

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

PRINTED: 01/09/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ JAN 2013		(X3) DATE SURVEY COMPLETED  R-C 12/20/2012
NAME OF PROVIDER OR SUPPLIER  LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
(F 000)	INITIAL COMMENTS	(F 000)	<u>RESPONSE PREFACE</u>		
(F 502) SS=D	<p>On 12/18/12 through 12/20/12, a revisit to an abbreviated survey (KY #18900, KY #18959, and KY #18984) and recertification survey conducted on 08/20/12 through 09/07/12, was conducted to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S being "D." Deficiencies were recited at F502 and F520.</p> <p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's procedure, it was determined the facility failed to ensure one resident (#32), in the selected sample of eleven residents, received laboratory (lab) services in a timely manner.</p> <p>Findings include:</p> <p>A review of the Procedure for Monitoring Labs, undated, revealed floor supervisors check the medication records on each of their shifts to ensure there have not been any missed medication and also will follow through on checking any labs that were to be drawn in relation to the medication.</p> <p>Record review revealed Resident #32 was admitted to the facility on 12/21/00 with diagnoses</p>	(F 502)	<p>Lake Way acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Lake Way's response the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Lake Way reserves the right to submit documentation to refute any of the stated deficiencies of this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any administrative or legal proceeding.</p> <p>F502 Resident #32's physician ordered on 12/11/12 for a PT/INR to be drawn on 12/14/12. The Administrative Assistant called Gamma Lab on 12/11/12 to inform them that lab needed to be drawn on this date. On 12/15/12 Nurse Supervisor was conducting audits of MAR's as well as any labs ordered related to medications and noted that we had not received the PT/INR results. Nurse Supervisor called Gamma Lab for the results of the PT/INR. The PT/INR was drawn by the lab on 12/15/12. Upon receipt of the specimen on 12/15/12, it</p>	01-10-2013	

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

*Selena Beck NAA*

TITLE

*Administrator*

(X6) DATE

01-11-2013

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 502}	<p>Continued From page 1 to include Transient Cerebral Ischemia, Hypertension, Peripheral Vascular Disease, and a Cardiac Pacemaker.</p> <p>Review of the Physician's Order, dated 12/11/12, revealed an order to hold the resident's Coumadin (blood thinner) and perform a Prothrombin Time/International Normalized Ratio (PT/INR) on 12/14/12. A review of the facility's calendar at the nurse's desk, dated 12/14/12, revealed the PT/INR was due for Resident #32. A review of the Medication Administration Record (MAR), dated December 2012, revealed the resident's Coumadin order was scheduled for 5:00 PM daily. The Coumadin was marked "on hold" 12/11/12, 12/12/12, 12/13/12, and 12/14/12; however, the MAR did not indicate any information related to the PT/INR due on 12/14/12. The facility could not provide documentation of the PT/INR results on 12/14/12. A review of the Nurse's Notes, dated 12/15/12 at 10:20 PM, revealed in reviewing the resident's MAR, it was discovered the PT/INR was not completed, as ordered.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 12/20/12 at 4:30 PM, revealed she was the nurse for Resident #32 on 12/14/12 from 2:00 PM to 10:00 PM. She passed medications to the resident and noticed the Coumadin was "on hold." She indicated there was no information given to her in report related to the resident's PT/INR due on 12/14/12. She revealed the lab was written on the calendar at the nurse's desk; however, she did not check the calendar.</p> <p>An interview with Licensed Practical Nurse (LPN) #2, on 12/20/12 at 4:45 PM, revealed he was the</p>	{F 502}	<p>was determined that it was not a sufficient amount for running the lab. The resident's Physician was notified by the Nursing Supervisor on 12/15/12 with a new order to obtain the PT/INR on 12/16/12. The PT/INR was drawn on 12/16/12 by the lab. The physician was made aware of the results by the Nursing Supervisor on 12/16/12 with an order to restart the resident's coumadin. All other labs were reviewed back to 11/20/12 for this resident by the Director of Nursing. All other lab orders were found to have been drawn according to physician orders with physician notification of the results in a timely manner.</p> <p>A 100% lab audit for all lab orders during the time of 11/20/12 to 12/27/12 has been conducted by Director of Nursing and Facility Consultants to ensure that appropriate labs had been drawn per MD order, results received and timely MD notification of lab results. Any concerns were addressed through the QI Committee.</p> <p>All licensed nurses were in-serviced 12/24/12 through 12/31/12 by Director of Nursing that on Friday, Saturday and Holidays that they are responsible to check accordian folders to assure that lab company has drawn labs due for that day. Once verified the nurse must call lab to obtain the results for timely notification of the physician.</p> <p>All licensed nurses were in-serviced 12/27/12 through 01/10/13 by Assistant</p>		

