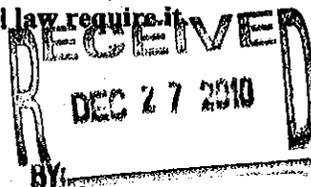


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165155</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF MOREHEAD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>933 NORTH TOLLIVER ROAD MOREHEAD, KY 40361</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS  Surveyor: 02123 A Life Safety Code survey was initiated and concluded on December 1, 2010. The facility was found to not meet the minimum requirements with 42 Code of the Federal Regulations, Part 483.70. Deficiencies were cited with the highest Scope and Severity of an "F".	K 000	This prepared plan of correction and creditable allegation of compliance does not constitute an admission or agreement to the alleged stated deficiencies by the provider or its	
K 017 88=D	NFPA 101 LIFE SAFETY CODE STANDARD  Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5  This STANDARD is not met as evidenced by: Surveyor: 29620 Based on observation and interview it was determined the facility failed to ensure the corridor walls were able to resist the passage of fire/smoke.  The findings include:	K 017	management company. This plan of correction and creditable allegation of compliance is prepared and executed only because state and federal law requires it.   K 017  1. The maintenance director on 12/3/2010 repaired the attic entry access on West wing.  2. A walk-thru of the facility was conducted on 12/4/2010 to identify any other areas in need of repair.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE  <i>Executive Director</i>	(X6) DATE  <i>12/27/10</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  LIFE CARE CENTER OF MOREHEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY, 40361	
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K 017	Continued From page 1  Observation on 12/01/10 at 10:35 AM, revealed the attic entry access in the West Wing hallway had gaps around the access door one and a half (1.5) inches to two (2) inches in width. This deficiency would not resist the passage of fire/smoke in a fire situation. The deficiency affected two (2) of nine (9) smoke compartments, staff and forty-six (46) residents. The facility is licensed for ninety-seven (97) beds and the census on the day of the survey was ninety-two (92). This was confirmed by the Maintenance Director.  Interview on 12/01/10 at 10:35 AM with the Maintenance Director, revealed the sprinkler company had torn down the trim around the door when they were working in the attic and he had not repaired the trim as of this date.  19.3.6.2 Construction of Corridor Walls. 19.3.6.2.1* Corridor walls shall be continuous from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above suspended ceilings, and through interstitial structural and mechanical spaces, and they shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1:* In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, a corridor shall be permitted to be separated from all other areas by non-fire-rated partitions and shall	K 017	Any area identified was corrected accordingly.  3. Facility rounds are conducted monthly by the Maintenance Director according to the facility preventative maintenance program (TELS). Any areas identified are repaired accordingly.  4. Audits will be conducted weekly x4 then monthly x 3 by the Maintenance Director and Executive Director to ensure compliance with this code. The results of these audits will be brought to the monthly Performance Improvement meeting for review and any further recommendations.  5. DATE OF COMPLIANCE: 1/12/2011	

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K 017	Continued From page 2 be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. Exception No. 2: Existing corridor partitions shall be permitted to terminate at ceilings that are not an integral part of a floor, construction if 5 ft (1.5 m) or more of space exists between the top of the ceiling subsystem and the bottom of the floor or roof above, provided that the following criteria are met: (a) The ceiling shall be part of a fire-rated assembly tested to have a fire resistance rating of not less than 1 hour in compliance with the provisions of 8.2.9.1. (b) The corridor partitions form smoketight joints with the ceilings (joint filler, if used, shall be noncombustible). (c) Each compartment of interstitial space that constitutes a separate smoke area is vented, in a smoke emergency, to the outside by mechanical means having sufficient capacity to provide not less than two air changes per hour but, in no case, a capacity less than 5000 ft <sup>3</sup> /min (2.36 m <sup>3</sup> /s). (d) The interstitial space shall not be used for storage. (e) The space shall not be used as a plenum for supply, exhaust, or return air, except as noted in 19.3.6.2.1(3). Exception No. 3: Existing corridor partitions shall be permitted to terminate at monolithic ceilings that resist the passage of smoke where	K 017		

