

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

PRINTED: 08/24/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185326	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2012
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NAME OF PROVIDER OR SUPPLIER CLINTON-HICKMAN COUNTY NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 388 S. WASHINGTON ST. CLINTON, KY 42031
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS A recertification survey was conducted on 08/12/12 through 08/14/12 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest S/S of a "E."	F 000	This plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies and procedures, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. The facility failed to ensure air conditioner gratings, ceiling fans, residents' showers and bathrooms were sanitary, and failed to ensure the residents' bathroom doors were in good repair. Findings include: A review of the facility's policy and procedure, "Residential Care Services," undated, revealed the facility premises would be kept in good repair with specifics mentioned in section 5.b. to include doors, plumbing and electrical fixtures. A review of the policy and procedure, "Guidelines for Cleaning Rooms," undated, revealed the process for cleaning lights and vents and staff should	F 253	This plan of correction serves as Clinton-Hickman County ICF credible allegation of compliance effective 9/20/12. F 253: The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. No residents were found to have been affected by the deficient practice: For residents having the potential to be affected by same deficient practice: All residents in these areas have the potential to be affected. Measures taken by the facility to ensure that the problem will be corrected and will not recur: The sharp edges on Room #206 and room # 208 bathroom doors have been sanded and resealed. This was completed on August 28, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Kel Br TITLE Administrator DATE 9/3/12

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

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/14/2012
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N 134	<p>Continued From page 1</p> <p>pest control issues.</p> <p>1. Observation during the initial tour, on 08/12/12 at 10:30 AM, revealed Room #206 and Room #208 had gouges with sharp edges in the wooden doors of the bathrooms.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 08/14/12 at 11:10 AM, revealed the process for reporting the gouges in the resident bathroom doors was to document information in the maintenance communication book, steno pad, which was located at the nurses' station. She stated the maintenance supervisor checked the book when he came to the floor.</p> <p>Interview, on 08/14/12 at 2:00 PM, with the facility Maintenance Supervisor, revealed the procedure for the repair of doors was to sand the sharp or rough edges and apply epoxy to cover the area. He stated he was not notified about the doors being in need of repair in Rooms #206 and #208.</p> <p>2. Observation during the General Observation tour, on 08/12/12 at 2:30 PM, revealed:</p> <p>a). The grating on top of the hallway air conditioning units had dust, lint, and round, fuzzy substances on the units. These units were located between Rooms #202 and #203, Rooms #215 and #216, Rooms #219 and #220, as well as in the residents' shower room.</p> <p>b). The ceiling fan blades on five ceiling fans in the dining area over tables where residents eat their meals, and three ceiling fans in the activity/therapy room were covered with thick lint and dirt.</p> <p>c). The top of the towel dispenser, located beside</p>	N 134	<p><i>All conditioning units located between rooms #202 and #203 rooms #215 and #216, rooms #219 and #220 have been thoroughly cleaned. This was completed on August 13, 2012.</i></p> <p><i>The residents shower room have been thoroughly cleaned. This was completed on August 28, 2012</i></p> <p><i>The ceiling fan blades on five ceiling fans in the dining area and three ceiling fans in the activity/therapy room have been cleaned. This was completed on August 28, 2012</i></p> <p><i>The top of the towel dispenser, located beside the refrigerator outside the Activities Director's office, has been cleaned. This was completed on August 28, 2012</i></p> <p><i>The leaking faucet at the hand washing sink in the residents shower room has been fixed by maintenance staff. This was completed on August 28, 2012</i></p> <p><i>The residents front shower room has been thoroughly cleaned including the ceiling air vent and tile grout at the edge where the floor met the wall. This was completed on August 12, 2012</i></p> <p><i>Both of the shower curtains in the residents shower rooms have been cleaned. This was completed on August 28, 2012</i></p>	

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F 253	<p>Continued From page 2 and dirt.</p> <p>c). The top of the towel dispenser, located beside the refrigerator outside the Activities Director's office, was covered with dust.</p> <p>d). The faucet at the handwashing sink in the residents' shower room was continuously leaking.</p> <p>e). The residents' front shower room had mildew odor.</p> <p>f). The residents' front shower room had visible black lint on the ceiling air vent.</p> <p>g). The residents' front shower room had areas of black substance in the floor tile grout at the edge where the floor met the wall.</p> <p>h). Both of the shower curtains in the residents' shower rooms had dried residue splattered over the shower side of the curtains.</p> <p>Interview with Housekeeper #5, on 08/14/12 at 11:15 AM, revealed she sprayed the shower room floor with Lysol spray, let it set, scrubbed the corners with a brush and then mopped. She stated she was taught to identify mold and instructed to notify maintenance by writing it in the book at the nurse's desk. Housekeeper #5 stated she was responsible for taking the shower curtains down when soiled and wash them in the laundry washing machine. She stated housekeeping was responsible for cleaning the ceiling fan blades and they were done on Friday when there were more housekeeping staff in the building and could get to the extra things. She stated housekeeping was responsible for wiping</p>	F 253	<p>Housekeeping dept in-servicing was conducted by Housekeeping Supervisor and Maintenance Director with the topic on proper cleaning techniques and notifying maintenance on repair issues.</p> <p>This was completed on August 31, 2012</p> <p><u>New guidelines have been created on how to:</u> Clean a ceiling fan Clean hallway air conditioning units Clean a paper towel dispenser Clean a shower curtain</p> <p>Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:</p> <p>The housekeeping supervisor will perform unannounced weekly quality work inspection for one month. After that, the process will be audited monthly for compliance. Any area that does not pass inspection will be re-cleaned immediately. This process will be reported in the QA meetings quarterly to ensure ongoing compliance.</p> <p>A maintenance service request form and binder have been created to log and track maintenance requests to ensure ongoing compliance.</p>	F 253: 8/31/12	