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{F 502}	<p>Continued From page 2</p> <p>nurse for Resident #32 from 2:00 PM to 10:00 PM, on 12/15/12. He noticed the resident's Coumadin had been "on hold" and requested the Weekend Supervisor to check on the resident's PT/INR results. It was determined that the lab had not been drawn, per the order.</p> <p>An interview with the Registered Nurse (RN) Weekend Manager, on 12/20/12 at 2:05 PM and 5:50 PM, revealed she worked from 2:00 PM to 10:00 PM on 12/15/12. She was reviewing the resident's MAR at the end of the shift and verified the PT/INR had not been drawn on 12/14/12, per the physician's order. She verified the nurses and supervisors were supposed to check for lab results on the weekend; however, there was no process in place to ensure ordered labs were obtained.</p> <p>An interview with the Administrative Assistant, on 12/20/12 at 4:00 PM, revealed there was a lab folder at the nurse's desk where lab requisition forms were kept. When the lab work was completed, the lab took the white copy of the form, leaving the yellow copy in the folder. She revealed every morning (Monday through Friday), she checked the lab folder and pulled the yellow copies to ensure lab results were received for each requisition form. The requisition form for Resident #32 was in the lab folder; however, the lab did not "usually" come to draw a PT/INR until "late." She left the facility at 3:30 PM on 12/14/12.</p> <p>Interview with the Director of Nursing (DON), on 12/20/12 at 6:00 PM; revealed she was notified by the Weekend Manager on 12/15/12 of the missed PT/INR for Resident #32. The lab does not make routine visits to the facility on Friday or</p>	{F 502}	<p>Director of Nursing on the new Laboratory Monitoring Sheet kept in the Lab Communication book to aid the licensed nurses in knowing who has a lab to be drawn that day. Licensed nurses were also in-serviced on these dates to call Gamma Lab if they have not received their results by 7pm. If the lab was omitted from being drawn, licensed nurses are to call the DON or ADON. The DON or ADON will come in and draw lab, and take them to Marshall County Hospital for testing.</p> <p>A Lab Monitoring Sheet to include Resident #32 has been placed in the lab communication book on each unit so that each licensed nurse has the ability to audit every shift when a lab is to be drawn, that lab was drawn timely and physician notified timely. This sheet is to aid the licensed nurses in the report communication from shift to shift.</p> <p>The Lab Communication Book will be brought to the Monday Department Head morning meeting where QI team members are present, for review of the lab monitoring sheet. This QI Committee members include the Administrator, DON, ADON, QI Coordinator, MDS, Activities, Social Service Director, Dietary Director, Maintenance Supervisor and Housekeeping/Laundry Supervisor. Upon identification of any potential or actual lab concern the QI Committee will follow up</p>	
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{F 502}	Continued From page 3 Saturday; therefore, a call was placed to the lab on 12/11/12 to make them aware of the order for the PT/INR for 12/14/12. The lab did not show up on 12/14/12 to draw the PT/INR. It was the responsibility of the charge nurse to ensure the lab was drawn on 12/14/12, per the physician's order. The nurse should have checked the lab folder and the calendar to ensure the PT/INR was drawn.  A review of the Lab Audit QI tool, dated 12/10-16/12, revealed a lab was ordered for 12/14/12; however, the lab was not completed. The physician was notified with a new order to obtain the lab 12/15/12. It was completed; however, there was not enough blood for the sample. It was redrawn on 12/16/12 and the physician was made aware of the results and an order was received to restart the resident's Coumadin.	{F 502}	and take action as deemed necessary to ensure that labs are drawn as ordered, results are obtained with timely physician notification of the results.  The results of these weekly reviews will be forwarded by the Administrator or QI Nurse to the Executive QI Committee monthly x 3 months then quarterly for review, follow up as necessary, evaluation of the effectiveness of the plan, and to determine the need for and frequency of continued QI monitoring.		
{F 520} SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	{F 520}	F520 Identification of the concern of Resident's #32 PT/INR not being drawn as ordered was identified by the Nurse Supervisor on 12/15/12 and reported to her Director of Nursing on 12/15/12. Upon completion of the analysis of the identified lab issue, the results were reviewed with the Medical Director on 12/19/12 during a QI Committee meeting. An Action plan to ensure labs are drawn as ordered and results are obtained with timely physician notification was developed at the time of the meeting on 12/19/12.  All department leaders and administrative nurses were in-serviced on 12/26/12 through	01-10-2013	