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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF MOREHEAD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351</b>	
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K 017	Continued From page 3 there is a smokelight joint between the top of the partition and the bottom of the ceiling.	K 017		
K 018 SS=F	19. Corridor walls shall form a barrier to limit the transfer of smoke. <b>NFPA 101 LIFE SAFETY CODE STANDARD</b> Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/2 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  Roller latches are prohibited by CMS regulations in all health care facilities.  This STANDARD is not met as evidenced by: Surveyor: 29620 Based on observation and interview it was determined the facility failed to ensure there were no impediments to the closing of resident room doors, according to NFPA standards. The deficiency affected forty-six (46) residents and	K 018	1. The privacy curtains in rooms numbered: 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324 and 325 were relocated on 12/5/2010 so that the doors would properly latch.  2. A walk-thru of the facility was conducted on 12/2/2010 by the Maintenance Director and Executive Director to identify any other doors that would not latch due to privacy curtains. Any issues were repaired immediately.  3. Privacy curtains were added to the facility's preventative maintenance schedule conducted by the maintenance director. Any further issues will be corrected accordingly.  4. Audits will be conducted weekly x 4 then monthly x 3 by the Maintenance Director to ensure compliance with this code. The results of these audits will be	

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K 018	Continued From page 4 two (2) of nine (9) smoke compartments.  The findings include:  Observation on 12/1/10 at 10:13 AM revealed privacy curtains in resident rooms numbered: 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324 and 325 were positioned so that it prevented the closing of the doors. The observation was confirmed with the Maintenance Director and Administrator, who were present at that time.	K 018	brought to the facility's monthly Performance Improvement meeting for review and further recommendations if needed.  5. DATE OF COMPLIANCE: 1/12/2011		
K 025 SS=D	Interview on 12/01/10 at 10:13 AM, with the Maintenance Director, revealed that they were not aware the curtains would not allow the doors to fully close.  Reference: NFPA 101 (2000 edition) 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.  A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches. 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	K 025	1. The unsealed hole on West wing was repaired by the Maintenance Director on 12/2/2010. 2. All other firewalls were inspected. No other holes were identified 3. Inspection of the firewalls has been added to the facility's preventative maintenance schedule. Any issues identified will be corrected accordingly.		

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K 025	Continued From page 5 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: Surveyor: 29620	K 025	4. Results of the inspections will be reviewed weekly x 4 then monthly x3 by the Executive Director to ensure compliance with this code. Any issues will be brought the facility's Performance Improvement meeting for review and any further recommendations.	
	Based on observation and interview it was determined 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 nine (9) smoke compartments, staff, and approximately forty-six (46) residents. The facility has the capacity for ninety-seven (97) beds with a census of ninety two (92) on the day of the survey.  The findings include:  Observation on 12/10/10 at 11:28 AM revealed, a unsealed five (5) inch hole in diameter containing cable wires penetrating the fire/smoke barrier wall above the West Wing corridor doors. Fire/smoke barrier walls must be properly maintained to prevent fire and smoke from spreading to other areas of the facility. This was confirmed by the Maintenance Director.  Interview on 12/01/10 at 11:28 AM with the Maintenance Director, revealed he was unaware of the hole.		5. DATE OF COMPLIANCE: 1/12/2011	

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K 025	Continued From page 6 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		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper	K 056	<p><b>K 056</b></p> <ol style="list-style-type: none"> <li>The front porch canopy has been scheduled to have sprinklers added.</li> <li>No other canopy's meet the requirement of having sprinklers.</li> <li>Any new construction will be completed according to life safety code.</li> <li>Construction of sprinklers on the front porch will be brought to the next Performance Improvement meeting for any further recommendations.</li> </ol> <p>DATE OF COMPLIANCE: 1/12/2011</p>	

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K 056	Continued From page 7 switches, which are electrically connected to the building fire alarm system. 19.3.5  This STANDARD is not met as evidenced by: Surveyor: 29620 Based on observation and interview, it was determined the facility failed to ensure that the outside canopy at the facility had sprinkler protection or noncombustible or limited combustibile construction, according to NFPA standards.  The findings include:  Observation on 12/01/10 at 9:45 AM revealed a canopy approximately forty (40) feet by twelve (12) feet at the front entry that was made of combustibile material. The observations were confirmed with the Maintenance Director.  Interview on 12/01/10 at 9:45 AM, with the Maintenance Director, revealed he thought that sprinkler heads were present under canopy.  Reference: NFPA 13 (1999 Edition).  5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width.  Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustibile construction.	K 056			
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 062	<p>K 062</p> <ol style="list-style-type: none"> <li>The combustibile storage was removed immediately in order to prevent obstruction of the sprinkler head.</li> <li>A walk through to the facility was conducted on 12/3/2010 by the Maintenance Director and Executive Director to identify any other areas where the sprinkler head may be obstructed. Any issues identified were corrected accordingly.</li> <li>An inservice will be conducted by the Executive Director by 1/8/2011 for all staff regarding proper clearance of sprinkler heads. Nothing to be stored above 18 inches of a sprinkler head.</li> <li>Accurate clearance is reviewed by the Maintenance Director through the facility's preventative maintenance program (TELS) to ensure compliance with this code.</li> </ol>		

