stated there was not a reason why the scrubber was not used daily. He stated he would not walk on the floor as the floor looked dirty and stained. The aide stated the soiled and stained floor could get the residents dirty as well. Interview with the Director of Environment Services, on 04/18/13 at 2:05 PM, revealed the C Unit shower room floor was mopped daily. She stated a scrubber had been used on the floor; however, the scrubber did not bring the floor back to the way it originally was. She stated the floor looked dirty and there was no way to remove the stains. Interview, on 04/18/13 at 2:05 PM, with the Director of Facilities revealed the C Unit shower room had been remodeled and the floor was less than a year old. He stated the floor had multiple stains and a representative from the flooring company had been to the facility to see the floor; however, the flooring company representative did not know how to care for it.	F 253	report when shower rooms need immediate attention. Included in the corrective action is the specific date of re-education and the title of person providing. Monitoring: Environmental Services Department will provide ongoing monitoring of shower rooms. The Director and/or Supervisor of Environmental Services will receive and review checklists each day they work, in order to maintain a clean and sanitary environment. Results of the reviews will be reported monthly to the QAPI Steering Committee. Corrective date: 05/06/2013 Addendums: Neighborhood Inspection Report, Environmental Inspection Audit tool sample, Sample of wheelchair cleaning schedule, Sample of nursing Asslgnment listing for w/c cleaning with nurse responsible for checking, Wheelchair safety, maintenance, cleaning/Lift cleaning/safety & maintenance Desktop Reference, staff counseling forms (12), Wheelchair Safety In-service records, Root Cause Analysis-wheelchairs, Life Floor ® Cleaning Guide, EVS Inspection Sheet, pictures of Clingman Shower/Whirlpool room floor.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280			



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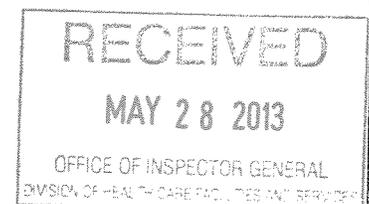
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F 280	<p>Continued From page 4</p> <p>participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an 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 observation, interview, record review and facility policy review, it was determined the facility failed to review and revise the comprehensive care plan for two (2) of twenty-four (24) sampled residents and five (5) unsampled residents (Residents #7 and #10) after falls.</p> <p>The findings include:</p> <p>1. Review of the facility's Falls Risk Policy, dated 01/07, revealed residents were assessed for falls on admission and quarterly thereafter. If the resident was determined to be a high risk, a care plan was developed and interventions were</p>	F 280	<p>F 280</p> <p>Additional Information: The Falls procedure provided was an old version. The latest update was dated 12/12 and is attached.</p> <p>Corrective Action on Found residents:</p> <p>Of the two resident listed, Resident #10 had the care plan reviewed and revised by the Nurse Manager in collaboration with the neighborhood nursing staff and Director of Clinical Services on 5/4/2013 and 5/7/2013. Resident # 7 was deceased. The nurses involved were re-educated through small group and Individual meeting with the Director of Clinical Services (DCS), ADON or Nurse Managers or House Supervisors 5/2, 5/3 and 5/7/13 on how to modify the care plan after each fall by looking at root causes and devising individually applicable approaches/interventions. Counselings of the nurse manager and nurses were administered by 5/6/13. Expectations for performance based upon the Falls Management procedure, prior training and discussion were already in place for guidance. Nurse Managers were asked to follow up by monitoring the care plan and to report outcomes to the Falls Meeting. The Assistant Director of Nursing has been assigned responsibility for ensuring the process is followed and ensuring all new employees are educated on it.</p> <p>Resident #7's CNA had been terminated and the resident has passed away-not related to the fall.</p>	5/8/13



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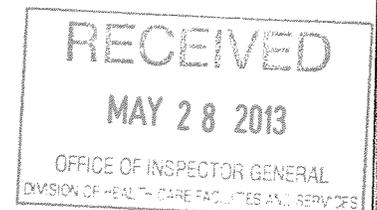
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F 280	<p>Continued From page 5</p> <p>implemented. If the resident had a fall, the care plan was to be reviewed and revised with appropriate interventions.</p> <p>Review of the facility's policy regarding Fall Management, dated 01/07, revealed actions would be put into place to prevent another fall. The Fall Committee composed of multiple disciplines were to review falls for risk factors, the need for further assessment and the effectiveness of the care plan. Specific interventions may include patterns, situations and behaviors associated with falls and included monitoring.</p> <p>Review of the clinical record for Resident #10 revealed the facility admitted the resident with diagnosis of Alzheimer's Disease with Behavior Disorder. The facility assessed the resident on 10/12/12 and 03/29/13 and found the resident to have a high risk of falls. The facility completed an Annual Minimum Data Set (MDS) assessment on 04/04/13. The resident had a severe cognitive impairment and required extensive assistance with all care. In addition, the resident received psychoactive medications and had behaviors.</p> <p>Review of the Nursing Notes revealed Resident #10 had falls on 10/25/12, 11/02/12, 12/04/12 and on 02/02/13 there were two falls.</p> <p>Review of the care plan for Resident #10 revealed the resident was at risk for falls and the interventions included: restorative ambulation and administer Trazodone and Klonopin (psychotropic medications) as ordered by the physician. There</p>	F 280	<p>All Residents:</p> <p>All current residents who experienced a fall in the last three months were reviewed for care plan updating, appropriateness of interventions and Risk Watch information reviewed by the Director of Clinical Services in collaboration with the Nurse Managers MDS Coordinators, and staff nurses to ensure appropriate causation or contributing factors were identified in the care plan. All residents using a wheelchair were reviewed by the Nurse Managers, nurses, and aides for leg rest usage and the need for using. Consideration of safety awareness, decision-making abilities, mobility – self-propelling, and other abilities, fatigue factors, travel distance and falls circumstances-was undertaken if use would contribute more to falling or not. (A total of 37 residents met at least one of the 2 criteria.) Nurse aides and nurses were re-educated by the Nurse Managers, House Supervisors, and ADON using a structured instruction plan on wheelchair safety with written instruction provided 4/30/13-5/8/13. See Addendum for F 253 for content.</p> <p>Measures:</p> <p>MDS, all staff nurses and Nurse Managers were re-educated by the DCS on the process to use to identify root causes by involving the care team and using the 5 WHY's technique. See dates above. The Falls Committee was refocused by the DCS to ensure the identification of root causes and entering and reviewing the data entered in the Risk Watch database and the care</p>	



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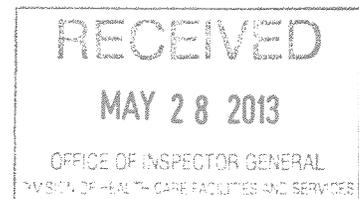
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F 280	<p>Continued From page 6</p> <p>was no evidence of other interventions to prevent falls.</p> <p>Interview with Certified Nurse Aide (CNA) #8, on 04/17/13 at 12:50 PM, revealed Resident #10 had behaviors and refused care, hit at staff and was very confused. She stated the resident could get out of the chair fast, especially when irritated. She stated some residents had alarms or barriers to slow them down and prevent falls; however, Resident #10 did not.</p> <p>Interview with Registered Nurse (RN) #3, on 04/18/13 at 10:10 AM, revealed care plans were reviewed and revised as needed. She stated a fall would be a reason to review the care plan. She stated she could not locate any documentation to show Resident #10's care plan had been revised to reflect falls or new interventions. She stated the care plan needed to be reviewed and revised especially since the drugs were not appropriate interventions to improve safety for the resident. She stated the nurses could add to the care plan; however, it appeared as if no one had reviewed or revised the resident's care plan for falls.</p> <p>2. Review of Resident #7's medical record revealed the facility admitted the resident on 01/21/13 with the diagnoses of Alzheimer's Disease with behaviors, Immobilization Syndrome and Anxiety. On 01/22/13, the Physical Therapy Department completed a safety assessment and identified concerns with the length of the leg rests on the resident's wheelchair. On 01/24/13, the Physical Therapy Department shortened the length of the resident's wheelchair leg rests for</p>	F 280	<p>plan problem statements to help drive the selection of appropriate goals and interventions. The Risk Watch education processes were expanded with nurse managers' and ADON roles and responsibilities for monitoring and investigating clarified by the DCS. The nurse managers are to complete the investigative phase as soon as possible, but within seven days of the occurrence and enter their findings in Risk Watch. As a part of their process, the care plan update monitoring is included. Verification of completion of the process is to be done by the ADON. This verification is to be reflected in minutes of the weekly Falls Committee meeting which is distributed to all departments by the ADON.</p> <p>To make care plans more accessible, the care plans were removed from the individual resident chart and placed in a separate care plan binder. Root cause analysis indicated that the chart was often unavailable with multiple team members needing to use it simultaneously causing the care plan updating step to be forgotten. Reports solicited by the DCS are that this change has been helpful.</p> <p>The root cause exploration also identified that some residents were identified as at the end of life for which restlessness was noted. This condition was the case with the deceased resident #7. If after all possible adaptations have been made with limited or no success, we- the Nursing Leadership Team- have directed the nurses to note that the plan of care had been</p>	