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{F 520}	<p>Continued From page 4</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy/procedure and Plan of Correction (PoC), it was determined the facility's Quality Assessment and Assurance Program failed to follow their PoC related to the implementation of an appropriate action plan related to the timeliness of laboratory (lab) services for one resident (#32), in the selected sample of eleven residents. Resident #32 received an order for a Prothrombin Time/International Normalized Ratio (PT/INR) on 12/14/12; however, it was not completed until 12/15/12. The Director of Nursing (DON) completed the Lab Audit Quality Improvement (QI) Tool for the week of 12/10/12 through 12/16/12, where it was identified the lab was not drawn as scheduled; however, a corrective action was not implemented at that time. The missed lab was discussed in the QI Committee meeting, on 12/19/12; however there was no plan of action implemented.</p> <p>Refer to (F502)</p> <p>Findings include:</p>	{F 520}	<p>12/27/12 by the Administrator on their role in recognizing concerns, developing a plan of action, training staff members, evaluating the plan, measuring outcomes and recommending changes.</p> <p>On 01/03/13 Administrator in-serviced the QI Coordinator on bringing all action plans to the morning department head meeting every Friday morning to review with each department the current action plans and progress with each.</p> <p>Upon this review weekly, the QI Committee will evaluate the effectiveness of the action plans with revision as appropriate to ensure continued compliance. This QI Committee members include the Administrator, DON, ADON, QI Coordinator, MDS, Social Service Director, Activities, Dietary Director, Maintenance Supervisor and Housekeeping/Laundry Supervisor.</p> <p>The results of these weekly reviews will be forwarded by the Administrator or QI Coordinator to the Executive QI Committee monthly x 3 then quarterly for review, follow up as necessary, evaluation of the effectiveness of the plan, and to determine the need for and frequency of continued QI monitoring.</p>	
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{F 520}	Continued From page 5  A review of the Quality Improvement policy/procedure, dated 01/11, revealed through the Quality Improvement Program, the facility would recognize concerns in resident care and develop a plan of action for the resolution of those concerns. Train staff members on the plan, put the plan into effect and evaluate the plan to ensure that the concerns were resolved and do not reoccur.  A review of the facility's PoC, dated 11/20/12, revealed the Administrative Assistant would complete a Daily Lab Audit form (5 times weekly) with tracking of labs drawn, results received and appropriate follow up to include physician notification. Any lab results received after hours or on the weekends would be addressed by the nurse assigned to the specific resident. The Lab Audit QI tool would be used to review the Daily Lab Audit form weekly. The Lab Audit QI tool reviewed the number of labs ordered, the number of labs received, timeliness of physician notification, if the physician replied, if there was a new order, and corrective action needed. Results of the Lab Audit QI tool would identify corrective action needed which the DON would be responsible for validating completion of the corrective action. The results of the Daily Lab Audit forms and Lab Audit QI tool would be reviewed weekly in a QI committee meeting with the Administrator and the DON. The compiled results of these audits would be assessed for any trends by the QI committee and actions taken based on these assessments.  Review of Resident #32's Physician orders revealed an order on 12/11/12 to hold the	{F 520}			

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{F 520}	<p>Continued From page 6</p> <p>resident's Coumadin and perform a PT/INR on 12/14/12. Interview with the Weekend Manager and record review revealed she discovered the lab was not obtained when reviewing Resident #32's Medication Administration Record at the end of her shift, on 12/15/12 at 10:00 PM.</p> <p>A review of the Lab Audit QI tool, dated 12/10-16/12, revealed a lab was ordered for 12/14/12; however, the lab was not completed. The physician was notified with a new order to obtain the lab 12/15/12. It was completed; however, there was not enough blood for the sample. It was redrawn on 12/16/12 and when the physician was made aware of the results, an order was received to restart the resident's Coumadin. There was no corrective action identified on the Lab Audit QI tool.</p> <p>An interview with the DON, on 12/20/12 at 6:00 PM, revealed she thought their lab system worked, the problem was the contract lab company "did not show up" to draw the PT/INR. She revealed a QI committee meeting occurred on 12/19/12 where the staff talked about the missed PT/INR; however, no new action plan was implemented.</p> <p>An interview with the Facility Consultant, on 12/20/12 at 6:30 PM, revealed the weekend managers would be completing the Lab Audit form on the weekends; however, she could not provide documentation that verified the implementation of the action plan prior to 12/20/12.</p> <p>An interview with the Administrator, on 12/20/12 at 6:50 PM, revealed the missed lab was</p>	{F 520}			

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{F 520}	<p>Continued From page 7</p> <p>discussed in the QI committee meeting on 12/19/12; however, an action plan had not been implemented.</p> <p>An interview with the Vice President of Operations, on 12/20/12 at 7:45 PM, revealed he was aware of the concern related to the missed lab; however, he felt it was an issue with the contract lab as they did not show up to draw the PT/INR. He verified there was no corrective action in place.</p>	{F 520}		
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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: 1978.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (000).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with 25 smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator installed in 1979. Fuel source is Liquid Propane.</p> <p>A standard Life Safety Code survey was conducted on 09/04/12 thru 09/05/12. Lake Way Nursing &amp; Rehab Center was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for ninety-six (96) beds with a census of eighty-seven (87) 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		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jim Henry* TITLE ADMINISTRATOR (X6) DATE 10-5-2012