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K 062	Continued From page 8 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: Surveyor: 28820  Based on observation and interview it was determined the facility failed to maintain the sprinkler system according to NFPA standards.  The findings include:  Observation on 12/01/10 at 12:05 PM with the Maintenance Director, revealed storage of combustibles was less than eighteen (18) inches from the sprinkler head. This deficiency would prevent the pattern from fully developing of the sprinkler head.  Interview with the Maintenance Director on 12/01/10 at 12:05 PM, revealed the combustibles would be removed. The Maintenance Director stated they just do not know why the combustibles were in there.  5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.6.2.1 Continuous or noncontiguous obstructions less	K 062	Rounds/audits will be conducted by the department managers weekly x 4 then monthly x 3 to ensure compliance as well.  5. DATE OF COMPLIANCE: 1/12/2011	

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K 062  K 072 SS=F	<p>Continued From page 9</p> <p>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><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p>	K 062  K 072	<p><b>K 072</b></p> <p>1. Items identified in the corridors were removed immediately.</p> <p>2. All other means of egress were observed. Any issues identified were corrected accordingly.</p>	
	<p>This STANDARD is not met as evidenced by: Surveyor: 29620 Based on observation and interview it was determined the facility failed to ensure that corridors were maintained free from obstructions to the full instant use in the case of fire or other emergency Exits must be maintained to ensure their use in an emergency. The deficiency(ies) has the potential to affect all staff and residents.</p> <p>The findings include:</p> <p>Observation on 12/01/10 at 9:51 AM, revealed medication carts stored and not in use in front of the nursing stations at the South Wing Station, North Wing Station and West Wing Station. Also noted were soiled linen and trash carts in the corridors and not in use outside rooms 114, 210 and 311. Rosie charging stations stored and not in use in corridors at South Wing station exit, dish room and West nurse's station. Jazzy chairs</p>		<p>3. An inservice will be conducted by the Executive Director or designee on 1/8/2011 regarding the importance of keeping fire exits, corridors and other means of egress free from obstructions.</p> <p>4. Facility round/audits will be conducted by the department managers and licensed nursing staff weekly x 4 then monthly x 3 to ensure means of egress are kept free of obstructions. The results of these audits will be brought to the Performance Improvement meeting for review and further recommendations.</p> <p>5. DATE OF COMPLIANCE: 1/12/2011</p>	

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K 072	Continued From page 10 stored and not in use in corridors near rooms 114 and 104. Patient lifts, walkers and wheelchairs stored and not in use in corridors near rooms 110, 100, 210, 308, 312, 314, 318 and the conference room. Clean chairs, clean linen carts not in use and stored in the corridor in front of rooms 122, 124, 214 and 248. The observations were confirmed with the Maintenance Director.  An interview, on 12/01/10 at 9:51 AM, with the Maintenance Director, revealed the carts were routinely left in the halls due to lack of storage space.	K 072		
K 073 89=F	Reference: NFPA 101 (2000 edition) 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency NFPA 101 LIFE SAFETY CODE STANDARD  No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4.  This STANDARD is not met as evidenced by: Surveyor: 29620  Based on observation and interview, it was determined the facility failed to ensure decorations used in the facility were flame retardant, according to NFPA standards. The deficiency has the potentially affected approximately sixty-nine (69) residents. The facility is licensed for ninety-seven (97) beds and the census the day of survey was ninety-two (92).	K 073	K 073  1. Decorations identified not be fire retardant were removed.  2. All resident rooms were inspected by the maintenance director for flame retardant materials on 12/2/2010. Any issues found were removed or scheduled to be sprayed by a fire resistant chemical by the Maintenance Director.  3. A letter will be mailed to the families of the residents by the Executive Director instructing them not bring decorations into resident rooms without being checked through the maintenance department for proper fire rating.  4. Facility round/audits will be conducted by the department managers weekly x 4 then monthly x 3 to ensure compliance with the code. The results of these audits will be brought to the facility's Performance Improvement meeting for review and further recommendations.  5. DATE OF COMPLIANCE: 1/11/2012	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186155	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/01/2010
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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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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)	(X6) COMPLETION DATE
K 073	Continued From page 11  The findings include:  Observation on 12/01/10 at 10:02 AM, revealed decorations (wreaths) on resident room doors located in the facility. The resident rooms were numbered: 202, 203, 204, 205, 212, 308, 310, 316, 319, 320 and 323. Combustible decorations used in a health care facility must be flame retardant to prevent the spread of fire. The observations were confirmed with the Maintenance Director.	K 073	K 130  1. The lock was removed immediately from bathroom in room 325 by the Maintenance Director.  2. All other doors were inspected by the Maintenance Director on 12/2/2010 to ensure no improper locks were attached. No other areas were identified.	
K 130 SS=D	Interview on 12/01/10 at 10:02 AM with the Maintenance Director, revealed the facility does not treat decorations to make them flame retardant.  Reference: NFPA 101 (2000 edition) 19.7.5.4 Combustible decorations shall be prohibited in any Health care occupancy unless they are flame-retardant. Exception: Combustible decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present. NFPA 101 MISCELLANEOUS  OTHER LSC DEFICIENCY NOT ON 2786  This STANDARD is not met as evidenced by: Surveyor: 29820 Based on observation and interview, it was determined the facility failed to maintain doors	K 130	3. The Executive Director inserviced the Maintenance Director regarding proper locking mechanisms.  4. Facility rounds will be conducted by the Maintenance Director weekly times 4 then monthly x 3 to ensure doors are locked using appropriate locking mechanisms. The results of these audits will be brought to the facility's Performance Improvement meeting for review and further recommendations.  5. DATE OF COMPLIANCE: 1/12/2011	