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F 253	Continued From page 3 the top of the hallway air conditioning unit every day. When all assigned rooms were completed, she would get extra cleaning done such as using a brush to get in the grating on top of the air conditioning unit. Interview with the Housekeeping Supervisor, on 08/14/12 at 11:30 AM, revealed the housekeeping department was responsible for cleaning the hallway air conditioning units and described the procedure as using Lysol AC cleaner and a brush to get down in the grooves. She stated this cleaning was done quarterly, and housekeeping was also responsible for cleaning the ceiling fans. She revealed she cleaned them herself on a quarterly basis. She stated the residents' showers were cleaned on Sunday each week using Lysol with bleach and described the floors and walls being scrubbed with a brush. A sanitizing cleaner was also left in the locked shower rooms for use by the nursing staff after each resident shower. The employees were trained to identify mold during new employee orientation and instructed to watch for black, "fuzzy growth," especially in the shower room. Any housekeeping staff who identified "black growth" was responsible for writing the information in the maintenance communication book. The housekeeping staff was also responsible to notify maintenance of a leaking faucet. The Housekeeping Supervisor stated the shower curtains were taken down and washed in the laundry washing machines when there were soiled. She revealed she completed quarterly Quality Assurance rounds to ensure her staff was providing services as expected.	F 253		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	<p>Continued From page 4</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and review of the facility's policies and procedures, it was determined the facility failed to store, prepare and serve food under sanitary conditions. A review of the facility's Census and Condition, dated 08/12/12, revealed 43 out of 44 residents received meals from the kitchen. The facility failed to ensure the Dietary Manager, Assistant Manager, and Kitchen Aides followed dietary policies and procedures related to frozen food in unsealed, undated containers, refrigerated raw meat without a date or label, meat slicer and heavy can opener with visible residue, refrigerated eggs with no date, and left-over foods with no label or date, staff's hair not completely covered with a hair net, utensils dried with a paper towel, clean utensils handled with staff's ungloved hand, obtaining food temperatures, and documentation of temperature logs without dates.</p> <p>Findings include:</p> <p>A review of the facility's policy and procedure, "General Cleaning," undated, revealed each dietary employee is responsible for cleaning</p>	F 371	<p>F 371:</p> <p>The facility must (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions.</p> <p>No residents were found to have been affected by the deficient practice.</p> <p>For residents having the potential to be affected by same deficient practice: All residents in these areas have the potential to be affected.</p> <p>Measures taken by the facility to ensure that the problem will be corrected and will not recur:</p> <p>The open bags of frozen diced green peppers and biscuits without dates were appropriately dated and sealed on 8/12/12</p> <p>The seven (7) packages of ribs without a label or date located in the walk-in refrigerator were appropriately dated and labeled on 8/12/12</p> <p>The can opener and meat slicer was thoroughly cleaned 8/12/12.</p>	

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F 371	<p>Continued From page 5 equipment used during their shift.</p> <p>A review of the facility's policy and procedure, "Frozen Storage," dated 03/01/2005, revealed all frozen food was to be properly wrapped, dated, and labeled and temperatures would be documented daily.</p> <p>A review of the facility's policy and procedure, "Refrigerated Storage," dated 03/01/2005, revealed temperature charts would be documented daily, raw meats would be wrapped, dated, and labeled, and all foods would be properly stored in sealed containers, dated, and labeled.</p> <p>A review of the facility's policy and procedure, "How to Store Leftovers Properly," undated, revealed foods would be labeled with contents and date.</p> <p>A review of the facility's policy and procedure, "Personal Appearance," undated, revealed all dietary employees would wear hair net that completely covered all hair while working in the dietary areas.</p> <p>A review of the facility's policy and procedure, "Temperatures at Meal Service," undated, revealed the temperature probe would be removed from food, the stem wiped of visible debris, and returned to the sanitizing tube after each use.</p> <p>A review of the facility's policy and procedure, "Warewashing," undated, revealed all washed items were to air dry completely. The policy also revealed employees must wash hands when</p>	F 371	<p>The fruit cocktail and pureed food was discarded into the trash on 8/12/12 and the 12 flats of eggs were appropriately dated and labeled.</p> <p>The dietary manager in-serviced dietary aides on proper hairnet usage on 8/27/12 and Consulting Dietitian in-serviced on 9/5/12 coverage and usage.</p> <p>The dietary manager in-serviced dietary staff on proper use and sanitation of temperature probe on 8/27/12 and again on 9/5/12 conducted by Consulting Dietitian.</p> <p>Dietary manager In serviced dietary staff on proper procedure of air drying items on 8/27/12 and will be again on 9/5/12 by Consulting Dietitian.</p> <p>The dietary manager in-serviced dietary staff on proper glove use on 8/27/12 and will be again on 9/5/12 by the Consultant Dietitian.</p>		

