

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

PRINTED: 05/21/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185330	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING RECEIVED MAY 28 2010 1980 OLD GREENSBURG ROAD CAMPBELLVILLE, KY 40121 Southern Enforcement Branch	(X3) DATE SURVEY COMPLETED 05/12/2010
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NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF CAMPBELLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG ROAD CAMPBELLVILLE, KY 40121
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS A standard health survey was conducted on May 10-12, 2010. Deficient practice was identified with the highest scope and severity at an "E" level.	F 000	The submission of this plan of correction does not constitute an admission by the provider of any fact or conclusion set forth in this statement of deficiency. This plan of correction is being submitted because it is required by law.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to implement procedures to prohibit abuse, neglect, or misappropriation of resident property. The facility failed to conduct a Nurse Aide Abuse Registry screening for one (1) of six (6) sampled employees prior to initiating employment. The findings include: A review of the facility's Abuse Policy with a revision date of January 2007 revealed all potential employees would have their status on the Nurse Aide Registry verified during the hiring process. A review on May 11, 2010, of six randomly selected employee files revealed the facility had not conducted a timely Nurse Aide Abuse Registry screening for employee #1. A review of employee #1's personnel file revealed the employee had been hired by the facility on January 18, 2010; however, the facility failed to	F 226	1. CORRECTIVE ACTION FOR SAMPLE RESIDENTS No residents identified in sample. Employee identified in survey review, employee verified not on abuse registry. 2. IDENTIFYING OTHER FACILITY RESIDENTS 100% audit completed of employee files, all employee verified on abuse registry. 3. SYSTEM CHANGES Any potential new hire employee who does not have a nurse license number, certified nurse aide number /identifier number will be verified per name and Social Security number. Business office assistant and/or Education Training Director will fax potential new hire name and Social Security number to the office Kentucky Nurse Aide Abuse Registry. Confirmation will be received via U.S. mail to the facility. All procedures to be completed prior to being placed on payroll.	Compliance Date 06/18/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Nelda Beard</i>	TITLE <i>Administrator</i>	(X6) DATE <i>5-26-10</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF CAMPBELLSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718
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F 226	<p>Continued From page 1</p> <p>ensure the employee was not listed on the Nurse Aide Abuse Registry until February 22, 2010.</p> <p>An interview was conducted on May 11, 2010, at 3:00 p.m., with the Business Office Personnel (BOP) who was responsible for conducting the employee screenings. The BOP stated that when an attempt had been made to screen the employee utilizing the on-line service, an individual with the same name as employee #1 was given as an option to check for listing on the Nurse Aide Abuse Registry; however, that individual was not the individual being hired by the facility. The BOP stated no further attempts were made by the facility to ensure the employee being hired was not listed on the Nurse Aide Abuse Registry until February 22, 2010.</p>	F 226	<p>4. MONITORING</p> <p>Audit tool developed for continued monitoring and accuracy of new hire verifications. All potential new hire employee verification checks must be completed and presented to NHA prior to hire date to verify completion of Abuse register screening and/or other required screenings. Audit tool to be completed on all new hire employees to check verifications per Business office Manager to ensure continued compliance. Findings/audits presented to monthly QPI for review and changes as indicated.</p>	
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment</p>	F 279	<p>1. CORRECTIVE ACTION FOR SAMPLE RESIDENTS</p> <p>Resident # 6 clinical chart reviewed, care plan implemented for at risk for dehydration sec to diuretic use.</p> <p>2. IDENTIFYING OTHER FACILITY RESIDENTS</p> <p>A 100% audit of resident care plans has been completed per IPOC team to identify other residents at risk for the same deficient practice. Care plans updated for identified area.</p>	<p>Compliance Date 06/18/10</p>

