

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

PRINTED: 05/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185336	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/19/2014
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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069
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{F 000} INITIAL COMMENTS

{F 000}

An offsite revisit was conducted and based on the acceptable Plan of Correction (POC) the facility was deemed to be in compliance as alleged on 05/11/14.

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

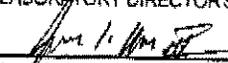
TITLE

(X6) DATE

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

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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069	
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F 000	INITIAL COMMENTS AMENDED A Standard Recertification Survey was initiated on 03/24/14 and concluded on 03/27/14. Deficiencies were cited with the highest Scope and Severity of an "F". In addition, an Abbreviated Survey to investigate #KY00021472 and #KY00021473 was conducted. #KY00021472 and #KY00021473 were unsubstantiated with no deficient practice identified.	F 000	Submission of this Plan of Correction is neither an admission to nor an agreement with the Deficient Practices noted below, but provided as required under the Conditions of Participation.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	The care plan for resident #2 was updated to include changing the foley catheter every 2 weeks per the MD order on 3/28/2014 by Linda Young, RN, Assistant Director of Nursing. An audit of all resident comprehensive care plans will be completed by Cindy Osborne, Director of Nursing; Linda Young, Assistant Director of Nursing; Mollie Lanham, Dietary Manager and Sheila Mann, Social Service Director on 5/6/2014 and will be updated if needed.	
This REQUIREMENT is not met as evidenced				
LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE
			ADMINISTRATOR	5-6-14

RECEIVED
MAY 16 2014

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F 280	<p>Continued From page 1</p> <p>by: Based on observation, interview and record review, it was determined the facility failed to ensure the Comprehensive Care Plan was revised for one (1) of fourteen (14) sampled residents (Resident #2).</p> <p>Resident #2 had a Physician's Order for an indwelling urinary catheter to be changed every two (2) weeks; however, the Comprehensive Care Plan was not revised to include this intervention.</p> <p>The findings include:</p> <p>Interviews with the Director of Nursing (DON), on 03/27/14 at 11:30 AM and 7:25 PM, revealed the facility had no policy related to revision of the Comprehensive Care Plan.</p> <p>Review of the clinical record revealed Resident #2 was admitted by the facility on 07/01/12 with diagnoses which included Paraplegia, Neurogenic Bladder, and a history of Urinary Tract Infections. (A neurogenic bladder causes difficulty or inability to pass urine without the aid of a catheter.)</p> <p>Review of the Annual Minimum Data Set (MDS) Assessment, dated 01/08/14, revealed the facility assessed Resident #2 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), which indicated no cognitive impairment. Further review of the MDS revealed the facility assessed Resident #2 as having an indwelling urinary catheter.</p> <p>Observation of Resident #2, on 03/28/14 at 9:15 AM, revealed the resident was lying on the bed and a urinary drainage bag was noted hanging on</p>	F 280	<p>All licensed nurses will be re-educated on updating resident care plans that require specific MD orders for care, by Trena Lee, Education and Training Director on 5/6/2014.</p> <p>All new MD orders will be reviewed daily in the clinical morning meeting by the Interdisciplinary team to ensure they are placed in the residents' plan of care when applicable. A monthly audit of all resident care plans will be conducted by Cindy Osborne, Director of Nursing; Linda Young, Assistant Director of Nursing; Mollie Lanham, Dietary Manager and Sheila Mann, Social Service Director for 2 months with the results taken to the Quality Assurance Committee for any further recommendations.</p>	5/11/2014
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F 280	<p>Continued From page 2 the bed frame.</p> <p>Review of the monthly Physician's Orders, dated February 2014 and March 2014, revealed orders to change Resident #2's indwelling urinary catheter every two (2) weeks.</p> <p>Review of the Comprehensive Care Plan, dated 03/06/13, revealed Resident #2 had a care plan for alteration in elimination as evidenced by Neurogenic Bladder, Spinal Cord Injury and a risk for complications related to the Foley (indwelling) Catheter. Continued review revealed the goal of the care plan stated the resident would be free of complications related to the Foley Catheter. Further review revealed no documented evidence of an intervention to change the indwelling urinary catheter every two (2) weeks, as ordered by the Physician.</p> <p>Interview with the MDS Coordinator, on 03/27/14 at 4:10 PM, revealed she only worked part time. She stated she was filling in for the regular MDS Coordinator and was not very involved with revising the care plans.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 03/26/14 at 2:30 PM and 03/27/14 at 4:25 PM, revealed care plans were revised Monday through Friday during the Daily Clinical Review (DCR) Meeting. She stated the original Physician's Order to change the catheter every two (2) weeks was written on 01/03/14 and should have been transcribed to the Care Plan by the DCR team.</p> <p>Interview with the DON, on 03/27/14 at 11:30 PM, revealed the care plans were to be updated, based on each new Physician's Order, during the</p>	F 280			