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  K 018 SS=E	<p>Continued From page 1 Fire).</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></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 1¼ 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 doors to resident rooms were in accordance with NFPA standards. The deficiency had the potential to affect four (2) of four (4) smoke compartments, eighty-eight (88) residents, staff and visitors. The facility is certified for ninety-six (96) beds with a</p>	K 000  K 018	<p>K-018</p> <p>The maintenance director and assistant, have adjusted the patient room corridor door latches and hinges in rooms 100, 111, 116, 208, and 214, to correct the gap around the doors to proper clearance to provide a smoke passage barrier required in Life Safety code K-018.</p> <p>All other patient room corridor doors have been check for proper cleared to meet the Life Safety Code K-018. For any door that it is determined can not be adjusted to proper clearance, the door will be replaced.</p> <p>The maintenance director and assistant, have been re-inserviced by the administrator on the requirements in Life Safety code K-018</p> <p>The maintenance director and assistant will do a monthly Q.I. Audit to maintain proper patient room corridor door clearance, to provide the proper smoke barrier required in Life Safety code K-018. The results of the audits will be reviewed in the monthly Executive Q.I. committee meeting for the next three months, with the Administrator, D.O.N., and Medical Director.</p> <p>Completion Date 10/19/2012</p>	

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NAME OF PROVIDER OR SUPPLIER  LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025		
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K 018	<p>Continued From page 2</p> <p>census of eighty-seven (87) on the day of the survey. The facility failed to ensure five (5) corridor doors to the resident rooms did not have a gap larger than ½ inch around the jamb.</p> <p>The findings include:</p> <p>Observations, on 09/04/12 between 12:00 PM and 3:00 PM with the Maintenance Supervisor, revealed the corridor doors to rooms 116, 111, 100, 208, and 214 would not resist the passage of smoke around the jamb of the doors.</p> <p>Interview, on 09/04/12 between 12:00 PM and 3:00 PM with the Maintenance Supervisor, confirmed the observation of the doors having a large gap around the jamb of the doors. The Maintenance Supervisor was not aware of the allowable gap around the jamb of the resident doors.</p> <p>Interview, on 09/05/12 at 9:45 AM with the Administrator, revealed she was unaware of the large gaps on the resident doors. She stated she relies on the Maintenance Supervisor for Life Safety and has sent him to training at KY Dam Village and provides manuals to him.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 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,</p>	K 018			

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K 018	Continued From page 3 Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 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 NFPA standards.	K 018			
K 025 SS=F	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	K 025	K-025 All pipe and wire penetrations in the smoke barrier partitions above the ceilings, have been checked and where necessary, properly resealed with a sealant capable of maintaining the smoke resistance of the smoke barrier to meet the requirement of Life Safety code K-025		

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K 025	<p>Continued From page 4 heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for ninety-six (96) beds with a census of eighty-seven (87) on the day of the survey. The facility failed to ensure the smoke barriers were sealed around pipes and wires.</p> <p>The findings include:</p> <p>Observations, on 09/04/12 between 11:00 AM and 12:00 PM with the Maintenance Supervisor, revealed the smoke partitions, extending above the ceiling located throughout the facility, were penetrated by pipes and wires.</p> <p>Interview, on 09/04/12 between 11:00 AM and 12:00 PM with the Maintenance Supervisor, revealed he was not aware of the requirement to seal the smoke barriers. He stated that he was aware the homemade doors had to be sealed but was unaware of the wall requiring sealant.</p> <p>Interview, on 09/05/12 at 9:45 AM with the Administrator, revealed she was unaware of the penetrations in the smoke barriers. She stated she relies on the Maintenance Supervisor for Life</p>	K 025	<p>The maintenance director and assistant, have been re-inserviced by the administrator on the requirements in Life Safety code K-25</p> <p>The maintenance director and assistant will do a monthly Q.I. Audit to include maintaining the pipe and wire penetrations in the smoke barrier partitions above the ceilings, with proper sealant capable of maintaining the smoke resistance of the smoke barrier as required in Life Safety code K-25. The results of the audits will be reviewed in the monthly Executive Q.I. committee meeting for the next three months with the administrator, Director of Nursing, and Medical Director</p> <p>Completion Date 10/19/2012</p>		

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K 025	<p>Continued From page 5</p> <p>Safety and has sent him to training at KY Dam Village and provides manuals to him.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(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</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> <li>1. Be made on either side of the smoke barrier, or</li> <li>2. Be made by an approved device designed for the specific purpose.</li> </ol>	K 025		
K 029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from</p>	K 029	See next page	

