

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

PRINTED: 06/15/2012
FORM APPROVED
OMB NO. 0938-0391

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|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185396 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/01/2012 |
| NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO | | | STREET ADDRESS, CITY, STATE, ZIP CODE 811 EAST PARRISH AVENUE OWENSBORO, KY 42303 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENTS A standard recertification survey was conducted on 05/31/12 through 06/01/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of an "E." | F 000 | | |
| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies and procedures, it was determined the facility failed to ensure food was stored under sanitary conditions and cookware was properly sanitized. Findings include: 1. A review of the facility's "Procurement-Receiving and Storage" policy/procedure, revised 06/30/11, revealed each food item would be stored and handled in a safe, sanitary, and appropriate manner. All food should be stored in such a manner as to maintain the wholesomeness of the food for human consumption. The procedure for dry storage | F 371 | F 371 #1 None of the residents were found to be affected. 24 residents had the potential to be affected because all food preparation occurs in observed kitchen. On June 1, 2012 procedure for dry storage was reviewed by leadership and the decision was made that all items not in original container would be labeled with expiration date from the original container or the date received. If no expiration date available, posted storage guidelines will be used to determine discard date. No open unused product will be returned to the stock room. Purchasing Agent and Receiving Clerk will complete daily log with compliance to policy findings/incorrect or expired items found in storage areas. Corrective action will be taken for any non-compliance to policy. Director, Assistant Director/Patient Service and Executive Chef will re-educate all production staff on correct procedures for storing food including covering, labeling, and dating. Executive Chef will re-educate production staff on correct procedures and Policy 8052-208 on storing, reheating and use of used portions foods. Education will include detailed | 6/29/12 |

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

TITLE

(X6) DATE

Joyce Lynn Johnson, MPA, WPA Administrator 6/22/12

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

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| F 371 | <p>Continued From page 1</p> <p>included removal of items for which the expiration date had expired. The procedure for refrigerated storage included to discard food past the use-by date. Frozen storage procedures included to wrap food tightly to prevent cross contamination.</p> <p>An observation of dry storage, on 05/31/12 at 11:45 AM, revealed the following:</p> <p>a). One plastic bag containing Couscous, opened but not dated.</p> <p>b). One plastic bag containing Quinoa, opened but not dated.</p> <p>c). A plastic bag of peanut butter chips, opened, unsealed, undated, and overflowing into the box.</p> <p>d). A plastic bag of butterscotch chips sitting in a box opened, unsealed, and undated.</p> <p>An observation of the refrigerator and freezer, on 05/31/12 at 12:15 PM, revealed the following:</p> <p>a). A crate of fresh sliced carrots, expiration date 05/29/12.</p> <p>b). A plastic bag of frozen sugar cookie dough, opened and unsealed.</p> <p>c). A plastic bag of frozen crescent rolls, opened and unsealed.</p> <p>An interview with the Director of Food Services, on 05/31/12 at 5:00 PM, revealed she expected the staff to follow the facility's policy related to food storage.</p> <p>2. A review of the facility's policy/procedure, "Dish Room Ware Washing," revised 09/11/08, revealed to empty, clean, and refill the power sinks as needed. In the power soak sink, dispense the correct amount of cleaning agent into the water. Use the test kit to ensure the correct level has been dispensed (level should be</p> | F 371 | <p>procedures for labeling, dating and discarding expired foods. Competency will be demonstrated by post- test. All current production staff will review and successfully complete the post test. Staff will be tested bi-annually and new employees will pass the post test before beginning their first scheduled shift.</p> <p>To ensure sustained compliance, production staff will be assigned to monitor refrigerator or freezer and all storage in their key work area. Duties will include monitoring for correct labeling, dating, storage and discarding of foods.</p> <p>Staff will document findings related to stored/expired/discarded food on daily log. To ensure compliance, the Executive Chef will monitor daily logs and complete a monthly audit from the findings.</p> <p>F 371 #2 None of the 24 residents were found to be affected. All 24 residents had the potential to be affected because all food preparation occur observed kitchen.</p> <p>Measures put in place / systemic changes made to ensure the deficient practice will not recur include: Assistant Director/Patient Service, Executive Chef, and Patient Service Supervisor reviewed</p> | 6/29/12 |