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F 280	Continued From page 3 Daily Clinical Review Meeting held Monday through Friday. She stated the intervention to change Resident #2's indwelling catheter every two (2) weeks should have been on the care plan.	F 280			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure residents received appropriate treatment and services to prevent Urinary Tract Infections (UTIs), and to restore as much bladder function as possible, for one (1) of fourteen (14) sampled residents (Resident #2). There was no documented evidence Resident #2 had her/his indwelling urinary catheter changed every two (2) weeks for 02/14/14 and 03/14/14, per Physician's Orders, although the resident had a history of UTIs. The findings include: Review of Resident #2's medical record revealed	F 315	The indwelling foley catheter for resident #2 was changed on 3/30/2014 by Victor Ferrell, LPN. The procedure for changing the indwelling foley catheter for resident #2 was documented on the treatment record by Victor Ferrell, LPN on 3/30/2014. An assessment of all residents with indwelling catheters to determine if they needed an indwelling catheter changed was completed by Cindy Osborne, Director of Nursing and Kellie Elder, RN on 4/21/2014. An audit of all treatment records for residents with an indwelling catheter was completed by Cindy Osborne, Director of Nursing on 4/18/2014, to determine that indwelling		

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F 315	<p>Continued From page 4</p> <p>the resident was admitted by the facility on 07/01/12 with diagnoses which included Paraplegia, Neurogenic Bladder, and a History of Urinary Tract Infections. (A neurogenic bladder causes difficulty or inability to pass urine without the aid of a catheter.)</p> <p>Review of the Annual Minimum Data Set (MDS) Assessment, dated 01/08/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of fifteen (15), which indicated the resident was cognitively intact. Further review revealed the facility assessed the resident as having an Indwelling urinary catheter.</p> <p>Observation of Resident #2, on 03/28/14 at 9:15 AM, revealed the resident was in bed on her/his back. A urinary drainage bag was noted to be hanging on the bed frame.</p> <p>Review of laboratory data revealed a urine specimen was collected on 02/10/14 and reported on 02/12/14 as Proteus Mirabilis, an organism which can cause a UTI. Review of the Physician's Orders dated 02/12/14 revealed an order for Bactrim DS (an antibiotic) twice a day for fourteen (14) days, for a UTI. Further review revealed orders for Macrobid (an antibiotic) 50 mgs (fifty milligrams) every day, to alternate every other month with another antibiotic, (trimethoprim 100 mg every day), to start 02/27/14.</p> <p>Further review of laboratory data revealed a urine specimen was collected on 02/18/14 and reported on 02/22/14 as the organisms Enterococcus Faecalis and Proteus Mirabilis. Review of the Physician's Orders, dated 02/23/14, revealed orders to discontinue Macrobid and start Ampicillin (antibiotic) 500 milligrams every day</p>	F 315	<p>catheters were changed per the MD orders. All MD orders for indwelling catheters were reviewed by Cindy Osborne, Director of Nursing and Linda Young, Assistant Director of Nursing on 4/21/2014 to ensure MD orders were current, correct and followed by the licensed nurses.</p> <p>All licensed nurses will be re-educated by Trena Lec on 5/6/2014 to assess residents with indwelling foley catheters each shift to ensure the catheter is patent, secure and closed, not touching the floor and the appearance of the urine draining into the catheter bag. The education will also include completion of documentation on the treatment record, by initialing the treatment record when the foley catheter is changed per orders and if occluded obtaining MD orders to</p>		