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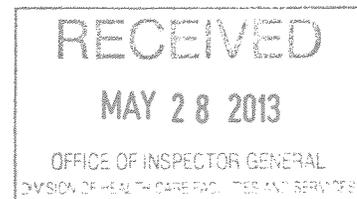
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F 280	<p>Continued From page 7</p> <p>appropriate fit and safety. The facility completed an Admission Minimum Data Set, dated 01/27/13, and assessed the resident as being totally dependent for locomotion on and off the unit, utilizing a wheelchair, and with the assistance of one (1) person. The facility assessed the resident as having severely impaired cognition with a Brief Interview of Mental Status (BIMS) of three and exhibiting physical behaviors directed towards others four to six days of the assessment period.</p> <p>Review of Resident #7's comprehensive plan of care revealed the facility identified a problem of impaired mobility related to generalized weakness and a history of falls. However, the facility did not identify a mobility plan or assistive devices to use during transport.</p> <p>Review of the Occurrence Report, dated 03/07/13, revealed a Certified Nursing Assistant (CNA) was propelling the resident backwards in a wheelchair to the dining room, when the resident put their feet down on the floor, they fell out of the wheelchair and landed on the floor.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 04/17/13 at 2:28 PM, revealed witnessing Resident #7 sitting close to the edge of the wheelchair seat as the CNA was pulling the resident backwards in the dining room area. The LPN revealed no leg rests were noted to the wheelchair at the time of the incident.</p> <p>Interview with LPN #1, on 04/18/13 at 9:05 AM, revealed Resident #7 was to have leg rest to the wheelchair and did not have the leg rests on at the time of the fall. The LPN revealed the CNA</p>	F 280	<p>reviewed, and, if no further interventions were identified to be of help in preventing falls, to write that the review occurred and to continue the plan of appropriate interventions until the case can be further discussed with the care team including the physician and family. Notes are to be made in the medical record of these discussions.</p> <p>Measures instituted in relation to the wheel chair fall of resident #7, were to re-educate the nursing staff on safety practices for using a wheelchair. Note: The nurse had intervened to attempt to prevent the fall, but was too late. Wheel Chair safety education has been incorporated into New Hire Orientation and was completed May 6, 2013. Leg rest usage was added into the temporary care plan as a routine option by the DCS on May 2, 2013. A storage area was designated for leg rests when not in use or found to be more of a hazard than a safety measure. Staff had identified a root cause of non-use of leg rests was that they could not easily find them. A desktop reference on wheel chair usage, safety and cleaning was also formalized by a Nurse Manager and approved by the Nursing Leadership Team on 5/2/13.</p> <p>Monitoring Performance:</p> <p>The Assistant Director of Nursing will be responsible for working with the Nurse Managers to determine if each fall is being addressed properly. The Nurse Manager will involve the staff on the neighborhood in the</p>		



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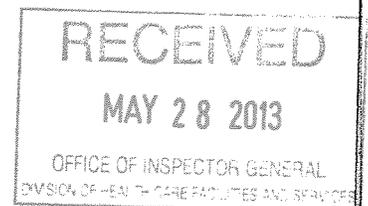
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F 280	<p>Continued From page 8</p> <p>was one of the resident's usual caregivers and knew they should have been in place and not to transfer anyone backwards in a wheelchair.</p> <p>Observation of Resident #7, on 04/18/13 at 12:30 PM, revealed the resident sitting in the dining room area with no leg rest in place to the wheelchair. Observation of the resident, on 04/18/13 at 1:00 PM, revealed a male resident transporting the resident from the dining room to the residents room with no leg rests in place while CNA #1 watched as she was engaged in a casual conversation with a visitor.</p> <p>Interview with CNA #1, on 04/18/13 at 1:00 PM, revealed use of Resident #1's leg rests were dependent upon the resident's behavior at the time of the transfer. The CNA revealed the resident probably should have them on at all times, but revealed she could not find the ones therapy had adjusted to fit the resident's wheelchair. The CNA revealed the CNA care plan did not identify which residents required leg rests for safe transfer.</p> <p>Interview with the D Hall Unit Manager, on 04/18/13 at 1:40 PM, revealed Resident #7 did not self propel their wheelchair with their feet, and should have leg rests on during transfers. However, the Unit Manager revealed this information was not on the CNA care plan or on the resident's comprehensive plan of care. The Unit Manager revealed the resident's comprehensive plan of care was not revised to reflect the fall or updated with interventions for safe transfer.</p> <p>Interview with the ADON, on 04/18/13 at 3:45</p>	F 280	<p>plans to prevent further falling with each fall.</p> <p>The Falls Committee led by the ADON will be the mechanism for review and monitoring with minutes being recorded and scanned to other departments and the Director of Clinical Services to ensure this process has happened. Care plans are to be brought to the Falls Meeting for interdisciplinary review. Risk Watch will be accessed to monitor documentation and the investigation of each incident to include root cause analysis. The ADON or DCS, the Medical Director and Associate Administrator are reviewing the occurrence reports in Risk Watch. Reporting will also be made by the DCS to the QAPI Steering Committee via the Nursing Department reporting with the monthly meeting.</p> <p>Completion: 5/7/2013</p> <p>Addendum: Falls Management desk top reference, Wheelchair Safety, maintenance, cleaning Lift Cleaning/safety & maintenance-see in Addendum for F253, Revised Care Plan Resident #10 & Resident # 1, w/c safety records of training-see in Addendum for F253, Counseling of nurses failing to update care plan, Care Plan Memo 5/3/13-read & sign reflecting care plan changes, Orientation checklist, Potential for Injury Temporary Care Plan, Wheel Chair safety teaching plan.</p>		



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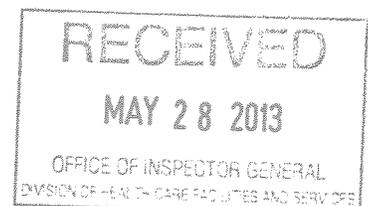
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F 280	Continued From page 9 PM, revealed the Unit Manger completed the falls investigation and determined it was an isolated incident. The ADON revealed she did participate in the dismissal of the CNA but did not know the circumstances of the resident's fall. The ADON stated the care plan should have been revised to include the use of the leg rests during resident transport.	F 280		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and the facility's policies Falls Management, Occurrence Tracking, and Fall Risk Assessment, it was determined the facility failed to ensure four (4) of twenty four sampled and five (5) unsampled residents received the supervision and assistance necessary to prevent falls and accidents. The findings include: 1. Review of Resident #7's medical record revealed the facility admitted the resident on 01/21/13 with diagnoses of Alzheimer's Disease, Immobilization Syndrome and Anxiety. On 01/22/13, the Physical Therapy Department	F 323	F323 Additional Information: Male resident cited as pushing resident # 7 was her spouse. Corrective Action-Residents Found A review of Resident #7 was performed at the time of the occurrence and the employee was terminated. The resident has since died due to a non related cause. A nurse had intervened by telling the aide to stop at the time of the incident, but was too late to prevent the fall. Resident #10: The Falls Management policy dated 1/07 cited was not the latest updated reference. See addendum completed 12/12 after implementing the Risk Watch Occurrence Reporting software program. Resident # 10's care plan was reviewed and revised. See addendum. Re-education of the MDS nurses, managers and the staff nurses were completed to emphasize the need to carefully involve the whole care team to review the cause/ contributing factors or root causes of the falls. The education of the nurse managers, house	5/8/13