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| F 371 | Continued From page 2 200 parts per millions (ppm) on the test kit). An observation, on 05/31/12 at 4:10 PM, revealed pans were being cleansed in the three compartment sink. The power soak sink contained pans; however, a test of the water indicated there was no cleaning agent present. An interview with the Dishwasher, on 05/31/12 at 4:10 PM, revealed she tested the water earlier in the shift, but the water had been changed. She revealed she did not test the water prior to washing the pans. An interview with the Assistant Director of Food Services, on 05/31/12 at 4:15 PM, revealed she expected the Dishwasher to test the water prior to washing the cookware to ensure proper sanitation. | F 371 | with all dish room staff the Food Service policy (8052-513) for Manual Washing and Sanitizing Pot, Pans and Small Utensils. Policy 8052-513 is approved by Food Service Director and Assistant Director/Patient Service Education on Dishroom Ware Washing policy provided to all dish room staff. All staff has signed off on review of policy and job workflow. Education provided utilizing teach back method and post- test for all staff responsible for dish ware washing. For sustained compliance: New employees will be educated on dish ware washing policy utilizing teach back method with expectation that post-test is passed before new employees are allowed to operate three compartment sink for dishware washing. Quarterly review of policy and post-testing will be done with all staff. The expectation is that all current staff successfully passes post-test. Progressive counseling has been completed on 3 employees working the dish room for failure to follow the standard for testing and recording. Facility will monitor performance to ensure solutions are sustained by: Daily monitoring to ensure the established standard is met for testing and recording of correct concentration of sanitizing solution. Testing is to be done at least every 2 hours or when water is changed or water is added. | | |

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| K 000 | <p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1938, 1948, 1955, 1957, 1963, 1968, 1974, 1980, 1986, 1991, 1992, 1993, 1995, 2000, 2004</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Type I (443)</p> <p>SMOKE COMPARTMENTS: Two (2) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Six (6) Type I generators. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 05/31/12. The Transitional Care Unit of Owensboro was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for thirty (30) beds with a census of twenty four (24) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p> | K 000 | | |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joy Evelyn INSPIRE-UPANHA ADMINISTRATOR 7-23-12

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

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| K 000 | Continued From page 1 Fire) | K 000 | | | |
| K 018 SS=D | <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, residents, staff, and visitors. The</p> | K 018 | <p>K018 NFPA 101 Life Safety Code Standard</p> <ul style="list-style-type: none"> No residents were found to be affected. 12 residents on 3-3 hallway of facility had the potential to be affected. Measures put into place/systemic changes to ensure the deficient practice will not recur include: On 6/19/2012, an astragal was installed (by maintenance) on the door of room #3303. The astragal was placed to cover the gap around the door jamb, which will resist the passage of smoke. All other doors checked by maintenance on 5/31/12 – no other doors noted to have gaps that would not resist the passage of smoke. The Maintenance Manager and/or Supervisor will educate maintenance staff and the Transitional Care Survey Readiness Team on checking and ensuring all doors do not have a gap that would not resist the passage of smoke. The Transitional Care Survey Readiness Team will audit monthly x 4 months (June-September), for gaps that do not resist the passage of smoke. If no further problems are noted after 4 months, the audit will be discontinued. Audit results will be | 06/29/12 | |

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| K 018 | <p>Continued From page 2</p> <p>facility is licensed for thirty (30) beds with a census of twenty four (24) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/31/12 at 12:07 PM, with the Manager of Maintenance and the Corporate Safety & Security Manager revealed the corridor door to room #3303 had a gap too large around the jamb and would not resist the passage of smoke.</p> <p>Interview, c on 05/31/12 at 12:07 PM, with the Manager of Maintenance and the Corporate Safety & Security Manager confirmed the observation of the door having too large a gap that would not resist the passage of smoke.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.6.3 Corridor Doors.</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall</p> | K 018 | <p>reported to the monthly Environment of Care meeting.</p> | | |

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| K 018 | Continued From page 3 not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service. | K 018 | | | |
| K 052 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA | K 052 | K052 NFPA 101 Life Safety Code Standard • No residents were found to be affected. • 24 residents had the potential to be affected. | 06/29/2012 | |