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F 315	Continued From page 5 and repeat the urinalysis in one week. Further review revealed orders dated 02/24/14 to discontinue Ampicillin, start Macroductin 100 mg qd and discontinue trimethoprim. Review of the laboratory data collected 03/03/14 and reported 03/05/14 revealed the organism, Proteus Mirabilis. Review of the Physician's Orders, dated 03/07/14, revealed an order for Rocephin 1 GM (one gram) Intramuscularly (IM), to be administered daily for seven (7) days, for a UTI. (Rocephin is an antibiotic). Review of the monthly Physician's Orders for February 2014 and March 2014, revealed Resident #2's catheter was to be changed every two (2) weeks. Review of the Treatment Administration Record (TAR) for February 2014 revealed an intervention to change the catheter every two (2) weeks. The TAR was marked to indicate the catheter was to be changed on 02/14/14 and 02/28/14 on the night shift. Continued review revealed the TAR was not initialed to indicate the catheter had been changed on those dates. Further review of the TAR for March 2014 revealed an intervention to change the catheter every two (2) weeks which was marked to be changed on 03/14/14 on the night shift; however, the TAR was not initialed to indicate the catheter had been changed. Review of the Nurse's Notes for February 2014 and March 2014 revealed there was no documented evidence the urinary indwelling catheter had been changed. Interview with Registered Nurse (RN) #3, on 03/27/14 at 9:00 AM, revealed she worked the night shift on the West Wing where Resident #2 resided. She stated she was unsure if she had	F 315	allow changing the indwelling foley catheter at that time and documenting on the treatment record. An audit of all treatment records will be conducted weekly by Cindy Osborne, Director of Nursing during morning clinical meeting x 2 months and the results taken to the Quality Assurance Committee for further recommendations. If an indwelling catheter change that was due and not initialed is revealed, the licensed nurse responsible will be contacted by the Director of Nursing who will then begin an investigation into the reason and results of the investigation will be discussed with the Administrator for further action needed.	5/11/2014

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F 315	<p>Continued From page 6</p> <p>changed the indwelling urinary catheter during February or March.</p> <p>Interview with RN #4, on 03/27/14 at 11:45 AM, revealed she worked the night shift on the West Wing. Continued interview revealed she did not remember if she had changed the catheter in February or March, but did not think she had because the resident stayed up in the wheelchair until 5:00 AM on the night shift. She further stated if she had changed it, she would have documented it on the TAR.</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on 03/27/14 at 1:35 PM, revealed he worked the night shift on the West Wing and had changed Resident #2's indwelling urinary catheter some time during the month of February because the catheter was clogged. He stated it was important to document when the catheter was changed; however, he stated, on the nights he changed the catheter it was not due to be changed per the dates indicated on the TAR, so he had not documented on the TAR. Further interview revealed he could have documented it in the Nurses' Notes. He stated he rarely got into the computer because he was not good at working the computer. Continued interview revealed he had not worked in March.</p> <p>Interview with LPN #5, on 03/27/14 at 5:10 PM, revealed she worked the night shift on the West Wing. She stated she had not changed Resident #2's indwelling urinary catheter in February or March.</p> <p>Interview on 03/27/14 at 5:00 PM with Resident #2 revealed her/his indwelling urinary catheter was changed every two (2) weeks on a regular</p>	F 315		
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F 315	Continued From page 7 basis for the past two (2) months. Interview with the Assistant Director of Nursing (ADON) on 03/26/14 at 2:30 PM revealed the indwelling urinary catheter was usually changed prior to each urine specimen obtained; however, she stated by reviewing the record of the TAR and Nursing Notes, there was no proof the catheter was changed. She stated the night shift staff were to change the catheter and stated they should have documented when they changed the catheter on the TAR or the Nurse's Notes. Interview with the Director of Nursing (DON), on 03/27/14 at 11:30 PM, revealed the nurses were to follow the Physician's Orders in regards to changing the indwelling urinary catheter every two (2) weeks. She stated she or the ADON checked the Medication Administration Record (MAR) and TARS periodically to ensure accurate documentation; however, she was unaware the staff had not been documenting changing the indwelling urinary catheter for Resident #2.	F 315		
F 371 SS=F	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371	All Dietary staff have been re-educated by Karen Baker, Registered Dietician 4/17/2014 on proper handwashing technique, glove changing while handling food sources, infection control and "Good sanitation to serve food safely."	