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NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF CAMPBELLSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718	
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F 279	<p>Continued From page 2 under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to develop an individualized comprehensive plan of care for one (1) of nineteen (19) sampled residents. Resident #6 had a new order for a diuretic; however, the facility failed to develop a comprehensive care plan to address the resident's risk/potential for dehydration.</p> <p>The findings include:</p> <p>Review of the medical record revealed resident #6 was readmitted to the facility on April 11, 2008, with diagnoses of Advanced Dementia, Anorexia, Anxiety, and Prolapsed Bladder. Review of the Quarterly Minimum Data Set (MDS) assessment on April 11, 2010, revealed the facility assessed resident #6 as being severely impaired in daily decision-making and resident #6 was dependent on staff for all activities of daily living (ADL).</p> <p>Review of a physician's order dated January 27, 2010, revealed an order for Hydrochlorothiazide (a diuretic used to remove excessive fluid from the body and aid in lowering blood pressure) 12.5 milligrams once every day.</p> <p>Review of the Comprehensive Care Plan for resident #6 revealed the facility failed to develop a care plan that addressed resident #6's potential for dehydration/fluid maintenance.</p> <p>Interview on May 11, 2010, at 3:45 p.m., with the MDS Coordinator revealed the Coordinator was</p>	F 279	<p>3. SYSTEM CHANGES</p> <p>Staff in-serviced and care plan team on new procedure: daily review of any new physician orders for diuretic's or resident at risk for dehydration noted in morning triage meeting. Clinical chart then taken to IPOC meeting for update of care plans as indicated.</p> <p>4. MONITORING</p> <p>Audit developed to ascertain care plan implementation of all new admits, re-admits of new diuretic orders are reviewed and Plan of Care established. Daily audit M-F during IPOC meeting for new admits/orders wkly x 4, then audit per MDS schedule for Quarterly and annual and significant assessments x 8 wks. Then randomly per DON, ADON or designee. Finding and audits presented to monthly QPI for review and changes as indicated.</p>	

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F 279	Continued From page 3 responsible for developing/updating the residents' care plans. The MDS Coordinator stated the care plans are updated when the MDS assessments are completed every three months or with any change in a resident's condition. The MDS Coordinator stated all new orders were reviewed in a daily clinical meeting and the care plans were revised or developed as needed. The MDS Coordinator stated residents that required diuretics were at risk for dehydration and a care plan was required to address the potential for dehydration. The MDS Coordinator stated the Coordinator had just overlooked the new order for resident #6 and failed to develop a care plan.	F 279		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	1. CORRECTIVE ACTION FOR SAMPLE RESIDENTS No residents identified in sample. Medications and/or supplies found with expired dates removed from medication storage room removed. NHA notified facility lab provider of expired supplies, lab director stated he would make corrective action for his staff to check for expired dates. 2. IDENTIFYING OTHER FACILITY RESIDENTS Potential for risk to residents. 100% audit of medication and storage rooms completed, all medications and supplies with expired dates removed.	Compliance Date 06/18/10

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F 425	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide pharmaceutical services (including administering and disposition of all drugs and biologicals) to meet the needs of each resident. Multiple drugs and biologicals were observed to be expired and available for resident use.</p> <p>The findings include:</p> <p>An observation of the East Hall Medication rooms on May 10, 2010, from 4:00 p.m. until 4:40 p.m., revealed the following items to be expired and available for resident use:</p> <ul style="list-style-type: none"> -The East medication storage room contained one 1000-milliliter unopened bottle of Osmolite 1.2-calorie tube feeding formula that expired on April 1, 2010, and had yellow sediment on the top of the formula, and a white clabbered-appearing substance at the bottom of the container. -41 purple top Vacutainer blood collection tubes with an expiration date of February 2010. -Four mint green top Vacutainer blood collection tubes with an expiration date of October 2009. -Five light blue top Vacutainer blood collection tubes with an expiration date of January 2009. -Four BacT/Alert anaerobic culture tubes with an expiration date of April 30, 2010. -One Dollar General Brand multiple-dose (150 tabs) bottle of calcium antacid tablets approximately half full was observed to have an 	F 425	<p>3. SYSTEM CHANGES</p> <p>System developed for routine verification of overflow medications/supplies in storage. 1st & 3rd Monday each month nurse administering medications will conduct audit of medication carts. Charge nurse will on these days will check overstock medication, lab and medical supplies in locked med rooms.</p> <p>4. MONITORING</p> <p>Audit tool developed for assurance of continued system, usage and monitoring by DON, ADON or designee; to be completed bi-monthly x 3 months, monthly x 3 monthly then random. Findings presented to QPI monthly for review and changes as indicated.</p>	