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F 371	<p>Continued From page 6</p> <p>switching between handling soiled items and clean items but it was not necessary to wear gloves when handling clean items.</p> <p>1. Observations during the initial kitchen tour, on 08/12/12 at 10:20 AM, revealed:</p> <p>a). Opened bags of frozen diced green peppers and biscuits without dates.</p> <p>b). Seven (7) packages of ribs without a label or date in the walk-in refrigerator.</p> <p>c). The meat slicer was uncovered and the heavy can opener had visible moist, black residue below the cutting edge.</p> <p>d). Twelve (12) undated flats of eggs, in the side-by-side refrigerator, two (2) small bowls of leftover fruit cocktail and one (1) small bowl of pureed food without labels or dates.</p> <p>e). A dietary aide with uncovered hair behind each ear at the hairline.</p> <p>f). The food temperature probe was moved from food to food without sanitizing the probe between each food.</p> <p>2. Observations, on 08/13/12 at 9:40 AM, revealed:</p> <p>a). A knife, measuring cup, and rubber spatula was dried with a paper towel and placed in storage.</p> <p>b). The Assistant Dietary Manager moved from cleaning the manual dishwashing area without</p>	F 371	<p>The Dietary manager created new log form and in-serviced dietary staff on proper procedure temperature logging on 8/27/12 and in-serviced again on 9/5/12 conducted by Consultant Dietitian.</p> <p>Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:</p> <p>A QA audit tool has been developed and the dietary manager will audit proper air drying of items, proper glove use, use of hair nets, and proper cleaning and sanitizing of equipment. The first QA monitoring was completed on 8/29/12 and the report will be reviewed with the consultant Dietitian. The process will be completed weekly for one month then audited monthly for compliance and reported/reviewed in the QA meetings quarterly to ensure ongoing compliance.</p>	F 371: 9/05/12	

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F 371	<p>Continued From page 7</p> <p>washing her hands to handling clean silverware without gloves.</p> <p>c). The temperature logs for the walk-in freezer, chest freezer, and side-by-side refrigerator had no temperature readings documented for 08/11/12.</p> <p>Interview with the Assistant Dietary Manager, on 08/13/12 at 9:40 AM, revealed the eggs in the side-by-side refrigerator did not have a date and the stocking process was to place the new eggs in the back and under the old eggs.</p> <p>Interview with Dietary Aide #4, on 08/14/12 at 12:50 PM, revealed stored foods must be in a clean container, covered, labeled, and dated. For eggs, the stocking process was to check the date on the carton when they came in, then rotate the older ones to the front. The flats came in a carton and the expiration date was on the carton. The flats were removed from the carton, the carton was thrown away, and the flats were placed in the refrigerator. She stated they were always careful and the same two people put up stock every week. She stated they probably needed to date the flats. Equipment was cleaned after each use or every shift and there was also a person who came in and assigned to clean all day. The cleaning schedule depended on how often the equipment was used, but each person was responsible to clean after using equipment. She stated the meat slicer and mixer was covered after being cleaned thoroughly. For the smaller items, like silverware, it was air dried, but if needed immediately, was dried with a paper towel. She stated, according to the dress code, hair was to be covered completely. Handwashing</p>	F 371			

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F 371	<p>Continued From page 8</p> <p>was done with each glove change and she was to wash and change gloves with each new task. Utensils were to be completely air dried then bagged for the residents' trays. She stated she always wore gloves to handle clean utensils. Dietary Aide #4 revealed the food temperature probe was sanitized in it's container/tube and each day kitchen staff put in fresh sanitizer. She was to take food temperatures, then remove the probe from the tube and wipe it off with a paper towel. Place the probe into the food and read the dial. She stated she wiped the probe with a paper towel between hot foods and if changed to a cold food, she sanitized the probe. If the food was sticky, she washed the probe off and sanitized it again. She stated the freezer and refrigerator temperature logs were written by the Dietary Manager or the Maintenance Supervisor during the week and on weekends, the temperature was checked and documented by the Assistant Dietary Manager.</p> <p>Interview with the Dietary Manager, on 08/14/12 at 1:15 PM, revealed any stored left-overs were covered, dated, and labeled. The eggs were ordered as they were needed and stored in the side-by-side refrigerator. When stock was at 1-2 flats, the order was placed. When the order was received the person who was stocking was to put the new one on the bottom, first in, first out. She stated the same two people do all the stocking, but all staff know the policy was first in, first out. She stated equipment was to be cleaned after each use. At the end of the shift, everything was to be cleaned, sanitized, and then air dried. The Dietary Sanitation check list was done by one person that was dedicated to do the cleaning and the General Cleaning list was each individual's</p>	F 371			

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F 371	Continued From page 9 responsibility to clean the equipment after each use. She stated dietary staff was to have their hair covered completely when working anywhere in the dietary area. She stated handwashing was completed after every task and before putting on gloves. Staff was to change gloves with every new task, "routinely and all the time, change gloves and wash hands, change gloves and wash hands." She stated when items came out of the washer, they were left in the rack until dry and not stored until completely dry. She stated kitchen aides might use a paper towel to dry a tray or something that food was not going to be on. The storage of silverware was done after the utensils were completely dry by using gloves to put them in the white caddy with prongs down and handles up. The food temperature probe was kept in the sanitizing tube with sanitizer. The kitchen aide was to take it out of the sanitizer, wipe it off with a paper towel, take the food temperatures, wipe it off with a napkin, then test the food. She stated there was no sanitization between foods if going from cooked food to cooked food. If the food changed from cooked food to cold food, then the probe was re-sanitized, probe wiped off, and the food was checked. The sanitizing solution was changed before and after each meal. The Dietary Manager stated documentation of the refrigerator and freezer temperature log was the responsibility of the morning cook and the afternoon/evening cook on the weekend. She stated she was responsible during the week.	F 371			
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 425	F425: The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement.		