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F 371	<p>Continued From page 8</p> <p>by: Based on observation, interview and review of facility policies, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by improper hand washing technique between glove changes and tasks. In addition, observations revealed Improper washing, rinsing and sanitization of equipment between tasks and improper storage of the cleaning rag by dietary staff.</p> <p>The findings include:</p> <ul style="list-style-type: none"> Review of the facility policy titled "Food Preparation and Service", with a revised date of 11/2010, revealed food service employees were to prepare and serve food in a manner that complied with safe food handling practices. Continued review revealed food preparation staff were to adhere to proper hygiene and sanitary practices to prevent the spread of food-borne illness. Review of the facility policy titled "Sanitization", revised 12/2008, revealed cloths and towels used to wipe kitchen surfaces will be soaked in container filled with approved sanitizing solution between uses. Continued review revealed manual washing and sanitizing employed a three-step process for washing, rinsing and sanitizing equipment. Observation of the evening meal service from the kitchen, on 03/25/14 at 5:05 PM, revealed Cook #1 brought the covered tray cart into the kitchen and changed gloves without washing her hands. Further observation of the resident tray line, revealed Cook #1 changed gloves, wiped his/her 	F 371	<p>All residents have the potential to be affected by improper food handling, poor handwashing and improper glove changing while handling food. The Dietary Manager will monitor and observe daily the meal preparations for all meals for 5 days to ensure all dietary staff have been monitored preparing and serving meals and are able to competently complete a return demonstration checklist by 5/8/2014.</p> <p>All Dietary staff have been re-educated by Karen Baker, Registered Dietician 4/17/2014 on proper handwashing technique, glove changing while handling food sources, infection control and "Good sanitation to serve food safely."</p>		

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F 371	<p>Continued From page 9</p> <p>hands on a rag and put on new gloves. Cook #1 left the rag on the resident tray line and during service the rag fell into the breaded fish. Cook #1 took the rag out of the fish and threw it on the floor.</p> <p>During interview on 03/25/14 at 5:25 PM, the Dietary Assistant revealed Cook #1 should have kept the rag in the bucket of sanitizer and the fish should have been removed and replaced after the rag had fallen into the end of the pan. She further revealed staff received training in January 2014 which covered hand washing and proper changing of gloves.</p> <p>Review of in-service records for Cook #1, revealed training titled "Skills for Basic Patient Skills Check" was completed on 10/18/13 and included the 10 steps for proper handwashing technique.</p> <p>Interview with Cook #1, on 03/25/14 at 6:15 PM, revealed she received in-service training in January 2014 concerning hand washing and changing gloves. She stated the fish should have been discarded after the rag fell into the pan. Continued interview revealed she "blew it" today, and she should have washed her hands after bringing in the resident cart and before changing her gloves.</p> <p>Observation of the lunch tray line, on 03/26/14 at 10:50 AM, revealed Cook #1 had a rag on tray line until 11:27 AM prior to meal service.</p> <p>Observation, on 03/26/14 at 11:28 AM, revealed Cook #1 washed her hands for five (5) seconds and put on new gloves. She rinsed a stainless steel whisk and stainless steel blender and</p>	F 371	<p>The Dietary Manager will complete an observation of all 3 meals 2x a week for 1 week, then all 3 meals 1x a week for the next 3 weeks. Any improper handling of food sources or infection control break will be corrected immediately and results of the observations will be reported to the Quality Assurance Committee for further recommendations.</p>	5/11/2014
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F 371	Continued From page 10 reused them for pureed foods. Continued observation revealed, while throwing trash away, she put her left gloved hand into the trash can and rested her gloved left hand on the inside of the trash can while holding the stainless steel whisk in her right gloved hand. She did not wash her left hand or change her gloves after touching the trash can and while preparing pureed foods. Review of in-service training records for February 2014 revealed Cook #1 received training related to handwashing, which included guidelines for employees to wash hands frequently, before putting on gloves, after removing gloves and after handling or touching garbage or touching any soiled surface or equipment. Interview with the Dietary Manager, 03/26/14 at 1:15 PM, revealed staff received in-service training every three (3) months related to handwashing and glove changing, with a return demonstration of proper hand-washing techniques incorporated into the training. She stated the Dietary Assistant presented the last in-service concerning hand washing technique and changing gloves in January of 2014. Continued interview revealed gloves were to be changed, with hand washing, more often between than the staff currently practiced. She further stated all staff, except Cook #1, had received "Person In Charge Training" by the Local Health Department. She further revealed the fish should have been tossed when the rag fell into the fish, and the rags should be kept in the sanitizer bucket.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431	The Facility purchased two (2) new refrigerators, one	