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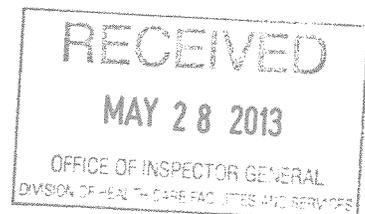
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F 323	Continued From page 10 completed a safety assessment and identified concerns with the length the leg rests on the resident's wheelchair. On 01/24/13, the Physical Therapy Department shortened the length of the resident's wheelchair leg rests. The facility completed an Admission Minimum Data Set, dated 01/27/13, and assessed the resident as being totally dependent for locomotion on and off the unit, utilizing a wheelchair, and with the assistance of one (1) person. The facility assessed the resident as having severely impaired cognition with a Brief Interview of Mental Status (BIMS) of three and exhibiting physical behaviors directed towards others four to six days of the assessment period. Review of Resident #7's comprehensive plan of care revealed the facility identified a problem of impaired mobility related to generalized weakness and a history of falls. However, the facility did not identify a mobility plan or the assistive devices to use for safe transport of the resident. Review of the Occurrence Report, dated 03/07/13, revealed a Certified Nursing Assistant (CNA) was propelling the resident backwards in a wheelchair to the dining room. When the resident put their feet down on the floor, they fell out of the wheelchair and landed on the floor. Interview with Licensed Practical Nurse (LPN) #2, on 04/17/13 at 2:28 PM, revealed witnessing Resident #7 sitting close to the edge of the wheelchair seat as the CNA was pulling the resident backwards in the dining room area. The LPN revealed no leg rests were noted to the wheelchair at the time of the incident.	F 323	supervisors, and Assistant Director of Nursing was done by the Director of Clinical Services (DCS) on 5/3/13 in small group and individually. Reeducation of the nursing staff began 4/30 thru 5/8/13 and was accomplished via shift supervisors and neighborhood nurse managers discussing information published 5/3/13 in a memo developed by the DCS. The 5 Why's technique was offered for use as a means to help identify the factors. This resident had a strong activity need that was not able to be anticipated. Many interventions used had not adequately been listed in the care plan. Nurses now know to list and identify the cause/ contributing factors of each fall and changes in interventional approaches. They have also been re-educated that they must have documented and tried other interventions first prior to using psychotropic medications. The primary physician had been involved in this case. This resident had transferred from personal care with the same falls issue. He would not use a recliner to rest in direct view or elsewhere. When laid down to rest, he got up in spite of frequent checks and monitoring by the staff. While staff attempted interventions to minimize his falls, falls were a part of who he is.		



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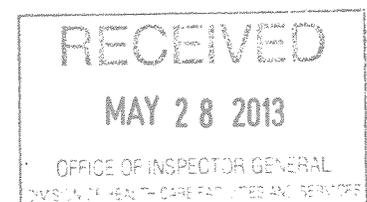
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F 323	<p>Continued From page 11</p> <p>Interview with the House Supervisor, on 04/17/13 at 4:30 PM, revealed she was notified of the fall and spoke with the CNA who stated the resident was putting their feet down on the floor, which prevented the wheelchair from propelling forward during transport. The House Supervisor revealed the resident should be transported with leg rests, and revealed the CNA reported she was unable to find the resident's leg rests. The House Supervisor revealed she was unable to find the leg rests therapy had made for the resident's wheelchair and had to get a pair out of supply to use until they could be located.</p> <p>Interview with LPN #1, on 04/18/13 at 9:05 AM, revealed Resident #7 was to have leg rest to the wheelchair, as the resident made no attempts to self propel the wheelchair, and was known to have behaviors of resisting care. The LPN revealed the resident did not have the leg rests on at the time of the fall. The LPN revealed the CNA was one of the resident's usual caregivers and knew they should have been in place and not to transfer anyone backwards.</p> <p>Observation of Resident #7, on 04/18/13 at 12:30 PM, revealed the resident sitting in the dining room area with no leg rest in place to the wheelchair. Observation of the resident, on 04/18/13 at 1:00 PM, revealed a male resident transporting the resident from the dining room to the residents room with no leg rests in place while CNA #1 watched and was engaged in a casual conversation with a visitor.</p> <p>Interview in CNA #1, on 04/18/13 at 1:00 PM, revealed Resident #1's leg rests were used dependent upon the resident's behavior at the</p>	F 323	<p>Diversional measures were not successful except for a very short period of time.</p> <p>Resident #1: This resident's family is unique and desired to control all aspects of the resident's life and care. Cultural expectations also play a role. ECH has requested the assistance of and consulted with two other state agencies concerning the resident/family. These areas were identified as part of the root causes of the first fall. The family had absolutely refused to allow the use of a mechanical lift as recommended. Much discussion and team conferences have been held with the family to discuss the plan of care and reach agreement on the prognosis of the resident. The Nurse Manager has been re-educated to investigate each occurrence to identify the cause/contributing factors and to reflect this investigation in her conclusions listed in Risk Watch software program. The care plan is to be updated accordingly. The care plan has been updated to include family and resident instruction.</p> <p>Resident #16 has muscle weakness requiring staff assistance, poor memory and unsteadiness with balance issues. ECH had been working on call light use reminders-in hopes of tagging it into his memory, proper foot wear, toileting checks, and tab alarm use. The resident tends to get up and go-</p>		



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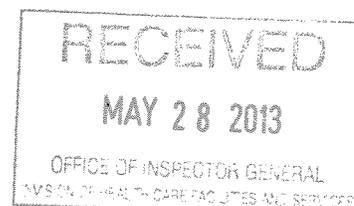
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F 323	Continued From page 12 time of the transfer. The CNA revealed the resident probably should have them on at all times, but revealed she could not find the ones therapy had adjusted to fit the residents wheelchair. Interview with LPN #1, on 04/18/13 at 1:15 PM, revealed the residents leg rests were to long so she removed them from the wheelchair. The LPN revealed the resident should have the leg rests in place but felt the residents wheelchair seat cushion looked like it was high enough to keep most of her feet off of the ground. Interview with the D Hall Unit Manager, on 04/18/13 at 1:40 PM, revealed Resident #7 was assessed by therapy for safety concerns and had leg rests adjusted to appropriate length for safe transfer. The Unit Manager revealed use of leg rests during transfer could be based upon a physicians order or nursing judgement for safety concerns. The Unit Manager revealed Resident #7 was not someone that self propelled their wheelchair with their feet, and should have leg rests on during transfers. The Unit Manager revealed this information was not on the CNA care plan, or on the resident's comprehensive plan of care because it was not an actual physicians order. The Unit Manager revealed after the resident's fall from the wheelchair the CNA was terminated, but no new interventions were put into place and no education was provided to the nursing staff on appropriate transfer or use of leg rests. Interview with the Director of Nursing (DON), on 04/18/13 at 3:15 PM, revealed all falls were reviewed in the falls committee to determine a	F 323	not always with a reason we can determine. Diversional activities, in the community area, have been added for this resident. The care plan has been revised- see Addendum. The Nurse Manager has been instructed to identify cause/contributing factors via root cause analysis with each fall. Each shift is to pull together to look at a fall/occurrence to determine the root causes from each caregiver's perspective. ALL RESIDENTS We have reviewed the falls and care plans of all current residents who fell in the last three months to identify cause/contributing factor/root causes and incorporate them into the problem statement of the care plan. Goals and interventions were reviewed with attention to addressing the root causes and revised as indicated. See Addendum. MEASURES: The Falls Management Desktop Reference and how to care plan was reviewed with nurses and aides. Staff has been asked to group together to discuss each fall and update the care plan based on cause/contributing factors. They are also instructed to report on their findings at shift change and update the SRNA worksheets timely. Care plans were moved out of the		