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NAME OF PROVIDER OR SUPPLIER CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 386 S. WASHINGTON ST. CLINTON, KY 42031		
(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 425	<p>Continued From page 10</p> <p>§483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide safe and accurate pharmaceutical services related to the accountability of medications received and dispensed from the Emergency Medication Box. The facility failed to provide a safe and accurate procedure to monitor the use, replacement, and disposition of the medication supply in the Emergency Medication Box related to the amounts of medications and the dosages/strengths provided. Additionally, the facility failed to ensure safety and accountability by ensuring staff signed the form when they dispensed or replaced medications in the Emergency Medication Box.</p> <p>Findings include:</p>	F 425	<p>No residents were found to have been affected by the deficient practice.</p> <p>All Residents charts were reviewed to identify any residents having potential to be affected by the deficient practice.</p> <p>Measures taken by the facility to ensure that the problem will be corrected and will not recur:</p> <p>Par levels have been implemented for all medication by the pharmacy on 8/21/2012.</p> <p>The ER box was updated to reflect the par levels and a list has been created for the nursing staff to follow.</p> <p>New form was implemented to include specific signature line for all medication removed/replaced.</p> <p>The ER box will be checked at shift change to ensure lock # has not been tampered with.</p> <p>Policy has been updated to reflect the changes in procedures. All licensed nursing staff will have been in-serviced and educated by the Director of Nursing on the new process by 9/20/2012</p>		

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F 425	<p>Continued From page 11</p> <p>A review of the Emergency Medication Box procedure and signature sheet revealed any medication removed from the box must be signed out and when the medication is replaced a signature is also required. The signature portion of the document contained 15 entries and 9 of the entries were without a signature.</p> <p>A review of the Emergency Box Medications list (undated), on 08/13/12 at 4:30 PM, revealed medications were listed in categories of Orals, Injectables, and Emergency Box in Refrigerator. The list contained names of medications and dosages; however, there were no numbers of the stock levels for any of the medications.</p> <p>Observation of a count of the medications in the Emergency Box with Registered Nurse (RN) #1 revealed the medication Tobramycin 80 mg/2 ml was noted as "backordered 5/10/11" with a supply of 25 vials. The medication Furosemide 10 mg/ml was found in the Emergency Box with dosages of 40 mg/ml (6 vials) and 20 mg/ml (1 vial).</p> <p>Interview with RN #1, on 08/13/12 at 4:30 PM, revealed the pharmacist consultant was responsible for counting and making sure the correct medications were in the Emergency Medication Box. The RN stated the process for the use of medications from the Emergency Medication Box included a required signature when a medication was removed from the box and a signature was required when the medication was replaced. RN #1 stated she recognized her writing on the signature sheet; however, she did not sign the sheet as required.</p>	F 425	<p>Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:</p> <p>Consultant Pharmacy will check the ER box monthly during routine visits.</p> <p>The process will be audited weekly for four weeks then monthly for a year for compliance and reviewed in the QA meetings quarterly to ensure ongoing compliance.</p>	F 425: 9/20/12	

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F 425	<p>Continued From page 12</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 08/14/12 at 2:00 PM, revealed when a medication was taken out of the Emergency Box, it was to be signed out on the signature sheet. LPN #1 stated the Pharmacist Consultant counted the medications in the Emergency Medication Box one time each month.</p> <p>Interview with the Pharmacist Consultant, on 08/14/12 at 2:45 PM, revealed he was responsible for the medications in the Emergency Medication Box and for counting the medications. He stated he created the Emergency Box Medications list and he "keeps watch" of the medications in the box to ensure the medications were properly accounted for, but had not put a "keep stock at" level on the medication list because it was not requested. He stated he reviewed the Emergency Box when he conducted the monthly Quality Assurance audit, and reviewed the signature sheet when he counted the medications in the box.</p> <p>Interview with the Director of Nursing (DON), on 08/14/12 at 3:30 PM, revealed her expectations of the nursing staff and the Emergency Medication Box form was that the nurses were to sign the form where it said "Removed by." The DON stated she did not do spot checks of the Emergency Box or the medication carts because the Pharmacist Consultant conducted those audits for the Quality Assurance program.</p>	F 425			

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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: 1967.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type II (222).</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with 62 smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 08/14/12. Clinton-Hickman Nursing Facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for forty-six (46) beds with a census of forty-four (44) 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 Fire).</p>	K 000	<p>This plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies.</p> <p>The Plan of Correction is submitted solely because it is required by the provision of federal and state law.</p> <p>This plan of correction serves as Clinton-Hickman County ICF credible allegation of compliance effective 9/20/12.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator DATE: 9/3/12

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

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K 000	Continued From page 1	K 000		
K 027 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1½-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect three (3) of six (6) smoke compartments, all residents, staff and visitors. The facility is certified for forty-six (46) beds with a census of forty-four (44) on the day of the survey. The facility failed to ensure the cross corridors doors would close properly once the fire alarm released them from the magnetic locks.</p> <p>The findings include:</p> <p>Observation, on 08/14/12 at 2:30 PM with the Maintenance Director, revealed the cross-corridor doors located in the center of the north and south</p>	K 027	<p><u>K027:</u> <i>NFPA 101 Life Safety Code Standards</i></p> <p>No residents were found to have been affected by the deficient practice.</p> <p>For residents having the potential to be affected by same deficient practice:</p> <p><i>All residents in these areas have the potential to be affected.</i></p> <p>Measures taken by the facility to ensure that the problem will be corrected and will not recur:</p> <p><i>A coordinating device for the doors located in the center of north and south corridors has been ordered (through Accurate Door & Hardware LLC) to prevent the active door from closing until the inactive door is closed. Once the part arrives it will be immediately installed. Installation date is scheduled to be completed on September 20, 2012.</i></p>	