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F 431	<p>Continued From page 11</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy, it was determined the facility failed to ensure drugs and biologicals were stored at the</p>	F 431	<p>for the West Nurse Station and one for the East Nurse Station. A new form has been designed which clearly states the proper temperatures for the refrigerators, between 36 and 46 degrees Fahrenheit.</p> <p>No other medication refrigerators were identified without temp. logs when checked by the Director of Nursing on 3/27/2014.</p> <p>All licensed staff will be re-educated by Carol Hornback, Pharmacist 5/9/2014 ensuring that drugs and biologicals were stored according to the manufacturer's guidelines keeping in mind the proper temperatures required for each drug and biological. The education will include proper refrigerator temperatures, checking the temperatures and logging the temperatures by the night shift licensed nurse and correctly dating vials of</p>	
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F 431	<p>Continued From page 12 appropriate temperatures. Observation revealed the medication room refrigerator thermometer on the West Unit had registered twenty (20) degrees.</p> <p>The findings include:</p> <p>Review of the facility "Storage of Expiration of Medications, Biologicals, Syringes, and Needles", revised 01/01/13, revealed the facility should ensure medications and biologicals were stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers. Further review revealed infusion products should be stored under appropriate temperatures, according to the manufacturers recommendations. There was no reference to the appropriate temperature for the medication refrigerators.</p> <p>Review of the facility "Refrigerator Temperature Log", revealed if the refrigerator temperature was not between thirty-six (36) and forty-six (46) degrees, adjust and recheck. If the refrigerator temperature was still not between 36 and 46 degrees, notify maintenance.</p> <p>Observation of the medication room on the West Unit on 03/27/14 at 10:45 AM, revealed the medication room refrigerator thermometer registered at twenty (20) degrees Fahrenheit. The medication room refrigerator contained a bag of Vancomycin liquid medication-250 milligrams/five (5) milliliters, a vial of Novolin Regular Insulin, two (2) vials of Lantus Insulin, a vial of Aplisol (tuberculin purified protein derivative), and a vial of cyanocobalamin injection 1000 mg/1 ml which did not appear to be frozen. Further observation revealed an emergency kit in the refrigerator which contained a vial of 70/30 Regular Insulin which did not appear to be frozen. However,</p>	F 431	<p>medications when opened and discarding when expired per the manufacturers' guidelines.</p> <p>Refrigerator Logs and medication storage areas for drugs and biologicals will be audited by the Director of Nursing or designee daily for a week to ensure all drugs and biologicals are being stored and tempered according to manufacturers' guidelines. Any drugs or biologicals not stored appropriately will be discarded and re-ordered immediately by the Director of Nursing or designee. Weekly audits will then be completed by the Director of Nursing or designee x 8 weeks, then weekly x 4 weeks with the results of the audits being reviewed by the Quality Assurance Committee for further recommendations.</p>	5/11/2014
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F 431	<p>Continued From page 13</p> <p>there was a bag of Vancomycin 500 mg/200 ml intravenous which appeared to be frozen.</p> <p>Review of the Refrigerator Temperature Log which was taped to the front of the medication refrigerator, revealed temperatures were not consistently obtained. The temperatures were obtained on 03/6, 03/18, 03/14, 03/16, 03/17, 03/19, 03/20, 03/24, 03/26, and 03/27. Further review revealed the temperatures recorded ranged from thirty-six (36) to forty (40) except low temperatures were noted on 3/14-34 degrees, 03/16/14 32 degrees, 03/17-18 degrees, 03/20-22 degrees, 03/24-22 degrees, 03/26-20 degrees, and 03/27-20 degrees.</p> <p>Interview on 03/27/14 at 10:45 AM with Registered Nurse (RN) #2, revealed the temperatures should not be in the twenties, and the night shift nurses were to check the medication refrigerator nightly and obtain and log the temperatures. She stated the temperature control could have inadvertently been lowered.</p> <p>Interview on 03/27/14 at 11:30 AM with the dispensing pharmacist, revealed the vancomycin intravenous medication was delivered frozen and was safe to use when thawed. She further stated the other medications in the refrigerator would not be safe to use if frozen, especially the insulin which was made up of a proteln. However, she stated if the medication was not in a frozen state at the time of the observation, it could be used safely.</p> <p>Interview on 03/27/14 at 11:35 AM with the Director of Nursing (DON), revealed the night shift charge nurses were to check the medication refrigerators each night and should take action if</p>	F 431			