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K 029	<p>Continued From page 6</p> <p>other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, eight (8) residents, staff and visitors. The facility is certified for ninety-six (96) beds with a census of eighty-seven (87) on the day of the survey. The facility failed to ensure seven (7) rooms were properly protected due to the storage in the rooms.</p> <p>The findings include:</p> <p>Observation, on 09/04/12 between 11:00 AM and 12:00 PM with the Maintenance Supervisor, revealed the dry storage in the kitchen, dietary manager, copy room, Director of Nursing office, accounts payable, social services, and the activities office need a closer added to the door.</p> <p>Interview, on 09/04/12 between 11:00 AM and 12:00 PM with the Maintenance Supervisor, revealed he was unaware the storage in a room determined whether the room was a hazardous storage area or not.</p>	K 029	<p>K-029</p> <p>Automatic door closers have been installed on the door of the Dietary dry storage room, the Dietary manager's office, the Copy Machine room, The Director of Nursing office, The accounts payable /business office, the Social Services Director's office, and the Activity Director's office. All other doors to storage rooms and offices have been inspected by the maintenance director and assistant, for proper closers if required in Life Safety code K-029.</p> <p>The maintenance director and assistant, have been re-inserviced by the administrator on the requirements in Life Safety code K-29</p> <p>The maintenance director and assistant will do a monthly audit of all storage rooms , offices and other doors through out the facility to insure they have proper automatic closer devices if required in Life Safety Code K-029. The results of the audits will be reviewed in the monthly Executive Q.I. committee meeting for the next three months with the administrator, Director of Nursing, and Medical Director</p> <p>Completion Date 10/19/2012</p>		

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K 029	<p>Continued From page 7</p> <p>Interview, on 09/05/12 at 9:45 AM with the Administrator, revealed she was unaware of the areas requiring a door closer to be added to the door. She stated she relies on the Maintenance Supervisor for Life Safety and has sent him to training at KY Dam Village and provides manuals to him.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> <li>(1) Boiler and fuel-fired heater rooms</li> <li>(2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>)</li> <li>(3) Paint shops</li> <li>(4) Repair shops</li> <li>(5) Soiled linen rooms</li> <li>(6) Trash collection rooms</li> <li>(7) Rooms or spaces larger than 50 ft<sup>2</sup> (4.6 m<sup>2</sup>), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction</li> </ol>	K 029			

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K 029	Continued From page 8 (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029			
K 040 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure exit discharge doors opened in the direction of egress in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, thirty-eight (38) residents, staff and visitors. The facility is certified for ninety-six (96) beds with a census of eighty-seven (87) on the day of the survey. The facility failed to ensure the gates around the facility would swing in the out direction in the event of an evacuation.  The findings include:  Observation, on 09/05/12 at 9:30 AM with the Maintenance Supervisor, revealed the exit gate at the west end of the west wing exit did not swing outward. The gates would have to be pulled against egress travel in the event of an	K 040	K-040  The latch on the gate of the fence outside the West wing exit door, has been changed to allow the gate to swing outward to allow for proper, easy egress travel.  The maintenance director and assistant, have been re-inserviced by the administrator on the requirements in Life Safety code K-040  The maintenance director and assistant will do month Q.I. audits of all outside gates and entry ways to insure the allow for proper, easy egress travel, as required in Life Safety Code K-040. The results of the audits will be reviewed in the monthly Executive Q.I. committee meeting for the next three months with the administrator, Director of Nursing, and Medical Director  Completion Date 10/19/2012		

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K 040	Continued From page 9 evacuation.  Interview, on 09/05/12 at 9:30 AM with the Maintenance Supervisor, revealed he was not aware the exit discharge gate needed to open in the direction of egress.  Interview, on 09/05/12 at 9:45 AM with the Administrator, revealed she was unaware of the gate at the west end of the facility not swinging in the correct direction. She stated she relies on the Maintenance Supervisor for Life Safety and has sent him to training at KY Dam Village and provides manuals to him.  NFPA 101 (2000 edition) 7.2.1.4.3 A door shall swing in the direction of egress travel where used in an exit enclosure or where serving a high hazard contents area, unless it is a door from an individual living unit that opens directly into an exit enclosure.	K 040		
K 052 SS=E	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 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	See next page	

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K 052	Continued From page 10  This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure smoke detectors were inspected and tested in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for ninety-six (96) beds with a census of eighty-seven (87) on the day of the survey. The facility failed to ensure three (3) smoke detectors at the facility were properly tested at least once in the last two years.  The findings include:  Record review, on 09/04/12 at 2:10 PM with the Maintenance Supervisor, revealed a Smoke Detector Sensitivity Test being performed on the fire alarm smoke detectors on 07-27-12. The report noted the facility had twenty-five (25) smoke detectors and only twenty-two (22) were tested. Smoke detectors must be tested according to NFPA 72 (1999 edition) to ensure their reliability.  Interview, on 09/04/12 at 2:10 PM with the Maintenance Supervisor, revealed he was unaware the facility did not have a current sensitivity test on all fire alarm smoke detectors. He stated that when the company came to do the test he was under the assumption all detectors were tested.  Interview, on 09/05/12 at 9:45 AM with the	K 052	K-052  The facility has 23 smoke detectors, one of those was missed on the 7-12-2012 testing visit, it is located in the Kitchen pantry. A second visit was completed and sensitivity testing completed on the 23 <sup>rd</sup> detector on 9-9-2012 by Premier Fire and Security.  The maintenance director and assistant, have been re-inserviced by the administrator on the requirements of Life Safety code K-052  The maintenance director and assistant will do a monthly Q.I. audit of all smoke detector sensitivity testing records to insure that they meet the requirements in Life Safety Code K-052. The results of the audits will be reviewed in the monthly Executive Q.I. committee meeting for the next three months with the administrator, Director of Nursing, and Medical Director  Completion Date 10/19/2012		