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F 425	<p>Continued From page 5</p> <p>"opened" date of January 14, 2009, and an expiration date of May 2009.</p> <p>-One bottle (four fluid ounces) of Hydrogen Peroxide with an expiration date of March 2009.</p> <p>-Pharmacy dispensed container of 10 Promethazine 25-milligram tablets for resident #16 which expired on February 15, 2010.</p> <p>-Pharmacy dispensed container of 30 Docusate Sodium 8.6/50-milligram caplets for resident #17 which expired on March 15, 2010.</p> <p>-Pharmacy dispensed container of 30 Reglan 5-milligram tablets for resident #18 which expired on October 31, 2009.</p> <p>Additionally, an observation of the West Hall medication room on May 10, 2010, from 4:45 p.m. until 5:00 p.m., revealed the following items to be expired and available for resident use:</p> <p>-Six mint green top Vacutainer blood collection tubes with an expiration date of October 2009.</p> <p>-17 light lavender top Vacutainer blood collection tubes with an expiration date of February 2010.</p> <p>-One light blue top Vacutainer blood collection tube with an expiration date of November 2009.</p> <p>-Pharmacy dispensed container of 30 Tylenol 325-milligram tablets for resident #19 which expired in April 2010.</p> <p>Interviews were conducted on May 10, 2010, at 5:10 p.m., with the Licensed Practical Nurse (LPN) responsible for administering medications</p>	F 425			

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F 425	Continued From page 6 for residents on the West Hall, and at 5:30 p.m., with the Charge Nurse (CN) for the East Hall. Both nurses stated the multiple containers of pharmacy dispensed medications stored in the medication rooms were active prescribed medications for individual residents. The nurses stated that a 90-day supply of medications was delivered when filled by the pharmacy, and all the medications would not fit in the medication carts, resulting in the excess being stored in the medication rooms. The nurses also stated the facility utilized a laboratory service that came to the facility and obtained routine labs, however, during off hours, on weekends, and for laboratory tests ordered immediately the lab tests were obtained by the facility utilizing the lab materials observed in the medication storage rooms. Additionally, the interviews conducted with the LPN and CN revealed no systemic process was utilized by the facility to routinely inspect the medication storage rooms to ensure drugs and biologicals stored were not expired. An interview was conducted on May 11, 2010, at 9:15 a.m., with the Administrator and Director of Nursing (DON) who confirmed that no system had been in place prior to May 10, 2010, to inspect the medication storage rooms for expired drugs and biologicals.	F 425			
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465	I. CORRECTIVE ACTION FOR SAMPLE RESIDENTS All environmental areas identified in survey tour has been corrected.	Compliance Date 06/18/10	