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K 027	<p>Continued From page 2</p> <p>corridors would not close completely when tested. This was due to the doors not having a coordinating device installed on the doors.</p> <p>Interview, on 08/14/12 at 2:30 PM with the Maintenance Director, revealed he was unaware the doors needed a coordinating device to ensure the door without the astragal would always close first.</p> <p>Interview, on 08/14/12 at 3:00 PM with the Administrator, revealed he was unaware the doors were not closing properly. Further interview revealed the QA process developed did not address the closure of the cross-corridor doors.</p> <p>NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.</p> <p>Reference: NFPA 80 (1999 Edition)</p> <p>2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.</p> <p>Reference: NFPA 101 (2000 edition)</p>	K 027	<p>Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:</p> <p>The fire drill evaluation form has been updated adding monitoring of smoke barrier doors. The doors will be checked during fire drills and included in the monthly fire drill report to be discussed at QA meetings to ensure ongoing compliance.</p>	K 027: 9/20/12	

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K 027	Continued From page 3	K 027			
K 029 SS=D	<p>8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <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 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 six (6) smoke compartments, twenty-six (26) residents, staff and visitors. The facility is certified for forty-six (46) beds with a census of forty-four (44) on the day of the survey. The facility failed to ensure four (4) rooms were properly protected due to the storage in the rooms.</p> <p>The findings include:</p>	K 029	<p><u>K029:</u> NFPA 101 Life Safety Code Standards</p> <p>No residents were found to have been affected by the deficient practice.</p> <p>For residents having the potential to be affected by same deficient practice:</p> <p><i>All residents have the potential to be affected</i></p> <p>Measures taken by the facility to ensure that the problem will be corrected and will not recur:</p> <p><i>Door closers and door knobs were installed on the doors located at:</i></p> <ul style="list-style-type: none"> -Cleaning supply closet in the kitchen. -Clean linen storage. -Janitor closet. -The soiled linen storage. <p><i>The kitchen cleaning supply closet door has been replaced with a smoke proof door.</i></p>		

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K 029	<p>Continued From page 4</p> <p>Observation, on 08/14/12 between 11:00 AM and 2:00 PM with the Maintenance Director, revealed the cleaning supply closet for the kitchen, clean linen storage, janitor closet, and the soiled linen storage need a closer added to the door plus the door needs to be smoke proof due to the storage of combustibles inside the areas.</p> <p>Interview, on 08/14/12 between 11:00 AM and 2:00 PM with the Maintenance Director, revealed he was unaware the storage in a room determined whether the room was a hazardous storage area or not.</p> <p>Interview, on 08/14/12 at 3:00 PM with the Administrator, revealed he was unaware of the requirements that make up hazardous storage in the facility.</p> <p>Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler 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>	K 029	<p>Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:</p> <p>A maintenance service request form and binder have been created to log and track maintenance requests to ensure ongoing compliance.</p> <p>Date correction action will be completed: 8/29/12</p>	K 029: 8/29/12	

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K 029	Continued From page 5 (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 040 SS=E	NFFA 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 NFFA standards. The deficiency had the potential to affect three (3) of six (6) smoke compartments, twenty (20) residents, staff and visitors. The facility is certified for forty-six (46) beds with a census of	K 040	<p><u>K040:</u> NFFA 101 Life Safety Code Standards</p> <p>No residents were found to have been affected by the deficient practice.</p> <p>For residents having the potential to be affected by same deficient practice:</p> <p><i>Any resident needing to exit that location has the potential to be affected.</i></p>	

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K 040	<p>Continued From page 6</p> <p>forty-four (44) 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.</p> <p>The findings include:</p> <p>Observation, on 08/14/12 at 1:55 PM with the Maintenance Director, revealed the exit gates at the end of the south porch exit did not swing outward. The gates would have to be pulled against egress travel in the event of an evacuation.</p> <p>Interview, on 08/14/12 at 1:55 PM with the Maintenance Director, revealed he was not aware the exit discharge gate needed to open in the direction of egress.</p> <p>Interview, on 08/14/12 at 3:00 PM with the Administrator, revealed she was aware that egress gates should swing in the out direction but was unaware the gate at the end of the Solana unit swung inward. Further interview revealed his QA had not focused on the gates at the south exit. He has changed the fire drills, fire extinguisher checks, and is working on life safety code policies next.</p> <p>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.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 040	<p>Measures taken by the facility to ensure that the problem will be corrected and will not recur:</p> <p><i>The exit gates at the end of the south porch exit have been removed to allow and ensure no blockage of egress.</i></p> <p>Date correction action will be completed: 8/29/12</p>	K 040: 8/29/12
K 045 SS=E		K 045		

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K 045	<p>Continued From page 7</p> <p>Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect four (4) of six (6) smoke compartments, forty-six (46) residents, staff and visitors. The facility is certified for forty-six (46) beds with a census of forty-four (44) on the day of the survey. The facility failed to ensure the emergency lights had two (2) bulbs at the exits.</p> <p>The findings include:</p> <p>Observation, on 08/14/12 at 1:45 PM with the Maintenance Director, revealed the exterior exits on the west side of the building only had a single light for illumination of the outside of the exit.</p> <p>Interview, on 08/14/12 at 1:45 PM with the Maintenance Director, revealed he was unaware the lighting fixtures serving the exterior exits must include more than one bulb for illumination of the egress path. Further interview revealed the facility had removed the lights to keep the bugs away at night.</p> <p>Interview, on 08/14/12 at 3:00 PM with the Administrator, revealed they have a QA every</p>	K 045	<p>K045: NFPA 101 Life Safety Code Standards</p> <p><i>The egress was illuminated with one (1) bulb -the area was lit. No residents were found to have been affected by the deficient practice.</i></p> <p>For residents having the potential to be affected by same deficient practice:</p> <p><i>No residents have the potential to be affected.</i></p> <p>Measures taken by the facility to ensure that the problem will be corrected and will not recur:</p> <p><i>The facility has purchased new lighting fixtures with a two (2) bulbs light. These fixtures have been installed at the exterior exits on the west side of the building. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:</i></p> <p><i>A QA audit tool has been developed For maintenance to check lighting.</i></p> <p><i>A maintenance service request form and binder have been created to log and track maintenance requests to ensure ongoing compliance.</i></p> <p>Date of corrective action completed: 8/30/12</p>	K 045: 8/30/12