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K 052	<p>Continued From page 11</p> <p>Administrator, revealed she was unaware the proper testing of the smoke detectors had not been completed as she relied on the Maintenance Supervisor for Life Safety Code.</p> <p>Reference: NFPA 72 (1999 edition)</p> <p>7-3.2.1* Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <p>(1) Calibrated test method (2) Manufacturer ' s calibrated sensitivity test instrument (3) Listed control equipment arranged for the</p>	K 052			

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NAME OF PROVIDER OR SUPPLIER  LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025	
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K 052	Continued From page 12 purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced.  Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced.  Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2.  The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.	K 052		
K 056 SS=D	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	K 056	See next page	

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NAME OF PROVIDER OR SUPPLIER  LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42026		
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K 056	<p>Continued From page 13</p> <p>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 switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, fifty (50) residents, staff and visitors. The facility is certified for ninety-six (96) beds with a census of eighty-seven (87) on the day of the survey. The facility failed to ensure two (2) sprinkler heads were located at least four (4) inches from the wall.</p> <p>The findings include:</p> <p>Observation, on 09/04/12 between 12:10 PM and 1:00 PM with the Maintenance Supervisor, revealed a sprinkler head located in the east wing nurses' station area and a sprinkler head located in the east nourishment room located within one (1) inch of the wall.</p> <p>Interview, on 09/04/12 between 12:10 PM and 1:00 PM with the Maintenance Supervisor, revealed he was unaware of the sprinkler heads being too close to the wall.</p>	K 056	<p>K-056</p> <p>The sprinkler head located in East wing nurses station, and the sprinkler head located in the East wing nourishment room, have been relocated to meet the requirements of Life Safety code K-056</p> <p>The maintenance director and assistant, have been re-inserviced by the administrator on the requirements of Life Safety code K-056</p> <p>The maintenance director and assistant will do a monthly Q.I. audit of all sprinkler heads in the facility, to insure that they meet the requirements in Life Safety Code K-056. The results of the audits will be reviewed in the monthly Executive Q.I. committee meeting for the next three months with the administrator, Director of Nursing, and Medical Director</p> <p>Completion Date 10/19/2012</p>		

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K 056	<p>Continued From page 14</p> <p>Interview, on 09/05/12 at 9:45 AM with the Administrator, revealed she was unaware of the two (2) sprinkler heads being too close to the wall. She stated she relies on the Maintenance Supervisor for Life Safety and has sent him to training at KY Dam Village and provides manuals to him.</p> <p>Reference: NFPA 13 (1999 edition) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</p> <p><b>K 062 SS=F</b> 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, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for ninety-six (96) beds with a census of eighty-seven (87) on the day of the survey. The facility failed to ensure the gauges on the sprinkler riser had been replaced or recalibrated within the past five (5) years.</p>	K 056	<p>K-062</p> <p>The bottom gauge on the main sprinkler system has been replaced with a new gauge.</p> <p>The maintenance director and assistant, have been re-inserviced by the administrator on the requirements of K-062</p> <p>The maintenance director and assistant will do a monthly Q.I. audit of the sprinkler system gauges, to insure proper calibration and or replacement as required in Life Safety Code K-062. The results of the audits will be reviewed in the monthly Executive Q.I. committee meeting for the next three months with the administrator, Director of Nursing, and Medical Director</p> <p>Completion Date 10/19/2012</p>	

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K 062	Continued From page 15  The findings include:  Observation and record review, on 09/04/12 at 2:10 PM with the Maintenance Supervisor, revealed the facility failed to provide documentation that the gauges on the sprinkler riser had been calibrated or replaced within the last 5 years.  Interview, on 09/04/12 at 2:10 PM with the Maintenance Supervisor, revealed he was not aware the gauges on the sprinkler riser had to be calibrated or replaced once every 5 years.  Interview, on 09/05/12 at 9:45 AM with the Administrator, revealed she was unaware the gauges on the sprinkler riser had not been replaced. She stated she relies on the Maintenance Supervisor for Life Safety and has sent him to training at KY Dam Village and provides manuals to him.  Reference: NFPA 25 (1998 Edition).  10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and	K 062			