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| K 052 | Continued From page 4 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on interview and fire alarm inspection review, the facility failed to test the fire alarm system quarterly per NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff, and visitors. The facility is licensed for thirty (30) beds with a census of twenty four (24) on the day of the survey. Findings include: Fire alarm inspection review, on 05/31/12 at 3:00 PM, with the Manager of Maintenance, and the Corporate Safety & Security Manager revealed the facility failed to provide documentation to show the fire alarm had been tested in the third quarter of 2011. Interview, on 05/31/12 at 3:00 PM, with the Manager of Maintenance, and the Corporate Safety & Security Manager revealed the third quarter inspection was completed 31 days late on | K 052 | <ul style="list-style-type: none"> The Director of Facilities will re-educate the Manager of BioMed and staff of the documentation requirements for quarterly fire alarm inspections. The education will include the NFPA Standard 101 9.6.1.4 "A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code." Review of records indicates compliance with quarterly testing from December 2011, March 2012, and June 2012. The quarterly fire alarm inspection was completed in September, however, the report was not written until October. The facility was in compliance per NFPA standards but the lack of proper documentation from the vendor, at the time of the survey, gave the impression of non-compliance. After reviewing and consulting with the vendor, it was noted that the facility was in compliance with fire alarm testing but not with documentation of testing. Information from quarterly testing will be accurately documented and maintained by the Biomed Department. To ensure sustained compliance Biomed Manager will review fire alarm testing at monthly Environment of Care Meetings. | | |

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| K 052 | Continued From page 5 10-31-11. | K 052 | | | |
| K 062 SS=F | <p>Actual NFPA Standard: NFPA 101, 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, it was determined the facility failed to maintain the sprinkler system according to NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is licensed for thirty (30) beds with a census of twenty four (24) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/31/12 at 11:35 AM, with the Manager of Maintenance, and the corporate Safety & Security Manager revealed storage of items to be within eighteen (18) inches of a sprinkler head located in a closet in the Lobby across from the Nurses' Station in the 3-2 Hall.</p> | K 062 | <p>K062 NFPA 101 Life Safety Code Standard</p> <ul style="list-style-type: none"> No residents were found to be affected 12 residents on hallway 3-2 of the facility had the potential to be affected. The item found to be within eighteen (18) inches of the sprinkler head was removed on 5/31/2012. All other areas of Transitional Care, were inspected by the Corporate Safety Security Manager and Maintenance Manager, and no items were found to be within eighteen (18) inches of a sprinkler head. Education with all transitional care staff, by the Manager of Transitional Care, on ensuring that no items shall be stored within eighteen (18) inches of a sprinkler head, will be provided. To ensure sustained compliance, the Transitional Care Survey Readiness Team will audit monthly x 4 months (June-September, 2012) to ensure that no items are stored within eighteen (18) inches of a sprinkler head. If no further problems are | 06/29/2012 | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185396 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | | (X3) DATE SURVEY COMPLETED 05/31/2012 |
|---|---|--|--|----------------------|--|
| NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO | | | STREET ADDRESS, CITY, STATE, ZIP CODE 811 EAST PARRISH AVENUE OWENSBORO, KY 42303 | | |
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| K 062 | <p>Continued From page 6</p> <p>Interview, on 05/31/12 at 11:35 AM, with the Manager of Maintenance, and the corporate Safety & Security Manager revealed the facility was aware of the requirement for maintaining eighteen (18) inches from a sprinkler head, but he was not aware someone had place the items so close to the sprinkler head.</p> <p>Observation, on 05/31/12 between 12:00 PM and 1:30 PM, with the Manager of Maintenance, and the corporate Safety & Security Manager revealed excessive dust and lint on the sprinkler heads located throughout the 3-3 Hall.</p> <p>Interview, on 05/31/12 between 12:00 PM and 1:30 PM, with the Manager of Maintenance, and the corporate Safety & Security Manager revealed they were not aware of the excessive dust and lint on the sprinkler heads located throughout the 3-3 Hall.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.</p> <p>2-2.1.1* Sprinklers shall be inspected from the</p> | K 062 | <p>noted after 4 months, the audit will be discontinued. Audit results will be reported to the monthly Environment of Care meeting.</p> <p>K062 NFPA 101 Life Safety Code Standard</p> <ul style="list-style-type: none"> No residents were found to be affected. 12 patients on hallway 3-3 of the facility had the potential to be affected. The dust and lint on the sprinkler head, located on the 3-3 Hall, were cleaned on 5/31/2012, by Environmental Staff. All eighteen (18) rooms on 3-3 were inspected by Environmental Staff. All sprinkler heads on the 3-3 hall were cleaned on 5/31/2012 by Environmental Staff and the rooms on 3-2 hall were inspected and found to be compliant (pertaining to clean sprinkler heads). The Environmental Services Manager and /or Supervisor will educate Environmental Services Staff, by June 29th, on ensuring that 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). To ensure sustained compliance, the Transitional Care Survey Readiness Team will audit monthly x 4 months (June- | 06/29/2012 | |