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F 431 Continued From page 14
the temperatures were low. She stated the temperatures should not be in the twenties. Further interview revealed they would need to check the medication refrigerator to see if was working properly.

F 431

F 441 483.65 INFECTION CONTROL, PREVENT SS=E SPREAD, LINENS

F 441

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program

The facility must establish an Infection Control Program under which it -

- (1) Investigates, controls, and prevents infections in the facility;
- (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
- (3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection

- (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
- (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
- (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

The nurse in question was re-educated on infection control and proper hand washing by the Director of Nursing on 3/28/2014. Unsampled resident was discharged on 3/28/2014.

All residents have the potential to be affected. All nurses were inservice beginning 4/18/2014 by Administrator on Hand Washing. An all staff inservice will be held 4/30/2014 to discuss Hand Washing and Contact Precautions.

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F 441	<p>Continued From page 15</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for three sampled residents (Resident #7, #2, #11) of fourteen (14) sampled residents and two (2) unsampled residents (Unsampled Resident D and Unsampled Resident C).</p> <p>Observation revealed Unsampled D entered Resident #11's isolation room and obtained a soda which was stationed near the biohazard bin while the nurse was setting up medications in front of Resident #11's room. Unsampled Resident D was then handed a plastic cup by the same nurse from Unsampled D's stack of cups in the room. Unsampled Resident D then exited the room without washing his hands and went down the hall. There was no education to Unsampled Resident D during the observation.</p> <p>Observation revealed a nurse entered Unsampled Resident A's room and did not wash or sanitize her hands prior to flushing an intravenous access with 0.9 Normal Saline ten (10) milliliters, and prior to starting an intravenous antibiotic.</p>	F 441	<p>All staff will be re-educated on the infection control practices, including handwashing technique, and isolation guideline by Trena Lee, Education and Training Director on 5/6/2014. All newly hired employees will receive this education by the Staff Development Coordinator, prior to starting employment.</p> <p>DON, ADON and Education Director will conduct return demonstration exercises on Nurses and CNA's. They will each do 10 per week for 4 weeks, then 1 nurse staff member per week for 4 weeks. DON and ADON will report the results to the QA Committee each week for 4 weeks then monthly thereafter.</p>	5/11/2014
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F 441	<p>Continued From page 15</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for three sampled residents (Resident #7, #2, #11) of fourteen (14) sampled residents and two (2) unsampled residents (Unsampled Resident D and Unsampled Resident C).</p> <p>Observation revealed Unsampled D entered Resident #11's isolation room and obtained a soda which was stationed near the biohazard bin while the nurse was setting up medications in front of Resident #1's room. Unsampled Resident D was then handed a plastic cup by the same nurse from Unsampled D's stack of cups in the room. Unsampled Resident D then exited the room without washing his hands and went down the hall. There was no education to Unsampled Resident D during the observation.</p> <p>Observation revealed a nurse entered Unsampled Resident A's room and did not wash or sanitize her hands prior to flushing an intravenous access with 0.9 Normal Saline ten (10) milliliters, and prior to starting an intravenous antibiotic.</p>	F 441	<p>All staff will be re-educated on the infection control practices, including handwashing technique, and isolation guideline by Trena Lee, Education and Training Director on 5/6/2014. All newly hired employees will receive this education by the Staff Development Coordinator, prior to starting employment.</p> <p>DON, ADON and Education Director will conduct return demonstration exercises on Nurses and CNA's. They will each do 10 per week for 4 weeks, then 1 nurse staff member per week for 4 weeks.</p>	5/11/2014	