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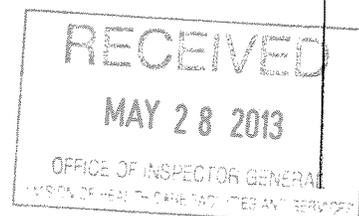
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F 323	<p>Continued From page 13</p> <p>root cause and possible interventions to prevent further falls. The DON revealed she was no longer a member of the Falls Committee and had delegated that responsibility to the Assistant Director of Nursing (ADON) with minimal supervision.</p> <p>Interview with the ADON, on 04/18/13 at 3:45 PM, revealed the D hall Unit Manger completed the falls investigation and determined it was an isolated incident. The ADON revealed she participated in the dismissal of the CNA, but did not know the circumstances or details of the resident's fall. The ADON revealed the facility did not provided training on appropriate transport with a wheelchair or appropriate usage of leg rests. The ADON stated the facility should have monitored for appropriate use of leg rests and provided education after the resident's fall.</p> <p>2. Review of the facility's policy regrding Fall Management, dated 01/07, revealed falls were investigated for causative factors and contributing circumstances that may have caused a fall. Actions would be put into place to prevent another fall. The Fall Committee composed of multiple disciplines were to review falls for risk factors, the need for further assessment and the effectiveness of the care plan. Specific interventions may include patterns, situations and behaviors associated with falls and included monitoring.</p> <p>Observation of Resident #10, on 04/16/13 at 11:45 AM, revealed the resident was sitting in a</p>	F 323	<p>chart into a notebook to be viewed confidentially by any member of the care team. Delays in being able to gain access to the chart had been identified as a root cause in not updating the care plan when many are trying to use one chart.</p> <p>The occurrence is to be recorded in the Risk Watch software program and in the Nurses Notes. The care plan is to be revised with each occurrence. The Nurse Manager is to investigate each fall/occurrence and identify the cause/ contributing factors/root causes and review the care plan and revising as necessary to reflect the findings of the investigation and prevent possible reoccurrence. Findings (care plan updating needs or changes in approaches) will be presented to the care team and the outcomes shared in shift report. Trending, patterns identified and summaries of progress in reducing falls or injuries in individuals as well as the entire group of residents will be presented by the nurse manager to the neighborhood teams at the monthly staff meeting.</p> <p>Monitoring: Performance will be monitored by the interdisciplinary Falls Committee where a review of the care plan and falls occurrence will occur. Attention to proper root cause</p>	



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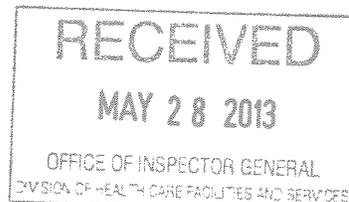
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F 323	<p>Continued From page 14</p> <p>wheelchair, in the dining room, and looking out the window.</p> <p>Review of the clinical record for Resident #10 revealed the facility admitted the resident with diagnoses of Alzheimer's Dementia with Behavior Disorder and Hard of Hearing. The facility completed an Annual Minimum Data Set (MDS) assessment on 04/04/13 which revealed the resident had a severe cognitive impairment and required extensive assistance with all care. The resident had behaviors of aggression toward staff and resisting care.</p> <p>Review of the nursing progress notes for 10/25/12 revealed Resident #10 was found on the floor in the bedroom. On 11/02/12, the resident was found on the floor in the common area. On 12/04/12, the resident was found on the floor in another resident's room. On 02/02/13 the resident was found on the floor in the hallway twice, once while ambulating unassisted.</p> <p>Review of the comprehensive care plan for Resident #10 revealed the resident was at risk for falls. There was no information located to indicate the resident had several actual falls. The interventions implemented were restorative ambulation and clonazepam and trazadone as ordered by the physician.</p> <p>Interview with Certified Nurse Aide (CNA) #8, on 04/17/13 at 12:50 PM, revealed Resident #10 did have falls and would be found on the floor. She stated the resident would ambulate or transfer without assistance. She stated the resident was very unsteady when ambulating. She stated she was not aware of any particular interventions to</p>	F 323	<p>analysis is to be given and the reflection of the causation reflected in the goals and interventions. The Assistant Director of Nursing is to coordinate these activities with regular reporting to the Director of Clinical Services and monthly to the QAPI Steering Committee.</p> <p>Completion Date: May 8, 2013</p> <p>Addendum: Cited residents' care plans, Care plan memo-in-service, 3 months of falls care plan revisions.</p>		



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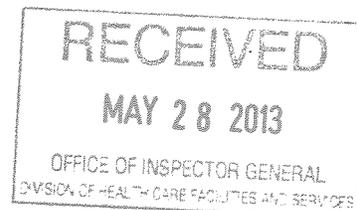
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F 323	<p>Continued From page 15 provide the resident with increased safety.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 04/18/13 at 2:30 PM, revealed the Falls Committee reviewed falls on a weekly basis and reviewed the care plan. She stated she participated on the Falls Committe and all falls were reviewed weekly and the fall investigation was reviewed. She stated most falls were caused by the resident transferring or ambulating without assistance.</p> <p>3. Observations, on 4/16/13 at 9:10 AM, 11:48 AM, 2:45 PM, and 4/17/13 at 8:30 AM, revealed Resident #1 was lying in bed on his/her back.</p> <p>Review of the clinical record for Resident #1 revealed the facility admitted the resident with diagnoses of Pancreatic Cancer and Muscle Weakness. The facility completed a re-admission MDS assessment, on 04/04/13, which revealed the resident was severely impaired cognitively and required extensive assistance with all care.</p> <p>Review of the comprehensive care plan for Resident #1, dated 03/14/13, for risk of falls, revealed the facility would transfer the resident with the assistance of two (2) staff, assist the resident to wear non-slick footwear, and to educate the family about requesting assistance to transfer the resident.</p> <p>Review of the facility's falls investigation reports revealed Resident #1 had a fall on 02/27/13 at 12:17 PM and on 04/13/13 at 1:00 AM. The facility investigation for the fall on 02/27/13 revealed Resident #1's family member had</p>	F 323			



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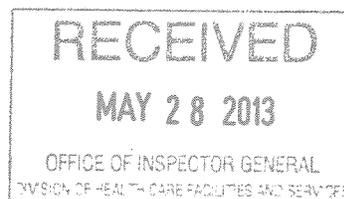
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185310	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/18/2013
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F 323	<p>Continued From page 16</p> <p>attempted to transfer the resident from the wheelchair to the bathroom without staff assistance. The conclusion to the investigation revealed the family member was educated to ask staff to assist the resident to transfer. The facility investigation for a fall, on 04/13/13, revealed two (2) staff were assisting Resident #1 to transfer from the recliner to the bed when the resident began to slide to the floor. The investigation's conclusion revealed the Therapy Department would evaluate the resident for possible use of a lift during transfers.</p> <p>Interview with RN #6, on 04/18/13 at 1:05 PM, revealed when a resident had a fall, the report was entered into the computer and the facility investigation was conducted by the Unit Manager (UM).</p> <p>On 04/18/13 at 1:15 PM and continued on 04/18/13 at 2:45 PM, interview with the A Unit Manager (UM) revealed she was responsible to conduct the resident fall investigations. The UM stated she attempted to determine the root cause of a resident's fall as part of the investigation to try and prevent another fall. The UM stated Resident #1's fall on 02/27/13 resulted from a family member transferring the resident independently. She stated Resident #1 was incontinent with a brief and did not toilet. The UM stated the family was educated after the fall to request assistance from the staff before attempting to transfer the resident; however, did not provide evidence of educating the family. The fall on 04/13/13 resulted when the resident's legs buckled and was no longer able to stand during the transfer. The UM stated she did not investigate further why the resident's family</p>	F 323			



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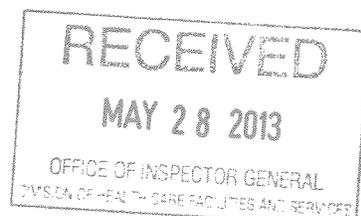
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F 323	<p>Continued From page 17</p> <p>member attempted to transfer the resident or why the resident's legs buckled. The UM stated she completed the fall analysis which was also reviewed in the facility's weekly falls committee meetings. She stated the falls committee meetings were to ensure resident care plans were updated and appropriate to the incident. The UM stated she reviewed the resident's care plan after it was updated by the nurse.</p> <p>Interview, on 04/18/13 at 3:15 PM, with the DON revealed she minimally monitored the falls committee meetings or the facility fall investigations. She stated the UM was responsible to complete the investigation and it would then be reviewed by the falls committee. The DON stated the investigations for Resident #1 did not identify the root causes which led to the resident being transferred by a family member or the resident's legs buckled during a transfer. She stated the facility did not conduct a falls risk assessment after a resident had a fall as the resident's fall makes the resident a high risk for falls.</p> <p>4. Observation, on 04/18/13 at 8:20 AM, revealed Resident #16 lying in bed with a wheelchair across the room. Observations, on 04/18/13 at 9:00 AM, 9:50 AM, 10:05 AM, 11:30 AM, and 1:00 PM revealed the resident sitting in a wheelchair in the A unit dining room and lounge.</p> <p>Review of the clinical record for Resident #16 revealed the facility admitted the resident with diagnoses of Muscle Weakness and History of Falls. The resident's comprehensive care plan, dated 02/14/13, revealed Resident #16's care plan related to falls included: reminding the</p>	F 323			