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NAME OF PROVIDER OR SUPPLIER CLINTON-HICKMAN COUNTY NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 366 S. WASHINGTON ST. CLINTON, KY 42031
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K 045	Continued From page 8 morning since he is a new Administrator to this facility. They focus on the fire drills and door alarms but the lighting at the exits was not part of their routine checks. Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045		
K 047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of six (6) smoke compartments, all residents, staff and visitors. The facility is certified for forty-six (46) beds with a census of forty-four (44) on the day of the survey. The facility failed to ensure the exit paths were clearly marked. The findings include: Observation, on 08/14/12 at 2:25 PM with the	K 047	<u>K047:</u> NFPA 101 Life Safety Code Standards No residents were found to have been affected by the deficient practice. For residents having the potential to be affected by same deficient practice: <i>All residents have the potential to be effected.</i>	

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NAME OF PROVIDER OR SUPPLIER CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 388 S. WASHINGTON ST. CLINTON, KY 42031	
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K 047	Continued From page 9 Maintenance Director, revealed egress paths to stair exit in the north and south corridors was not marked. The stair exit had an exit sign above it pointing to the north exit. Further observation showed once the fire doors closed on the center cross-corridor doors there were no visible exit signs above the doors. . Interview, on 08/14/12 at 2:25 PM with the Maintenance Director, revealed he was unaware the signage was missing for the exits. Interview, on 08/14/12 at 3:00 PM with the Administrator, revealed he was unaware the exit signage was not arranged in a proper way. The QA process he developed does not address the exit signage for the facility. Reference: NFPA 101 (2000 edition) 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.	K 047	Measures taken by the facility to ensure that the problem will be corrected and will not recur: <i>4 new exit signs have been installed to egress paths to stair exit. Two (2) located on the north and Two (2) located on the south corridors. This installation included a visible exit sign above the doors so once the fire doors are closed, the center cross-corridor doors there is a visible exit sign.</i> Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent: <i>A QA audit tool has been developed for maintenance to check/test exit signs.</i> A maintenance service request form and binder have been created to log and track maintenance requests to ensure ongoing compliance. Date correction action will be completed: 8/31/12	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on record review and interview, it was	K 054	<u>K 054:</u> NFPA 101 Life Safety Code Standards No residents were found to have been affected by the deficient practice.	<u>K 047:</u> 8/31/12

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K 054	<p>Continued From page 10</p> <p>determined the facility failed to ensure smoke detectors were inspected and tested in accordance with NFPA Standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, all residents, staff and visitors. The facility is certified for forty-six (46) beds with a census of forty-four (44) on the day of the survey. The facility failed to ensure the smoke detectors at the facility were properly tested at least once in the last two years.</p> <p>The findings include:</p> <p>Record review, on 08/14/12 at 10:30 AM with the Maintenance Director, revealed no documentation of a Smoke Detector Sensitivity Test being performed on the fire alarm smoke detectors within the last two years. Smoke detectors must be tested according to NFPA 72 (1999 edition) to ensure their reliability. Further observation showed the number of detectors in the facility changed with each quarterly inspection ranging from 62 to 24.</p> <p>Interview, on 08/14/12 at 10:30 AM with the Maintenance Director, revealed he was unaware the facility did not have a current sensitivity test on the fire alarm smoke detectors. Further interview revealed he did not know why there was a different number of detectors installed on each report.</p> <p>Interview, on 08/14/12 at 3:00 PM with the Administrator, revealed he was unaware the proper testing of the smoke detectors had not been completed. Further interview revealed there was no process to ensure the proper testing of the fire alarm system was being completed.</p>	K 054	<p>To identify any residents having the potential to be affected by the deficient practice:</p> <p><i>All smoke detectors were tested by Premier Fire & Security and were found to be working properly, all detectors passed the test. Therefore No residents had potential to be affected by the deficient practice.</i></p> <p>Measures taken by the facility to ensure that the problem will be corrected and will not recur:</p> <p><i>A smoke detector sensitivity test has been completed on a all smoke detectors to assure they are working in proper order.</i></p> <p><i>All 32 smoke detector were numbered to assure each detector is accounted for.</i></p>	

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K 054	Continued From page 11 Reference: NFPA 72 (1999 edition) 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. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where	K 054	Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent: <i>The smoke detector sensitivity test has been added to our scheduled services provided by Premier Fire & Security, Inc. to ensure the smoke detectors at the facility are properly inspected and tested in accordance with NFPA standards.</i> <i>A QA calendar tool has been developed for logging test dates and it will be reviewed in the QA meetings quarterly to ensure ongoing compliance.</i> <i>Date correction action will be completed: 8/23/12</i>	K 054: 8/23/12

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K 054	Continued From page 12 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 054			
K 061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1	K 061	K 061: NFPA 101 Life Safety Code Standards No residents were found to have been affected by the deficient practice.		