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| K 062 | Continued From page 7 floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used. | K 062 | September), for obstructions and cleanliness of sprinkler heads. If no further problems are noted after 4 months, the audit will be discontinued. Audit results will be reported to the monthly Environment of Care meeting. | |
| K 147 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 | K 147 | K147 NFPA 101 Life Safety Code Standard <ul style="list-style-type: none"> No residents were found to be affected. 24 patients had the potential to be affected. | 7/27/12 |

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| K 147 | <p>Continued From page 8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff, and visitors. The facility is licensed for thirty (30) beds with a census of twenty four (24) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 05/31/12 between 11:15 AM and 1:30 PM, with the Manager of Maintenance, and the Corporate Safety & Security Manager revealed:</p> <p>1) An extension cord in use as permanent wiring located in room #3211. 2) A microwave was plugged into a power strip located in the employee break room, of the 3-3 Hall.</p> <p>Interview, on 05/31/12 between 11:15 AM and 1:30 PM, with the Manager of Maintenance, and the Corporate Safety & Security Manager revealed they were not aware of the misuse of power strips and extension cords.</p> | K 147 | <ul style="list-style-type: none"> The extension cord located in Room #3211 was removed. Appropriate power supply to computer in room #3211, that does not require any type of extension cord, will be installed by 7/27/12. The power strip located in the employee break room was removed on 6/1/2012 by maintenance staff. All rooms on the Transitional Care Unit were inspected by maintenance and no other extension cords or power strips were found. Maintenance staff will be educated, by the Maintenance Manager and/or Supervisor on the proper use of extension cords and power strips. All Transitional Care Staff will be educated, by the Manager of Transitional Care on the proper use of extension cords and power strips. To ensure sustained compliance, the Transitional Care Survey Readiness Team will audit monthly x 4 months (June-September), for proper use of extension cords and power strips. If no further problems are noted after 4 months, the audit will be discontinued. Audit results will be reported to the monthly Environment of Care meeting. | |

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| K 147 | Continued From page 9 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. NFPA 70 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces. | K 147 | | |
| K 211 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD. Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. | K 211 | K211 NFPA 101 Life Safety Code Standard • No residents were found to be affected. • 12 residents on hallway 3-2 of the facility had the potential to be affected. • The Alcohol Based Hand Rub dispenser, which was installed adjacent to the light switch, was removed on 5/31/2012, by maintenance. | 06/29/2012 |

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| K 211 | <p>Continued From page 10</p> <ul style="list-style-type: none"> o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that Alcohol Based Hand Rub dispensers were not installed over or adjacent to an ignition source in accordance with NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, residents, staff and visitors. The facility is licensed for thirty (30) beds with a census of twenty four (24) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/31/12 at 11:15 AM, with the Manager of Maintenance, and the Corporate Safety & Security Manager revealed an Alcohol Based Hand Rub dispenser was installed over or adjacent to the light switch in the Conference Room of the 3-2 Hall.</p> <p>Interview, on 05/31/12 at 11:15 AM, with the Manager of Maintenance, and the Corporate</p> | K 211 | <ul style="list-style-type: none"> • All areas in Transitional Care were inspected by maintenance and no other alcohol based hand rub dispensers were found to be out of compliance. • Maintenance staff will be educated, by the Maintenance Manager and/or Supervisor on the following – “Alcohol based hand rub dispensers are not to be installed over or adjacent to an ignition source.” • To ensure sustained compliance, the Transitional Care Survey Readiness Team will audit monthly x 4 months (June-September), for proper installation of alcohol based hand rub dispensers. If no further problems are noted after 4 months, the audit will be discontinued. Audit results will be reported to the monthly Environment of Care meeting. | |

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| K 211 | <p>Continued From page 11</p> <p>Safety & Security Manager revealed they were not aware the dispenser was mounted adjacent to an ignition source.</p> <p>Reference:</p> <p>Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 | K 211 | | |