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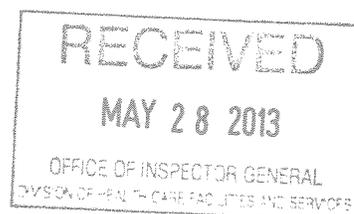
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F 323	Continued From page 18 resident to call for assistance before transferring him/herself from the bed or chair; keep area free of obstruction; and remind the resident to use transfer assist devices. Review of the facility falls investigation revealed Resident #16 had a fall, on 03/18/13 at 2:45 PM. The resident was lying in bed, then a loud crash was heard from the hallway. The resident was found sitting on the floor in the closet with the glass doors shattered. The root cause identified in the investigation report was due to resident action or internal risk factors. The conclusion to the investigation revealed Resident #16 had attempted to get out of bed unassisted. Interview with the A Unit UM, on 04/18/13 at 1:15 PM and continued at 2:45 PM, revealed Resident #16 had only one fall and stated it was an isolated incident. The UM stated she attempted to identify the root cause during the facility fall investigation. She stated the resident had internal motivations for attempting to transfer independently; however, did not attempt to identify what the resident's motivation was. The UM stated the purpose of determining the root cause of a resident's fall as part of the investigation was to try and prevent another fall by the resident. Interview, on 04/18/13 at 3:15 PM, with the DON revealed Resident #16's fall that shattered the glass closet doors was concerning as the resident could have been seriously injured. The DON stated the fall investigation for the resident did not identify what the root cause was that led to the resident attempting to transfer independently or how to prevent it from occurring again.	F 323			
F 371	483.35(i) FOOD PROCURE,	F 371			



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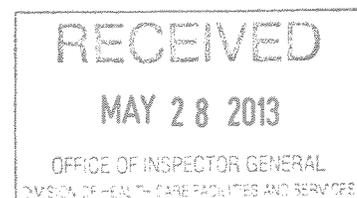
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F 371 SS=F	Continued From page 19 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility policies, it was determined the facility failed to ensure food was delivered and served in a sanitary manner for two (2) of three (3) nursing units. The facility failed to ensure dietary staff used soap and water to clean hands when changing from dirty to clean tasks and when changing gloves, failed to ensure food on the steam table that fell on to the steam table shelf was not reintroduced back into the steam table pan. Staff was noted to store the ice scoop in a pan of ice and water where milk and drinks were being held. A nursing cart holding boxes of hairnets, gloves and condiments had loose brown and black particles over the top and bottom shelves, built-up grime in the corners and large black stains were observed. Staff stored plate covers top down and water poured onto the food when righted to cover the plates. The staff had towel dry the wet trays before placing the paper place mats onto the trays. The findings include:	F 371	F 371 Issue: Handwashing No adverse affects to residents were found as a result of this occurrence. By reinforcement and monitoring of the policies and processes corrected as a result of this occurrence no residents will have any adverse effects. All Food Service Employees were re-educated on handwashing procedures on 4-19-2013 and 4-20-2013 by Trisha Ohlsen, RD,LD, Director of Dining Services. The nursing cart has been replaced with a cabinet with doors. Re-education corrected any violation by 4/20/2013. Marmian Neighborhood: The Dining Services aide will utilize the handwashing sink behind the nurse's station for handwashing. Clingman Neighborhood: The Dining Services Aide will utilize the handwashing sink in the kitchenette. For Neighborhood Service the wing set-up will be reviewed and altered to decrease the number of times that the Dining service's aide must change gloves, washing hands. Nonso Ebube and Corey Garner, servers on Clingman and Marmian received a written	5/8/13	



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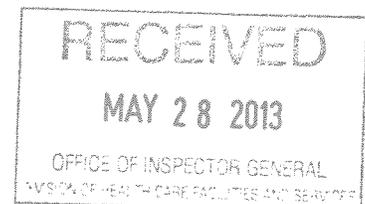
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F 371	Continued From page 20 1. Interview with the Food Service Manager, on 04/18/13 at 1:17 PM, revealed the facility's policy was to wash hands before the meal service and when changing gloves. The Food Service Manager stated she monitored the Dietary Aids at least one unit per meal. The Food Service Manager stated hands are the most dangerous thing in the kitchen and could spread germs if not cleaned properly. Observation of the lunch meal, on 04/16/13 at 11:50 AM, revealed Dietary Aide (DA) #2 setting up the steam table in the common area of Unit D. He was observed to have on gloves. He dropped some papers and then picked them up off the floor. He changed the gloves; however, he did not wash his hands before going behind the steam table to set up food for service. A nursing cart was set off to the side of the steam table and was observed to have grime built-up in the corners and brown and black loose particles on both shelves. The cart contained boxes of hairnets, gloves and condiments. DA #2 was observed to leave the steam table several times to go to the kitchen and when he returned he was observed washing his hands in the nursing soiled utility room. In addition, he was noted to use alcohol sanitizing gel twice in place of washing hands with soap and water as required. Plate covers were delivered on a cart and stored with outer surface facing down. When the lids were turned over to place over the resident's meal plate, being delivered to their rooms, water poured out into the food. Trays were observed to be wet requiring a CNA to get a towel to dry them prior to placing the paper place mats on the trays.	F 371	counseling for not following procedures for handwashing on 4-30 and 5-2 respectfully. Hand sanitizer will not be used in the kitchen or any dining room and all holders were removed from those are as of 4-30-2013. This is reflected in Policy #F007 as part of the re-education on Hand Hygiene. Dining Services: Meal observation Log will be utilized by Dining Services Managers to monitor job performance, adherence to policies and procedures, assure competency of staff. Further disciplinary action will take place with Dining Services staff for any further non-compliance with policies and procedures as appropriate. (Similar procedures are in place for Nursing Services.) The cleaning of the replacement cabinet has been added to the nursing task list. A monthly report of findings, actions, and follow-up will be presented to the QAPI Steering Committee by Trisha Ohlsen, RD,LD, Director of Dining Services. Completion Date: 5/2/2013 Issue: Cross-Contamination No adverse affects to residents were found as a result of this deficiency.	



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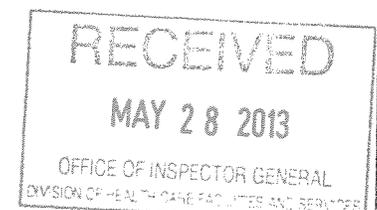
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F 371	Continued From page 21 interview with DA#2, on 04/17/13 at 9:15 AM, revealed he was not aware the room where he went to wash his hands was a soiled utility room and he was not educated on where to wash his hands on the D Unit. He stated he was not trained on where to wash his hands while working on the unit doing the meal service. In addition, he stated he was told he could use sanitizing gel on his hands while serving meals from the steam table. He stated handwashing prevented the spread of germs. Interview with the Dietician, on 04/18/13 at 10:10 AM, revealed the DA had received training on handwashing and was to wash his hands at the sink in the nursing station. She stated alcohol gel was allowed to be used in Dietary; however, after three (3) uses hands were to be washed with soap and water. She stated plate lids and trays should be dry and free of water prior to being placed back in service to prevent the spread of germs. She stated the facility did not have enough racks to allow lids and trays to be air dried prior to being placed back into service. Interview with CNA #8, on 4/17/13 at 12:15 PM, revealed the ice scoop should be stored in a dry clean area when not in use to prevent contamination and the spread of disease. She stated the water and ice bin where canned sodas and milk were kept cold prior to serving was not a clean dry place. She stated the water in the bin was contaminated by staff reaching in and getting drinks for residents. Interview with the Associate Director of Nursing (ADON), on 04/18/13 at 2:30 PM, revealed staff	F 371	By reinforcement and monitoring of the policies and processes corrected as a result of this deficiency no residents will have any adverse affects. Review of Food Handling Guidelines took place between 4-17-2013 and 5-4-13 to include the information on cross contamination by Trisha Ohlsen, RD, LD, Director of Dining Services. A Copy of Policy #B017 that was covered in the education is included. Corey Garner's counseling form addresses the cross-contamination issue. Meal observation Log will be utilized by Dining Services Managers to monitor job performance, adherence to policies and procedures, assure competence. Further disciplinary action will take place with Dining Services staff for any further non-compliance with policies and procedures as appropriate. Completion Date: 5/4/2013 Issue: Ice Scoop in Ice on Neighborhood A review of the infection control log identified no incidences of infection specifically linked to ice scoop use. By reinforcement and monitoring of the policies and processes corrected as a result of this deficiency no residents will have any adverse effects.		