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F 465	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The central baths on both the East and West Halls had multiple areas in need of repair/maintenance. In addition, the entry floor in room 107 and the hallway floor were uneven, creating a sharp edge.</p> <p>The findings include:</p> <p>Observation of the facility during the environmental tour on May 10-12, 2010, revealed the following items in need of maintenance/repair:</p> <ul style="list-style-type: none"> - The entry floor in resident room 7, and the hallway floor, were uneven creating a sharp edge. - East Hall central bath: <p>Several of the wall tiles adjacent to the floor in the first shower stall were uneven, leaving a sharp edge creating a potential for accidents.</p> <p>The metal grab bars in both shower stalls were observed to have multiple areas of green discoloration from metal corrosion, and "pitting" in the metal was observed, which left rough/sharp surfaces creating a potential for accidents.</p> <p>The metal door frame of the entry door inside the shower room was rusty in several places and in need of repair.</p> <p>The floor tile in the corner of the entry door was discolored with a heavy buildup of orange/rust discoloration and in need of maintenance.</p>	F 465	<p>2. IDENTIFYING OTHER FACILITY RESIDENTS</p> <p>100% environmental audit has been completed to identify other areas needing repairs.</p> <p>3. SYSTEM CHANGES</p> <p>Re-train all facility staff on procedure to report, completed facility work order request. Work Orders to be returned to NHA office box and presented to Maintenance Director the following morning for completion of repairs. NHA and Maintenance Director will completed weekly walking compliance rounds weekly to identify any needed repairs. Tool developed for walking rounds.</p> <p>4. MONITORING</p> <p>NHA will follow up for completion of work orders daily (M-F). Weekend Manager of Duty will check NHA office box for any work orders needing completed during the weekend, and take appropriate measures for repairs. Review of environmental round and work orders to be presented to monthly QPI for review and further action as needed</p>	

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F 465	<p>Continued From page 8</p> <p>-West Hall central bath:</p> <p>The wooden entry door on the inside of the shower room was observed to be chipped and splintered below the door knob and at the bottom of the door creating a potential for accidents.</p> <p>The metal door frame on the inside of the first shower was not flush with the wall, leaving a sharp area at the bottom of the stall door creating a potential for accidents.</p> <p>The metal grab bars and towel bars in both shower stalls were observed to have multiple areas of green discoloration from metal corrosion and were observed to have "pitting" in the metal, which left rough/sharp surfaces creating a potential for accidents.</p> <p>Several wall tiles adjacent to the floor below the window in the shower room, and on the wall behind the toilet, were broken/cracked and in need of repair.</p> <p>The privacy curtain in front of the toilet was observed to be soiled/stained and in need of cleaning.</p> <p>A tour and interview was conducted on May 10, 2010, at 5:00 p.m., with the Maintenance Supervisor (MS). The MS stated any areas reported by facility staff or observed by the maintenance staff were immediately addressed with appropriate action taken. However, the MS stated that the areas observed by the surveyor had not been reported by the staff and the MS had been unaware of the areas that were in need</p>	F 465			

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F 465	Continued From page 9 of repair/maintenance.	F 465			

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Received Time Jun 1, 2010 2:14PM No. 0379

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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on May 13, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain smoke barriers with at least a one-half hour fire resistance rating as required. The facility failed to ensure that penetrations above fire/smoke barrier doors were properly sealed. This deficient practice affected two (2) of four (4) smoke compartments, staff, and approximately thirty (30) residents. The facility has the capacity for 67 beds with a census of 62 the day of survey. The findings include:	K 025	1. CORRECTIVE ACTION FOR IDENTIFIED AREA Damper secured and cannot be opened, by-passed using alternate cooling for area identified. Unsealed penetrations around electrical wiring, conduit and holes in fire/smoke barrier wall noted above West Hall have been repaired to meet specified conditions and codes set forth in Life Safety Code NFPA 101. 2. IDENTIFYING OTHER FACILITY ENVIRONMENTAL, LIFE SAFETY AREAS 100% audit of facility fire/smoke barriers have been completed, corrections made for identified areas.	Completion date 05/28/10