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F 441	<p>Continued From page 16</p> <p>Observation revealed a nurse obtained an accucheck for Unsampled Resident C, then removed her soiled gloves and exited the room without performing hand hygiene. The nurse obtained a lancet from the medication cart and obtained another accucheck for the same resident and again exited the room without performing hand hygiene. LPN #4 then re-entered the room and administered insulin to Unsampled Resident C, then removed the soiled gloves and exited the room without performing hand hygiene.</p> <p>Observation revealed a nurse administered medication to Unsampled Resident B and did not wash her hands prior to exiting the room and signing out the medications.</p> <p>Observation on 03/26/14 revealed the supper tray dated 03/25/14 was left in the room on Resident #2's bedside table.</p> <p>Observation revealed a nurse performed Foley catheter care, then placed the soiled wash cloths and towels on Resident #7's sink counter.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the "Contact Precautions" Policy, undated, revealed the facility implemented Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. Examples of infections requiring contact isolation included Clostridium Difficile. Further review revealed; wear gloves when 	F 441		
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F 441	<p>Continued From page 17</p> <p>entering the room, change gloves after contact with infective material, wear a disposable gown upon entering the room, and implement a "See Nurse Before Entering" sign to alert staff and visitors of precautions.</p> <p>Review of Resident #11's medical record revealed diagnoses which included End Stage Renal Disease, Diabetes Mellitus, and Clostridium Difficile. Review of the Admission Minimum Data Set (MDS) Assessment dated 03/10/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status of a thirteen (13) out of fifteen (15).</p> <p>Review of the Physician's Orders dated 03/05/14 revealed orders for contact precautions. Further review of the Physician's Orders dated 03/05/14 revealed orders for Vancomycin (antibiotic medication) 125 milligrams every six (6) hours through 03/17/14, then Vancomycin 125 milligrams every twelve (12) hours through 03/31/14, then Vancomycin 125 milligrams every twenty-four (24) hours through 04/07/14. Further review of the Physician's Orders dated 03/08/14 revealed orders for Vancomycin 1000 milligrams intravenous every five (5) days.</p> <p>Review of the Comprehensive Plan of Care, dated 03/14/14, revealed the resident had a problem of Clostridium Difficile, and was followed by the infectious disease physician.</p> <p>Observation on 03/26/14 at 8:55 AM revealed Resident #11 had a sign on the door which stated, "See Nurse Before Entering". There was also Personal Protective Equipment (PPE) on the door including masks, gowns, and gloves.</p>	F 441		