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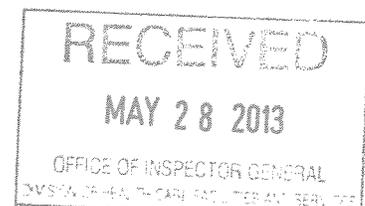
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F 371	<p>Continued From page 22</p> <p>were to use a clean dry container to store the ice scoop when not in use. She stated the soiled utility room was not to be used by dietary employees for handwashing, in order to prevent the spread of infection.</p> <p>2. Observation of the C Hall lunch meal service, on 04/16/13 at 12:10 PM, revealed Dietary Aide (DA) #2 put gloves on and began to serve meals. He was observed to remove his gloves after passing a utensil to a staff member and dropping a napkin on the floor and picking it up. He then put new gloves on without washing his hands. The sink was observed to be behind the nurses station (enclosed from eye view) approximately 30 to 50 feet from the tray line.</p> <p>Observation of DA #2 during tray line, on 04/16/13 at 12:40 PM, revealed his gloved hands touched puree meat. He then removed his gloves and did not wash his hands. He then placed new gloves on and preceded with the tray line.</p> <p>Interview with DA #2, on 04/18/13 at 9:09 AM, revealed he was to wash his hands after the removal of gloves. DA #2 stated he was allowed to use hand sanitizer when removing his gloves, but it depended on the situation. He stated he washed his hands before tray pass. When it becomes busy sometimes he does not have time to wash his hands and may have to use the hand sanitizer. He stated his manager instructed him to wash his hands when he removed his gloves. He stated he was not aware he did not wash his hands and further stated he should have washed his hands to prevent the spread of infection.</p>	F 371	<p>All Dining Services staff was re-educated between 4-16-2013 and 4-19-2013 by Trisha Ohlsen, RD, LD, Director of Dining Services and the Nursing Department staff, lead by Kathy Shireman, RN was re-educated via a Memo prepared by the DCS 5/1/13 and discussed by the nurse managers and house supervisors 4/17-5/7/13.</p> <p>Dining Services Leadership and Nursing staff are on an assigned rounding schedule. During the rounds the expectation is that each are monitoring for compliance to the infection control standards. See the attached Meal Observation Tool to be used in the observation monitoring to record data for the quality improvement processes. The form is shared with the Director of Dining Services who then shares immediate results with the Director of Clinical Services and the Nurse Manager.</p> <p>For Dining Services: Any deviation from the standard is to be communicated to the appropriate manager for follow-up. All incidents are to be documented in the Dining Services manager communication book and reported as QA results to the QAPI Steering Committee monthly.</p> <p>For Nursing Services: The Meal Observations will be recorded on a observation log by a nurse, nursing</p>		



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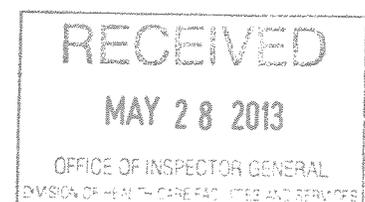
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F 371	<p>Continued From page 23</p> <p>Interview with the Food Service Manager, on 04/18/13 at 1:17 PM, revealed the facility's policy was to wash hands before the meal service and when changing gloves. The Food Service Manager stated she monitored the Dietary Aids at least once a meal each meal. The Food Service Manager stated hands are the most dangerous thing in the kitchen and can spread germs if not cleaned properly.</p> <p>Interview with the Director of Food Service, on 04/18/13 at 1:36 PM, revealed staff should wash their hands when removing their gloves. The Director of Food Service further stated staff were to wash their hands to prevent the spread of germs to the residents.</p> <p>3. Review of the facility's policy Employee Guidelines: Infection Control Practices, revised 01/2006, revealed employees should use a spatula or tongs; or wear disposable gloves when handling food. Employees should not perform multiple activities while wearing gloves which would be used in food handling. While serving food, store utensils in the food with the handle extending out of the food.</p> <p>Review of the facility's policy Food Handling Guidelines, revised 01/2013, revealed the staff should scrub their hands and change gloves. Contact surfaces and equipment should be clean and sanitized with food served on sanitized dishes, food must be prepared to avoid cross contamination.</p>	F 371	<p>supervisor or Dining Services supervisor on the Neighborhoods and overseen by the Nurse Managers & Evening Shift House Supervisor or Dining Services manager. The report will go the Nurse Manager for sharing with the care giving team for analysis and to problems solve deficient practices. A monthly report of the findings, actions and follow-up will be presented at the EARN meeting monthly to determine if an action plan is needed for further enactment and then to the QAPI Steering Committee by the Nurse Manager or DCS, Kathy Shireman, RN</p> <p>The competency of the staff will be ascertained thru the observation process with immediate intervention taken to correct issues. Repeating practice deficits will result in implementation of the progressive disciplinary process. Each department is to report concerns to the other and will share reporting forms for this purpose.</p> <p>Completion Date: 5/8/2013</p> <p>Issue: Wet Plate Covers</p> <p>A review of the infection control log identified no incidences of infection specifically linked to plate cover use.</p> <p>By reinforcement and monitoring of the policies and processes corrected as a result</p>		



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F 371	Continued From page 24 Observation of the D hall meal service, on 04/16/13 at 11:51 AM, revealed Dietary Aide (DA) #1 pushed carrots up onto the steam table then pushed them back into the pan while preparing the first two plates of the the tray line. He then placed the bread tongs onto the surface of the steam table multiple times during the tray line. While preparing the dessert service, he placed a dollop of nondairy whipped cream onto dishes of apple crlsp. Certified Nursing Assistant (CNA) #1 requested to apply topping and received the whipped cream in a metal container filled with ice water. The CNA pressed the tip of the whipped topping down into the dessert resulting in food particles on the tip of the whipped cream. She proceeded to apply the tip into each dessert. The CNA then stored the whipped cream back into the metal container with the open tip placed down into the iced water. When more apple crisp was placed in bowls, the CNA removed the whipped cream and again pressed it down into each dessert. Interview with DA #2, on 04/18/13 at 1:20 PM, revealed he did not realize he pushed the carrots back into the container during service and explained feeling nervous. He revealed a potential problem with cross contamination of the carrots by pushing food back into a container. The Dietary Aide revealed the nursing staff do assist with the tray line, but was not sure what they have been trained in and what they were allowed to do. Interview with CNA #1, on 04/18/13 at 1:38 PM, revealed she did have some training during orientation regarding tray line and wanted to help	F 371	of this occurrence no residents will have any adverse affects. Process was changed as of Tuesday PM, April 16, 2013. Lids are consistently stored round side up (we are using the term, "like a turtle walking, not a turtle on it's back". Lids are to be then wrapped in plastic wrap so they do not fall over for transportation on the ladder racks to the various neighborhoods. Staff was educated on this process beginning Tuesday, April 16' 2013 and completed by Wednesday, May 1' 2013 by Trisha Ohlsen, RD,LD, Director of Dining Services. Documentation of education is attached along with the policy on storage of pots, dishes, flatware, utensils. Dish room staff was re-educated on the procedure for the washing of trays and air-drying of said lids and trays by Trisha Ohlsen, RD,LD, Director of Dining Services and Greg Johnson, Dining Services Manager. The procedure for dishwashing is attached along with the dish room attendance record for the re-education. Greg Johnson, Manager for Dining Services, received a Level I Counseling for the wet plate covers. Greg is responsible for the dish room staff and their attendance to policies and procedures. This counseling was given on May 3, 2013. Dining Services Managers are responsible for the monitoring of all dish room policies		