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K 062	<p>Continued From page 16 by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance</p> <table border="0"> <tr> <td>Item</td> <td>Activity</td> <td>Frequency</td> <td>Reference</td> </tr> <tr> <td>Gauges (dry, preaction deluge systems)</td> <td>Inspection</td> <td>Weekly/monthly</td> <td>2-2.4.2</td> </tr> <tr> <td>Control valves</td> <td>Inspection</td> <td>Weekly/monthly</td> <td>Table 9-1</td> </tr> <tr> <td>Alarm devices</td> <td>Inspection</td> <td>Quarterly</td> <td>2-2.6</td> </tr> <tr> <td>Gauges (wet pipe systems)</td> <td>Inspection</td> <td>Monthly</td> <td>2-2.4.1</td> </tr> <tr> <td>Hydraulic nameplate</td> <td>Inspection</td> <td>Quarterly</td> <td>2-2.7</td> </tr> <tr> <td>Buildings</td> <td>Inspection</td> <td>Annually</td> <td>(prior to freezing weather)</td> </tr> </table>	Item	Activity	Frequency	Reference	Gauges (dry, preaction deluge systems)	Inspection	Weekly/monthly	2-2.4.2	Control valves	Inspection	Weekly/monthly	Table 9-1	Alarm devices	Inspection	Quarterly	2-2.6	Gauges (wet pipe systems)	Inspection	Monthly	2-2.4.1	Hydraulic nameplate	Inspection	Quarterly	2-2.7	Buildings	Inspection	Annually	(prior to freezing weather)	K 062		
Item	Activity	Frequency	Reference																													
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K 062	Continued From page 17 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10	K 062		
K 066 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Smoking regulations are adopted and include no less than the following provisions:  (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.  (2) Smoking by patients classified as not responsible is prohibited, except when under	K 066	See next page	

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K 066	<p>Continued From page 18 direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for ninety-six (96) beds with a census of eighty-seven (87) on the day of the survey</p> <p>The findings include:</p> <p>Observation, on 09/04/12 at 3:00 PM with the Maintenance Supervisor, revealed the Butt-Bucket located at the back exit for the west wing did not have a self-closing cover device. Further observation revealed the bucket in use was being used for trash as well as cigarette butts.</p> <p>Interview, on 09/04/12 at 3:00 PM with the Maintenance Supervisor, revealed he was not</p>	K 066	<p>K-066</p> <p>The cigarette disposal container at the back exit of West wing, has been replaced with a proper container with self closing cover. A separate container has been placed at this entrance for trash disposal.</p> <p>The maintenance director and assistant, have been re-inserviced by the administrator on the requirements of K-066</p> <p>The maintenance director and assistant will do a monthly Q.I. audit of all cigarette disposal containers to insure that they meet the requirements in Life Safety Code K-066. The results of the audits will be reviewed in the monthly Executive Q.I. committee meeting for the next three months with the administrator, Director of Nursing, and Medical Director</p> <p>Completion Date 10/19/2012</p>	
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K 066	Continued From page 19 aware of the requirement for self-closing cigarette butt bucket.  Interview, on 09/05/12 at 9:45 AM with the Administrator, revealed she was unaware of the wrong type of bucket in use for dumping cigarette butts. She stated she relies on the Maintenance Supervisor for Life Safety and has sent him to training at KY Dam Village and provides manuals to him.  Reference: NFPA Standard 101 (2000 Edition).  19.7.4 Smoking (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066			
K 068 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure combustion air and ventilation for boilers, incinerators, and heater rooms were installed in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for ninety-six (96) beds with a census of eighty-seven (87) on the	K 068	See next page		