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K 061	<p>Continued From page 13</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure valves located in the facility sprinkler system were electronically supervised by a tamper switch in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, all residents, staff and visitors. The facility is certified for forty-six (46) beds with a census of forty-four (44) on the day of the survey. The facility failed to ensure all water control valves were supervised on the sprinkler system.</p> <p>The findings include:</p> <p>Observation, on 08/14/12 at 1:36 PM with the Maintenance Director, revealed the sprinkler system had two supervised valves at the sprinkler riser but the main water valve coming into the facility was not electronically supervised. This valve was not equipped with a tamper switch, but was secured with chains. The observation was confirmed with the Maintenance Director.</p> <p>Interview, on 08/14/12 at 1:36 PM with the Maintenance Director, revealed he was unaware all valves leading to the sprinkler system must be electronically supervised. He was told upon hire to never turn the valve.</p> <p>Interview, on 08/14/12 at 3:00 PM with the Administrator, revealed he was under the impression that the two (2) supervised valves would detect there was no water flowing to them. He was unaware the supervisory switches check the position of the valve and not the amount of water flowing through the valve.</p>	K 061	<p>For residents having the potential to be affected by same deficient practice:</p> <p><i>Original chain and pad lock were secured, no unauthorized tampering. No residents were found to be affected.</i></p> <p>Measures taken by the facility to ensure that the problem will be corrected and will not recur:</p> <p><i>Premier Fire & Security, Inc. has installed an electronically supervised tamper switch to the main water valve coming into the facility's sprinkler system. The chain and pad lock has been replaced with an electronically supervised system to ensure all water control valves are supervised on the sprinkler system that meets NFPA standards.</i></p> <p><i>Date corrective action will be completed: 8/23/12</i></p>	K 061: 8/23/12
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K 061	Continued From page 14 Reference: NFPA 101 (2000 Edition). 9.7.2.1* Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.	K 061		
K 076 SS=D	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	K 076	K 076: NFPA 101 Life Safety Code Standards No residents were found to have been affected by the deficient practice. For residents having the potential to be affected by same deficient practice: <i>All residents residing in the facility had the potential to be affected by the deficient practice</i>	

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K 076	<p>Continued From page 15</p> <p>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 one (1) of six (6) smoke compartments, twenty-six (26) residents, staff and visitors. The facility is certified for forty-six (46) beds with a census of forty-four (44) on the day of the survey. The facility failed to ensure oxygen storage in a room stayed below 300 cubic feet.</p> <p>The findings include:</p> <p>Observation, on 08/14/12 at 1:15 PM with the Maintenance Director, revealed nineteen (19) oxygen tanks in the nurse supply 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. The observation was confirmed with the Maintenance Director.</p> <p>Interview, on 08/14/12 at 1:15 PM with the Maintenance Director, revealed he was unaware oxygen tanks could not be stored within five (5) feet of combustible materials once you are over the 300 cubic feet.</p> <p>Interview, on 08/14/12 at 3:00 PM with the Administrator, revealed he was unaware that there was an amount of oxygen that required separation from other storage in the vicinity.</p>	K 076	<p>Measures taken by the facility to ensure that the problem will be corrected and will not recur:</p> <p><i>A new area for holding O2 cylinders has been assigned. Its located behind lock doors with proper labeling, this area will contain no more than 12 cylinders in proper cylinder stands.</i></p> <p><i>O2 tanks were removed from previous storage so that no more than 12 cylinders are stored in one area.</i></p> <p><i>Oxygen storage policy and procedures has been updated to include new changes. Staff will be in-serviced by the DON and Maintenance Supervisor on the proper procedure 9/11/2012.</i></p> <p>Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:</p> <p><i>O2 storage will be monitored monthly and discussed in the QA meeting quarterly to insure; There are no more than 12 cylinders in one storage area There are no combustible items stored with in 5ft. of O2 cylinders.</i></p> <p>Date corrective action will be completed: 9/20/12</p>	<p>K 076: 9/20/12</p>
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K 076	Continued From page 16 Reference: NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m ³ (300 ft ³) but less than 85 m ³ (3000 ft ³) (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 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.	K 144	K 144: NFPA 101 Life Safety Code Standards No residents were found to have been affected by the deficient practice.		

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K 144	<p>Continued From page 17</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the emergency generator according to NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, all residents, staff and visitors. The facility is certified for forty-six (46) beds with a census of forty-four (44) on the day of the survey. The facility failed to ensure there was battery backup lighting at the generator transfer switch.</p> <p>The findings include:</p> <p>Observation, on 08/14/12 at 2:40 PM with the Maintenance Director, revealed the facility did not have any battery-powered lighting installed in the area where the transfer switch for the emergency generator was located.</p> <p>Interview, on 08/14/12 at 2:40 PM with the Maintenance Director, revealed he was not aware of the requirement for the battery backup lighting.</p> <p>Interview, on 08/14/12 at 3:00 PM with the Administrator, revealed he was aware of the requirement for the battery backup lighting at the generator but was unaware of the requirement at the transfer switch.</p> <p>Observation, on 08/14/12 at 10:50 AM with the Maintenance Director, revealed the generator's battery charger was hooked directly to the generator battery.</p>	K 144	<p>For residents having the potential to be affected by same deficient practice:</p> <p><i>No residents have the potential to be affected.</i></p> <p>Measures taken by the facility to ensure that the problem will be corrected and will not recur:</p> <p><i>A battery-powered light has been installed in the emergency generator transfer switch box. This will ensure there is battery backup lighting at the generator transfer switch.</i></p> <p><i>The generators battery charger has been rewired and is no longer hooked directly to the generator battery terminals.</i></p> <p>Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:</p> <p><i>A QA check tool has been created to test the battery-powered light. The monthly report will be discussed by the maintenance supervisor at the facility's quarterly QA meetings to ensure ongoing compliance.</i></p> <p>Date corrective action will be completed: 8/31/12</p>	K 144: 8/31/12

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NAME OF PROVIDER OR SUPPLIER CLINTON-HICKMAN COUNTY NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 388 S. WASHINGTON ST. CLINTON, KY 42031
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K 144	Continued From page 18 Interview, on 08/14/12 at 10:50 AM with the Maintenance Director, revealed he was not aware that the battery charger could not be hooked directly to the battery. Interview, on 08/14/12 at 3:00 PM with the Maintenance Director, revealed he was unaware the battery of the generator could not be hooked directly to the charging system. Reference: NFPA 110 (1999 Edition). 5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch. Reference: NFPA 110 (1999 Edition). 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 permanently connected. Connections shall not be made at the battery terminals.	K 144		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		