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F 371	<p>Continued From page 25</p> <p>the Dietary Aide. The CNA revealed she did not realize what she had done, but revealed it was potential for cross contamination of both the desserts and the tube of whipped cream.</p> <p>Interview with the Director of Dining Services, on 04/18/13 at 2:45 PM, revealed training was provided to the entire staff annually and upon hire. The Director of Dining Service revealed a potential for cross contamination by not preparing food in a sanitary manner.</p> <p>4. Review of the facility's Dishwashing Procedures, undated, revealed there was not a procedure listed for drying the insulated plate covers. However, the procedure stated to never put away wet dishes because they grow bacteria and were considered dirty.</p> <p>Observation, on 04/16/13 at 4:35 PM, revealed in the main kitchen, were insulated plate covers stored upside down, opening facing upward, under a counter. Five (5) covers in a stack of ten (10) were found to have standing water inside the cover.</p> <p>Observation, on 04/17/13 at 7:50 AM, revealed on Unit A insulated plate covers stored upside down. Four (4) in a stack of eleven (11) and four (4) in a stack of ten (10) were found to have water in them.</p> <p>Observation, on 04/17/13 at 8:30 AM, revealed all insulated plate covers on Unit C were stored upside down, which allowed water to stand inside the cover.</p> <p>Interview, on 04/17/13 at 7:45 AM, with Food</p>	F 371	<p>and procedures within the dish room and with any storage of pots, dishes, flatware, utensils. Such monitoring is documented in the daily communication log of the Dining Services Leadership Team. Further disciplinary action will take place with Dining Services staff for any further non-compliance with policies and procedures as appropriate.</p> <p>Completion Date: 5/8/2013</p> <p>Addendum: Policy # F007 Hand Hygiene; Counseling forms (2); Policy # F016 Ice Handling; Policy #B017 Food Handling Guidelines- detailing the proper procedures for handwashing; Food/Services Standards policy review attendance sheet; Counseling form (1); Nursing Meal Observation procedure/Infection control procedure and Supervisor attendance sheet; Nursing Ice Scoop Memo; Policy #F017 Storage of Pots, Dishes, Flatware, Utensils; Dish Room Procedures-detailing the standard of air drying all dishes; Supervisor Counseling; Nursing Meal Service/Food Handling DTR. This documentation is included to further detail the education provided to the Dining Services Staff by Trisha Ohlsen, RD,LD, Director of Dining Services.</p>	
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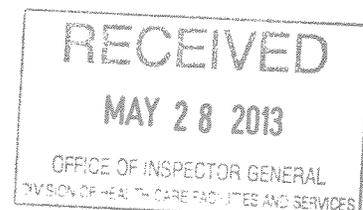
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F 371	Continued From page 26 Services Manager #1 revealed all dishes come from the main kitchen where the dishwashing machine was located. She stated water was not to be inside the lids (insulated dish covers) because of the spread of bacteria, mold or bugs. She revealed it was unsanitary and was dirty dishwater. Continued interview revealed the managers monitored the dishwashing; however, the insulated covers had never been monitored. Interview, on 04/17/13 at 8:15 AM through an interpreter, with Dishwasher #1 revealed the lids were to be stored face down. (The position of the insulated plate cover when it was placed over a plate.) It was revealed this was to prevent germs which could harm the resident. Interview, on 04/17/13 at 8:20 AM through an interpreter, with Dishwasher #2 revealed after the lids were run through the dishwasher machine, they were checked to make sure they were dry, then stored with the lid face down. No lids, in any area, had been observed stored face down. He revealed the lids needed to be dry to prevent germs which could harm the resident. Interview, on 04/17/13 at 11:00 AM, with the Dietary Director revealed the dishwashers were bypassing the process of stacking the insulated covers straight up because they would tip over. The facility did not have the racks to store the insulated covers in the correct position when not in use, preventing water from standing inside the lid. She revealed the standing water could produce germs. In addition, she stated the water in the lid could make the food soggy for the resident and decrease the quality of the food.	F 371		
F 465	483.70(h)	F 465		



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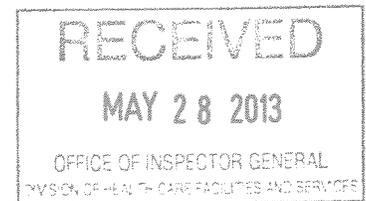
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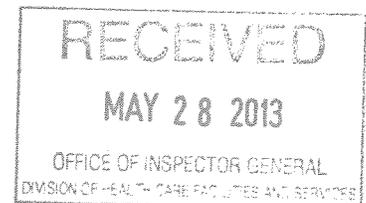
F 465 SS=D	Continued From page 27 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure one (1) of three (3) automatic self closing entrance doors to the kitchen from the facility were not manipulated to prevent the door from closing in the event of a fire. The door to the kitchen was held open by a table knife wedged under the door. The findings include: Interview with the Director of Facilities, on 04/17/13 at 3:30 PM, revealed fire doors were never to be propped open. He revealed the purpose of a fire door was to inhibit the transfer of heat. He stated the facility had no policy regarding fire doors. Observation, on 04/16/13 at 4:45 PM, revealed a table knife wedged under the fire door leading into the kitchen from the main dining room. The knife did not allow the door to close. Observation, on 04/17/13 at 8:07 AM, revealed the door leading to the kitchen from the dining room remained open with a knife wedged under	F 465	F 465 No adverse effects to residents were found as a result of this occurrence. By reinforcement and monitoring of the policies and processes corrected as a result of this occurrence no residents will have any adverse effects. The doors are listed as "automatic self closing". None of the kitchen doors self-close with a connection to the fire alarm system. All doors into the kitchen must be hand closed by personnel. The closure unit had been reported to maintenance two weeks prior to the survey. When the door was identified as being held open the manager removed the knife from beneath the door. Other times the staff had replaced the knife during meal service to facilitate ease of service for our residents. 4-18-2013 Dining Services wait staff was educated on the door closure issue. On April 17, 2013 the Facilities Director ordered a new door closure and had the repair completed by the AM on April 18, 2013. Dining Services staff were also re-educated on the process for reporting needed repairs and the safety practices of fire doors and the rules regarding fire doors. Also discussed was the policy of the non-use of any objects (.i.e. butter knife) to prop doors open for any reason by Trisha Ohlsen, RD,LD, Director of Dining Services and documented as Life Safety Code Education. These items discussed are listed on the Life Safety Code Training as attached. Each day that the door holder is not working correctly a call needs to be placed to maintenance. Dining Services Managers will continue to monitor the workings of all doors on their daily rounds as listed on the manager daily checklist. A log is kept in dining services to record the calls placed to maintenance. On a weekly basis the weekend Manager will check the week's repair list for completion of each item. An	4/18/2013
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F 465	<p>Continued From page 28 the door.</p> <p>Observation, on 04/17/13 at 2:00 PM, revealed the door leading to the kitchen from the dining room remained open with a knife wedged under the door.</p> <p>Interview, on 04/17/13 at 2:00 PM, with the Dietary Server revealed the door was opened in the morning and remained open during the day. She stated the door being very heavy as the reason the knife was used to keep the door open.</p> <p>Interview, on 04/17/13 at 2:20 PM, with Dietary Manager #1 revealed it was not acceptable to prop the door to the kitchen from the dining room open; however, the door stayed open because it was "always done." She revealed she knew the door was a fire door and in the event of a fire, the door would keep the fire from spreading from one area to another.</p> <p>Interview, on 04/18/13 at 1:35 PM, with the Dietary Director revealed she did not know the door to the kitchen from the dining room was a fire door or that the door was not to be propped open.</p> <p>Interview, on 04/18/13 at 2:30 PM, with the Safety Officer revealed she did not know how the door to the kitchen from the dining room had remained propped open for so long without having been identified. She revealed rounds of the facility were made by Environmental Services and the Director of Facilities, but the rounds were not documented.</p>	F 465	<p>additional call reporting any repairs not yet completed will be placed to maintenance. The manager checklist and its completion will be addressed in the monthly QAPI report by Trisha Ohlsen, RD, LD, Director of Dining Services.</p> <p>Completion Date: 4/18/2013</p> <p>Addendum: Life Safety Code Training/Wedge in Door; Attendance Sheet; Maintenance Call Log Life Safety Code Training:</p> <p>All doors in, out and within dining services are to be only held open with automatic devices. No items may be used to wedge a door open for any reason or at any time.</p> <p>If a door holder is not working correctly this must be immediately reported to maintenance and such request is to be recorded on the Dining Services Service Log.</p> <p>Each day that the door holder is not working correctly a call needs to be placed to maintenance.</p> <p>When the door holder is not working the following work flow changes are to take place.</p> <p>1) The drink glasses for water, iced tea and lemonade are to be set-up on cart and placed just outside the wait station area within the Canterbury Court Dining room to facilitate less need for going into the kitchen.</p> <p>2) While in the Canterbury Court Diningroom, Dining Service's staff can only enter the kitchen through the two door "In" door and only exit through the single "Out" door. This is a safety rule to eliminate the possibility of a collision at the door.</p>		



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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1975, 1986 SURVEY UNDER: 2000 Existing FACILITY TYPE: S/NF DP TYPE OF STRUCTURE: One (1) story, Type III Unprotected. SMOKE COMPARTMENTS: Eight (8) smoke compartments. FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier. FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system. GENERATOR: Type II, 55KW generator. Fuel source is diesel. A standard Life Safety Code survey was conducted on 04/16/13. Episcopal Church Home was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Adm/CEO* (X6) DATE: *5/28/13*

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.