Laboratory Director's or Provider/Supplier Representative's Signature <i>Neda Beaud</i>	Title <i>Administrator</i>	(X6) DATE <i>5-26-10</i>
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185330	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/13/2010
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF CAMPBELLSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 1 During the Life Safety Code survey on May 13, 2010, at 9:45 a.m., with the Director of Maintenance, unsealed penetrations around electrical wiring, conduit, and holes were noted in the fire/smoke barrier wall above the West Hall cross-corridor doors. Fire/smoke barrier walls must be properly maintained to prevent fire and smoke from spreading to other areas of the facility. An interview revealed the Director of Maintenance was not aware this wall had not been properly sealed. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025	3. SYSTEM CHANGES System change to implement when contractors, vendors and/or other workman are making repairs in areas of the facility containing smoke barriers; facility maintenance director will inspect area following completion of work to identify any penetration of fire barriers, and make repairs as indicated. 4. MONITORING NHA and Maintenance Director will complete weekly Life Safety Rounds to identify any others areas needing repairs; to be competed weekly x 4 weeks then monthly. Finding presented to monthly QPI for review and follow up as indicated.	
K 027	NFPA 101 LIFE SAFETY CODE STANDARD	K 027		

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K 027 SS=F	<p>Continued From page 2</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that cross-corridor fire doors were able to resist the passage of fire and smoke. This deficient practice affected three (3) of four (4) smoke compartments, staff, and all of the residents. The facility has the capacity for 67 beds with a census of 62 on the day of survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on May 13, 2010, at 8:25 a.m., with the Laundry Supervisor, a set of cross-corridor fire/smoke barrier doors located in the East Hall near the conference room were noted not to close all the way when tested. These doors must close all the way to help prevent fire/smoke from reaching other parts of the building in a fire situation. An interview revealed these doors are checked for proper operation during fire drills. The Laundry Supervisor was not aware these doors were not operating correctly. During the survey a set of cross-corridor fire/smoke barrier doors located at</p>	K 027	<p>1. CORRECTIVE ACTION FOR IDENTIFIED AREA</p> <p>Cross-corridor fire/smoke barrier doors located on east Hall near conference room and West Hall have been repaired to close properly per NFPA 80 requirements.</p> <p>2. IDENTIFYING OTHER FACILITY ENVIRONMENTAL, LIFE SAFETY AREAS</p> <p>Facility audit of other fire/smoke barrier doors have been inspected for proper closing.</p> <p>3. SYSTEM CHANGES</p> <p>Maintenance Director will make weekly check of fire/smoke barrier doors for proper closure and note on weekly Life Safety rounds tool.</p> <p>4. MONITORING</p> <p>Weekly Life Safety Rounds completed to ensure compliance of fire/smoke barrier doors. Findings presented to monthly QPI for review and follow up as indicated.</p>	<p>Completion date 06/18/10</p>
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K 027	Continued From page 3 the west corridor were noted to be rubbing and not closing all the way as required. Reference: NFPA 80 (1999 Edition). 15-1.4 Repairs. Repairs shall be made and defects that could interfere with operation shall be corrected immediately. 15-2.1.1* Hardware shall be examined frequently and any parts found to be inoperative shall be replaced immediately. 15-2.4.1 Self-closing devices shall be kept in proper working condition at all times.	K 027		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that sprinkler heads were maintained as required. This deficient practice affected two (2) of four (4) smoke compartments, staff, and four (4) residents. The facility has the capacity for 67 beds with a census of 62 on the day of survey. The findings include:	K 062	1. CORRECTIVE ACTION FOR IDENTIFIED AREA Sprinkler heads in resident R #3, laundry folding room and record storage room have been cleaned, paint and/or foreign matter removed to restore to required conditions specified in NFPA 25 2. IDENTIFYING OTHER FACILITY ENVIRONMENTAL, LIFE SAFETY AREAS 100% audit of facility sprinkler heads have been inspected for paint and/or foreign matter; identified sprinklers cleaned of paint and/or foreign matter to restore to required conditions specified in NFPA 25.	Completion date 06/18/10