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K 147	<p>Continued From page 19</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, no residents, staff and visitors. The facility is certified for forty-six (46) beds with a census of forty-four (44) on the day of the survey. The facility failed to ensure electrical panels maintained three (3) feet of clearance around them.</p> <p>The findings include:</p> <p>Observations, on 08/14/12 at 1:05 PM with the Maintenance Director, revealed the electrical panel in the Activities/Social Services Office had storage within 3 feet of the electrical panels. The panel was blocked by a filing cabinet and a copy machine.</p> <p>Interview, on 08/14/12 at 1:05 PM with the Maintenance Director, revealed he was unaware there could not be storage within 3 feet of electrical panels.</p> <p>Interview, on 08/14/12 at 3:00 PM with the Administrator, revealed he was unaware of the storage blocking the electrical panel in the office.</p>	K 147	<p>K 147: NFPA 101 Life Safety Code Standards</p> <p>No residents were found to have been affected by the deficient practice.</p> <p>For residents having the potential to be affected by same deficient practice: <i>No residents have the potential to be affected by the deficient practice.</i></p> <p>Measures taken by the facility to ensure that the problem will be corrected and will not recur:</p> <p><i>The filing cabinet and copy machine located in the Activities/Social Services office have been moved so the electrical panel is free from blockage.</i></p>		

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K 147	<p>Continued From page 20</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>110-26. Spaces</p> <p>10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> <p>(A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code.</p> <p>(1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.</p> <p>Table 110.26(A)(1) Working Spaces</p> <table border="1"> <thead> <tr> <th>Nominal Voltage to Ground</th> <th colspan="2">Minimum Clear Distance</th> </tr> <tr> <th>Condition 1</th> <th>Condition 2</th> <th>Condition 3</th> </tr> </thead> <tbody> <tr> <td>0-150 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> </tr> <tr> <td>151-600</td> <td>900 mm (3 ft)</td> <td>1 m (3½ ft)</td> </tr> <tr> <td>1.2 m (4 ft)</td> <td></td> <td></td> </tr> </tbody> </table> <p>Note: Where the conditions are as follows: Condition 1 - Exposed live parts on one side and</p>	Nominal Voltage to Ground	Minimum Clear Distance		Condition 1	Condition 2	Condition 3	0-150 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	151-600	900 mm (3 ft)	1 m (3½ ft)	1.2 m (4 ft)			K 147	<p>Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:</p> <p><i>Activities/Social Services staff has been in-serviced by the maintenance director on not to store items in front of the electrical panel.</i></p> <p><i>The Maintenance Director will perform unannounced weekly inspections for four weeks then monthly for a year. Any issue found during inspection will be address immediately. The monthly report will be discussed by the Maintenance Director at the facility's quarterly QA meetings to ensure ongoing compliance.</i></p> <p>Date corrective action will be completed: 8/31/12</p>	K 147: 8/31/12
Nominal Voltage to Ground	Minimum Clear Distance																		
Condition 1	Condition 2	Condition 3																	
0-150 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)																	
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K 147	<p>Continued From page 21</p> <p>no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts.</p> <p>Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as grounded.</p> <p>Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between.</p> <p>(a) Dead-Front Assemblies. Working space shall not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other than the back or sides. Where rear access is required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided.</p> <p>(b) Low Voltage. By special permission, smaller working spaces shall be permitted where all uninsulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc.</p> <p>(c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service</p>	K 147			

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K 147	<p>Continued From page 22</p> <p>the installation.</p> <p>(2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels.</p> <p>(3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or platform to the height required by 110.26(E). Within the height requirements of this section, other equipment that is associated with the electrical installation and is located above or below the electrical equipment shall be permitted to extend not more than 150 mm (6 in.) beyond the front of the electrical equipment.</p> <p>(B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded.</p> <p>(C) Entrance to Working Space.</p> <p>(1) Minimum Required. At least one entrance of sufficient area shall be provided to give access to working space about electrical equipment.</p> <p>(2) Large Equipment. For equipment rated 1200 amperes or more and over 1.8 m (6 ft) wide that contains overcurrent devices, switching devices, or control devices, there shall be one entrance to the required working space not less than 610 mm (24 in.) wide and 2.0 m (6½ ft) high at each end of the working space. Where the entrance has a personnel door(s), the door(s) shall open in the direction of egress and be equipped with panic bars, pressure plates, or other devices that are normally latched but open under simple pressure. A single entrance to the required working space</p>	K 147		

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K 147	<p>Continued From page 23</p> <p>shall be permitted where either of the conditions in 110.26(C)(2)(a) or (b) is met.</p> <p>(a) Unobstructed Exit. Where the location permits a continuous and unobstructed way of exit travel, a single entrance to the working space shall be permitted.</p> <p>(b) Extra Working Space. Where the depth of the working space is twice that required by 110.26(A)(1), a single entrance shall be permitted. It shall be located so that the distance from the equipment to the nearest edge of the entrance is not less than the minimum clear distance specified in Table 110.26(A)(1) for equipment operating at that voltage and in that condition.</p> <p>(D) Illumination. Illumination shall be provided for all working spaces about service equipment, switchboards, panelboards, or motor control centers installed indoors. Additional lighting outlets shall not be required where the work space is illuminated by an adjacent light source or as permitted by 210.70(A)(1), Exception No. 1, for switched receptacles. In electrical equipment rooms, the illumination shall not be controlled by automatic means only.</p>	K 147		