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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF MOREHEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 839 NORTH TOLLIVER ROAD MOREHEAD, KY 40351	
(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 130	Continued From page 12 within a required means of egress. They shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. The findings include: Observation on 12/01/10 at 11:50 AM with the Maintenance Director, revealed that an unapproved lock was installed on the outside of the bathroom door in resident room #325 (dead bolt). The deficiency would not allow the occupant to exit the bathroom at their will in the event of an emergency. Interview on 12/01/10 at 11:50 AM with Maintenance Director, revealed he did not know why the dead bolt was on the door and immediately removed the lock.	K 130		
K 147	18.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 18.1.1.1.5 and 18.2.2.2.5.) Exception No. 2: "Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. NFPA 101 LIFE SAFETY CODE STANDARD	K 147	1. The power strips identified were removed or relocated to ensure they were being used in an appropriate manner. 2. A walk through of the facility was conducted on 12/3/2010 by the Executive Director and the Director of Social Services to identify any other power strips being used inappropriately. Any issues identified were corrected immediately. 3. The Executive Director will inservice the Maintenance Director and staff on the proper use of power strips on 12/8/2010. A letter will be also mailed to the families of the residents instructing them not to bring power strips from home. 4. Facility rounds/audits will be conducted by the department managers daily Mon- Fri X 4	

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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF MOREHEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 833 NORTH TOLLIVER ROAD MOREHEAD, KY 40351		
(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 147 SS=D	Continued From page 13  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Surveyor: 29620 Based on observation and interview, it was determined the facility failed to ensure that electrical power strips were being used in an approved manner. This deficient practice has the potential to affect seventy-seven (77) residents, two (2) of nine (9) smoke compartments, staff, and approximately forty-six (46) residents. The facility has the capacity for ninety-seven (97) beds with a census of 92 on the day of the survey.  The findings include:  Observation on 12/01/10 at 11:38 AM with the Director of Maintenance, revealed an electric bed, oxygen concentrator equipment plugged into a multi-outlet adapter (power strip) in resident room 312. In addition, power strips were observed to be in use with medical equipment in resident room 325. Generally, multiple-outlet adapters 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 with the Director of Maintenance on 12/01/10 at 11:38 AM, revealed they did not know they could not use power strips for medical equipment.	K 147	weeks, weekly x 4 then monthly x 3 to ensure power strips are being utilized properly. The results of these audits will be brought to the Performance Improvement meeting for review and further recommendations.  5. DATE OF COMPLIANCE: 1/12/2011		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165155</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/01/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF MOREHEAD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>933 NORTH TOLLIVER ROAD MOREHEAD, KY 40361</b>		
(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 147	Continued From page 14 Reference: NFPA 99 (1999 Edition).  3-3.2.1.2 D 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.	K 147			