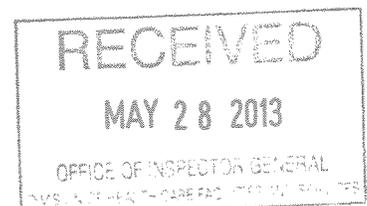
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If continuation sheet Page 1 of 6
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K 000	Continued From page 1 Fire). Deficiencies were cited with the highest deficiency identified at D level.	K 000	The following information is the Episcopal Church Home's credible allegation of compliance for the Life Safety Code survey of April 16, 2013	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiencies had the potential to affect two (2) of (8) smoke compartments, approximately forty (40) residents, staff and visitors. The facility has one-hundred and thirty-nine (139) certified beds and the census was one-hundred and eighteen (118) on the day of the survey. The findings include:	K 029	K-029 • The maintenance department will conduct monthly inspection/testing of self-closing devices on doors located in hazardous locations as identified in the survey. 1 – Boiler and fuel-fired furnace rooms, 2 – Central and bulk laundries larger than 100 ft ² , 3 – Paint shops, 4 – Repair shops 5 – Soiled linen rooms 6 – Trash collection rooms 7 – Rooms or spaces larger than 50 ft ² including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous 8 – Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.	5/9/13

MP/JA

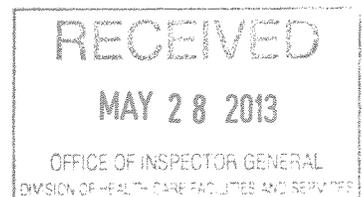


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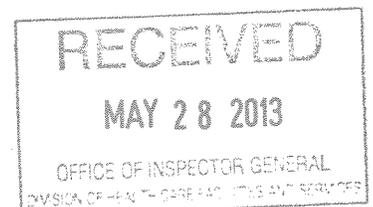
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K 029	<p>Continued From page 2</p> <p>1. Observation, on 04/16/13 at 8:45 AM, with the Director of Facilities revealed the door to the Clean Utility Closet located within the Nursing Office in Clingman Hall, did not have a self-closing device installed on the door.</p> <p>Interview, on 04/16/13 at 8:45 AM, with the Director of Facilities revealed he was not aware of the Clean Utility Room being categorized as a hazardous storage area and the requirement for the door to be equipped with a self-closing device.</p> <p>2. Observation, on 04/16/13 at 9:00 AM, with the Director of Facilities revealed the door to the Storage Room for Building Services, did not have a self-closing device installed on the door.</p> <p>Interview, on 04/16/13 at 9:00 AM, with the Director of Facilities revealed he was not aware of the Storage Room for Building Services being categorized as a hazardous storage area, and the requirement for the door to be equipped with a self-closing device.</p> <p>Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler</p>	K 029	<p>department director on a monthly basis. This information will be reported to the QAPI Steering Committee.</p> <ul style="list-style-type: none"> The new procedure has gone into effect on May 1, 2013 <p>K-147</p> <ul style="list-style-type: none"> Staff In-Services provided by the Director of Facilities were presented sharing the procedure developed to address Surge/Power Strips by May 9, 2013 A monthly monitoring and inspection of resident rooms will be conducted by the maintenance department. A monitoring procedure has been developed identifying the process to be used and the results recorded. The Surge/Power Strip inspection log will be reviewed by the Director of Facilities. This information will be reported to the QAPI Steering Committee, monthly.. All In-Services were completed on May 9, 2013. <p>Addendum: Approved Surge (Power) Strip Usage procedure; In-service Record sample & signed attendance sheets; Surge/Power Strip Inspection sample & completed form; Smoke/Fire Door Test procedure; Smoke/Fire door test form & completed form; signed attendance sheet for maintenance staff for Smoke/Fire Door Test</p>	



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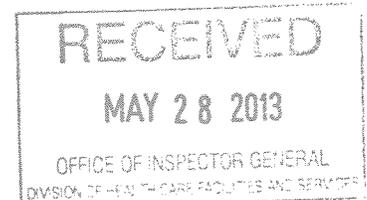
PRINTED: 04/17/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185310	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2013
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K 029	Continued From page 2 1. Observation, on 04/16/13 at 8:45 AM, with the Director of Facilities revealed the door to the Clean Utility Closet located within the Nursing Office in Clingman Hall, did not have a self-closing device installed on the door. Interview, on 04/16/13 at 8:45 AM, with the Director of Facilities revealed he was not aware of the Clean Utility Room being categorized as a hazardous storage area and the requirement for the door to be equipped with a self-closing device. 2. Observation, on 04/16/13 at 9:00 AM, with the Director of Facilities revealed the door to the Storage Room for Building Services, did not have a self-closing device installed on the door. Interview, on 04/16/13 at 9:00 AM, with the Director of Facilities revealed he was not aware of the Storage Room for Building Services being categorized as a hazardous storage area, and the requirement for the door to be equipped with a self-closing device. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler	K 029	<ul style="list-style-type: none"> The referenced inspection will occur throughout the facility. A procedure has been developed identifying a process to be used and the results recorded. Utilization of the inspection log sheet that will be contained in a binder for review by the department director on a monthly basis. This information will be reported to the QAPI Steering Committee. The new procedure has gone into effect on May 1, 2013 	
		K-147	<ul style="list-style-type: none"> Staff In-Services provided by the Director of Facilities were presented sharing the procedure developed to address Surge/Power Strips by May 9, 2013 A monthly monitoring and inspection of resident rooms will be conducted by the maintenance department. A monitoring procedure has been developed identifying the process to be used and the results recorded. The Surge/Power Strip inspection log will be reviewed by the 	



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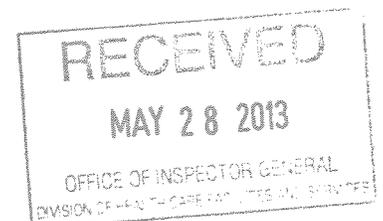
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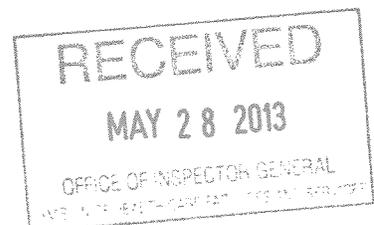
K 029	Continued From page 3 option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), 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	Addendum Life Safety Code	
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	K 147		



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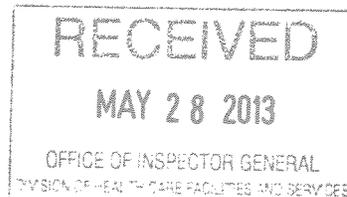
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K 029	Continued From page 3 option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), 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. 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	K 029	Director of Facilities. This information will be reported to the QAPI Steering Committee, monthly.. • All In-Services were completed on May 9, 2013. Addendum: Approved Surge (Power) Strip Usage procedure; In-service Record sample & signed attendance sheets; Surge/Power Strip Inspection sample & completed form; Smoke/Fire Door Test procedure; Smoke/Fire door test form & completed form; signed attendance sheet for maintenance staff for Smoke/Fire Door Test Addendum Life Safety Code
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K 147	<p>Continued From page 4</p> <p>wiring was maintained in accordance with NFPA standards and failed to ensure the staff was knowledgeable of the requirements. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, approximately fifty (50) residents, staff, and visitors. The facility has one-hundred and thirty-nine (139) certified beds and the census was one-hundred and eighteen (118) on the day of the survey.</p> <p>The findings include:</p> <p>1. Observation, on 04/16/13 at 8:47 AM, with the Director of Facilities revealed a refrigerator was plugged into a power strip located in the Nurses' Office within Clingman Hall.</p> <p>Interview, on 04/16/13 at 8:47 AM, with the Director of Facilities revealed he was aware of the requirements for the usage of power strips; however, he was not aware of the refrigerator within the Nurses' Office was plugged into a power strip.</p> <p>2. Observation, on 04/16/13 at 9:05 AM, with the Director of Facilities revealed a refrigerator was plugged into a power strip located in Resident Room A27 within Morton Hall.</p> <p>Interview, on 04/16/13 at 9:05 AM, with the Director of Facilities revealed he was aware of the requirement for the usage of power strips; however, he was not aware of a refrigerator in the Resident's Room being plugged into a power strip.</p>	K 147	



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K 147	Continued From page 5 Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147		