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K 068	<p>Continued From page 20</p> <p>day of the survey. The facility failed to ensure the fuel fired hot water heaters took air directly from the outside.</p> <p>The findings include:</p> <p>Observation, on 09/04/12 between 11:45 AM and 3:15 PM with the Maintenance Supervisor, revealed the fresh air vent for the water heaters located in the Laundry room and the mechanical rooms on the east and west wings did not vent to the outside but instead was open to the attic.</p> <p>Interview, on 09/04/12 between 11:45 AM and 3:15 PM with the Maintenance Supervisor, revealed he was aware the vent was open to the attic and not aware they were required to vent directly to the outside.</p> <p>Interview, on 09/05/12 at 9:45 AM with the Administrator, revealed she was unaware of the vents opening in the attic. She stated she relies on the Maintenance Supervisor for Life Safety and has sent him to training at KY Dam Village and provides manuals to him.</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition)</p> <p>Section 19.5 Building Services</p> <p>19.5.2.2 Any heating device other than a central heating plant shall be designed and installed so that combustible material will not be ignited by the device or its appurtenances. If fuel-fired, such heating devices shall be chimney connected or</p>	K 068	<p>K-068</p> <p>Modifications will be made to the fresh air vents for the water heaters located in the Laundry room and the Mechanical rooms located on East Wing and West Wing to vent to the outside thru the roof, to meet the requirements of Life Safety code K-068</p> <p>The maintenance director and assistant, have been re-inserviced by the administrator on the requirements of Life Safety code K-068</p> <p>The maintenance director and assistant will do a monthly Q.I. audit of boiler and water heater ventilation, to insure that they meet the requirements in Life Safety Code K-068</p> <p>The results of the audits will be reviewed in the monthly Executive Q.I. committee meeting for the next three months with the administrator, Director of Nursing, and Medical Director</p> <p>Completion Date 10/19/2012</p>	
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K 068	Continued From page 21 vent connected, shall take air for combustion directly from the outside, and shall be designed and installed to provide for complete separation of the combustible system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure.	K 068	K-076		
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for ninety-six (96) beds with a census of eighty-seven (87) on the day of the survey. The facility failed to ensure oxygen storage in a	K 076	Modifications have been made so that no more than 12 individual oxygen tanks, (less than 300 cubic feet) will be located in each of the smoke compartments used for oxygen storage on East wing and West wing. The facility will establish an outside storage area for any additional tanks that need to be stored on site, to meet the requirements of Life Safety code K-076  The maintenance director and assistant, have been re-inserviced by the administrator on the requirements of Life Safety code K-076  The maintenance director and assistant will do a monthly Q.I. audit of the oxygen storage on East wing and West wing, to insure that they meet the requirements in Life Safety Code K-076 The results of the audits will be reviewed in the monthly Executive Q.I. committee meeting for the next three months with the administrator, Director of Nursing, and Medical Director  Completion Date 10/19/2012		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185258	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED  09/05/2012
NAME OF PROVIDER OR SUPPLIER  LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025		
(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 076	<p>Continued From page 22</p> <p>smoke compartment stayed below 300 cubic feet.</p> <p>The findings include:</p> <p>Observation, on 09/05/12 between 8:00 AM and 9:00 AM with the Maintenance Supervisor, revealed twenty-three (23) oxygen tanks in the east storage room, and thirty (30) oxygen tanks in the west storage room, the oxygen tanks were being stored within five (5) feet of combustible items. Combustibles cannot be stored within five (5) feet of oxygen storage due to fire spread.</p> <p>Interview, on 09/05/12 between 8:00 AM and 9:00 AM with the Maintenance Supervisor, revealed he was unaware oxygen tanks could not be stored within five (5) feet of combustible materials once the storage equals over 300 cubic feet in a smoke compartment.</p> <p>Interview, on 09/05/12 at 9:45 AM with the Administrator, revealed she was unaware of the requirements on the storage of oxygen. She stated she relies on the Maintenance Supervisor for Life Safety and has sent him to training at KY Dam Village and provides manuals to him.</p> <p>Reference: NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m<sup>3</sup> (300 ft<sup>3</sup>) but less than 85 m<sup>3</sup> (3000 ft<sup>3</sup>) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous</p>	K 076			

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NAME OF PROVIDER OR SUPPLIER  LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025		
(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 076	Continued From page 23 oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.	K 076			
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the emergency generator was maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for ninety-six (96)	K 144	K-144 The battery charger has been removed from the Generator battery, and a sign posted noting that a charger can not be left connected to the Generator battery, to meet the requirements of Life Safety code K-144.  The maintenance director and assistant, have been re-inserviced by the administrator on the requirements of Life Safety code K-144.  The maintenance director and assistant will do a monthly Q.I. audit of Generator and battery, to insure that they meet the requirements in Life Safety Code K-144. The results of the audits will be reviewed in the monthly Executive Q.I. committee meeting for the next three months with the administrator, Director of Nursing, and Medical Director  Completion Date 10/19/2012		

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NAME OF PROVIDER OR SUPPLIER  LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42026		
(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 144	<p>Continued From page 24</p> <p>beds with a census of eighty-seven (87) on the day of the survey. The facility failed to ensure the generator battery charger was not hooked directly to the battery.</p> <p>The findings include:</p> <p>Observation, on 09/04/12 at 2:48 PM with the Maintenance Supervisor, revealed the generator's battery charger was hooked directly to the generator battery. Battery chargers cannot be hooked directly to the generator battery due to increase risk of fire.</p> <p>Interview, on 09/04/12 at 2:48 PM with the Maintenance Supervisor, revealed he was not aware that the battery charger could not be hooked directly to the battery.</p> <p>Interview, on 09/05/12 at 9:45 AM with the Administrator, revealed she was unaware of the battery of the generator hooked directly to the charger. She stated she relies on the Maintenance Supervisor for Life Safety and has sent him to training at KY Dam Village and provides manuals to him.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers ' recommendations and accepted engineering practices. Battery charger output wiring shall be</p>	K 144			

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NAME OF PROVIDER OR SUPPLIER  LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025		
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K 144	Continued From page 25 permanently connected. Connections shall not be made at the battery terminals.	K 144			