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K 062	<p>Continued From page 4</p> <p>During the Life Safety Code survey on May 13, 2010, at 8:30 a.m., with the Laundry Supervisor, observation revealed paint on a sprinkler head located in resident room 14. Foreign matter on sprinkler heads can decrease their ability to react as intended. An interview revealed the Laundry Supervisor was not aware of this requirement. During the survey paint was noted on sprinkler heads in resident room 3, the folding room, and the record storage room.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p>	K 062	<p>3. SYSTEM CHANGES</p> <p>Implement monthly inspections of sprinkler heads in facility for continued compliance; completed by Maintenance Director.</p> <p>4. MONITORING</p> <p>Monthly Life Safety Rounds to be completed to ensure compliance with sprinkler heads maintained per conditions specified in NFPA 25. Finding presented to monthly QPI for review and changes to system as indicated.</p>	
K 144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on an interview and record review, the facility failed to ensure that a weekly written maintenance schedule was being performed on</p>	K 144		

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K 144	<p>Continued From page 5</p> <p>the emergency generator. This deficient practice affected three (4) of four (4) smoke compartments, staff, and all of the residents. The facility has the capacity for 67 beds with a census of 62 on the day of survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on May 13, 2010, at 11:10 a.m., with the Director of Maintenance, observation revealed components associated with the emergency generator (hoses, wiring, etc.) were not documented on the written weekly maintenance schedule. An interview revealed the Director of Maintenance did perform the necessary maintenance checks on the generator but these weekly checks were not properly documented.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction</p> <p>6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established</p> <p>6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.</p>	K 144	<p>1. CORRECTIVE ACTION FOR IDENTIFIED AREA</p> <p>Generator (hoses, wiring, filters, etc) checked and noted on weekly check tool.</p> <p>2. IDENTIFYING OTHER FACILITY ENVIRONMENTAL LIFE SAFETY AREAS</p> <p>Other facility Life Safety Equipment checked and noted on weekly documentation.</p> <p>3. SYSTEM CHANGES</p> <p>Audit tool developed to document generator checks weekly to include hoses, wiring, filters, etc. Maintenance Director to inspect weekly and complete documentation.</p> <p>4. MONITORING</p> <p>NHA to review weekly documentation to ensure compliance. Maintenance Director to present generator maintenance documentation to facility monthly QPI for review and follow up as indicated.</p>	Completion date 06/18/10

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K 144	Continued From page 6 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.	K 144	1. CORRECTIVE ACTION FOR IDENTIFIED AREA Medical equipment has been removed from power strips and plugged into wall electrical receptacles in resident rooms 12, 3, and 13. 2. IDENTIFYING OTHER FACILITY ENVIRONMENTAL, LIFE SAFETY AREAS 100% facility room audit has been completed to identify any other incorrect usage of multi-outlet adapter (power strip) devices; multi-outlet adapter removed from rooms if not used for resident TVs, radios and other non-medical equipment. Medical equipment verified plugged into wall electrical receptacles in accordance to requirements set forth in NFPA 99.	Completion date 06/18/10
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, the facility failed to ensure that electrical power strips were being used in an approved manner. This deficient practice affected three (3) residents. The facility has the capacity for 67 beds with a census of 62 on the day of survey. The findings include:	K 147	3. SYSTEM CHANGES All facility staff has been re-trained on the correct electrical receptacles (wall) to plug in medical equipment and only non-medical devices plugged into multi-outlet adapters i.e.: resident TVs, radios, computers.	

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K 147	<p>Continued From page 7</p> <p>During the Life Safety Code tour on May 13, 2010, at 8:40 a.m., with the Laundry Supervisor, an oxygen concentrator and nebulizer suction pump was noted to be plugged into a multi-outlet adapter (power strip) in resident room 12. Generally power strips with surge protection may be used for resident TVs, computers, radios, etc., on an as-needed basis but not to be used with medical equipment to help prevent against electrical shock. An interview revealed the Laundry Supervisor was not aware of this requirement. During the survey resident rooms 3 and 13 were also noted to be using medical equipment with a power strip.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-3.2.1.2 D</p> <p>2. Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147	<p>4. MONITORING</p> <p>Weekly Life Safety Rounds to be completed per Maintenance Director to ensure correct usage of electrical receptacles to support medical equipment used in resident rooms. Findings presented to facility monthly QPI for review and follow up as indicated.</p>	