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F 441	<p>Continued From page 18</p> <p>Further observation on 03/26/14 at 8:55 AM, revealed Unsampled Resident D entered Resident #11's room and obtained two (2) cans of soda which was stationed near the biohazard bin and handed one (1) can to Resident #11, while Registered Nurse (RN) #1 was setting up medications outside the door of Resident #11's room. RN #1 then donned a gown and gloves and entered Resident #11's room and handed Unsampled Resident D a plastic cup from a stack of cups in Resident #11's room. Unsampled Resident D then exited the room without washing his/her hands and went down the hall. Unsampled Resident D came back with two (2) cups of ice and handed one (1) to Resident #11 while adjusting the water pitcher on Resident #11's bedside table and then sat down on his/her walker to talk to Resident #11. Although RN #1 was in Resident #11's room during this observation, RN #1 did no teaching or education related to the contact isolation with Unsampled Resident D.</p> <p>Interview on 03/26/14 at 9:00 AM with RN #1 revealed Resident #11 was in contact isolation for Clostridium Difficile and Unsampled Resident D should not have been entering Resident #11's room. She stated visitors had to wear gowns and gloves upon entering and wash hands prior to exiting.</p> <p>Interview on 03/27/14 at 11:35 AM with the Infection Control Nurse, revealed the nurse should have stopped Unsampled Resident D from entering Resident #11's room and should have educated Unsampled Resident D related to the contact precautions. Further interview revealed the cups and soda from Resident #11's room should not have come out of the room.</p>	F 441		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185336	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/27/2014
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069		
(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 441	Continued From page 19 2. Review of the "Administration of an Intermittent Infusion" Policy, revised 07/01/12, revealed the nurse should be competent in the safe delivery of infusion therapy within her or his scope of practice. Further review revealed licensed nurses caring for residents with infusion therapies were expected to follow infection control and safety compliance procedures. The procedure included; verifying Physician's Orders, identifying resident, explaining procedure, washing hands, assembling equipment and supplies, donning gloves, assessing venous access site, and inspecting new medication/solution. Observation on 03/26/14 at 5:15 PM revealed Licensed Practical Nurse (LPN) #3 entered Unsampler Resident A's room and did not wash or sanitize her hands. She cleaned the residents venous access device to the left hand with an alcohol pad and flushed the intravenous (IV) site with ten (10) milliliters of 0.9% Normal Saline. The nurse then removed the administration set tubing from the package and spiked the intravenous medication/solution (Cefazolin one (1) gram/100 milliliters of Normal Saline) (antibiotic medication), primed the medication/solution through the administration set tubing, and attached the administration set tubing to the needleless connector. Interview with LPN #3 on 03/26/14 at 5:25 PM, revealed she should have washed her hands prior to administration of the Normal Saline flush through the venous access and prior to administration of the intravenous antibiotic. Interview on 03/27/14 at 11:35 AM with the	F 441			

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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069
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F 441	<p>Continued From page 20</p> <p>Infection Control Nurse, revealed the nurses should wash their hands after entering the residents room and prior to any intravenous procedure.</p> <p>3. Review of the "Glucometer Cleaning Check Off" Policy, undated, revealed the nurse was to apply clean gloves and obtain a fingerstick, throw away the used supplies and remove gloves, and wash hands.</p> <p>Interview with the DON on 03/27/14 at 7:25 PM revealed there was no policy related to insulin administration.</p> <p>Observation on 03/25/14 at 5:50 PM revealed LPN #4 obtained an accucheck for Unsampled Resident C, then removed her soiled gloves and exited the room without washing or sanitizing her hands. LPN #4 then went to the hall and opened the medication cart and obtained a lancet from a drawer. The nurse then re-entered Unsampled Resident C's room and obtained another accucheck for Unsampled Resident C. Further observation revealed the nurse again removed the soiled gloves and exited the room without washing her hands, then sanitized her hands in the hall. LPN #4 then re-entered the room and administered insulin to Unsampled Resident C, removed the soiled gloves and exited the room without washing her hands.</p> <p>Interview on 03/25/14 at 5:58 PM with LPN #4 revealed she should have washed her hands after removing the soiled gloves and prior to exiting the room after she obtained accuchecks and after administration of insulin.</p> <p>Further interview on 03/27/14 at 11:35 AM with</p>	F 441		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/27/2014
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069		
(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 441	<p>Continued From page 21</p> <p>the Infection Control Nurse, revealed the nurse should have washed her hands after removing the soiled gloves and prior to exiting the resident's room after the accuchecks and after the insulin administration to help prevent the spread of infection.</p> <p>4. Observation on 03/26/14 at 9:15 AM, revealed there was a supper tray on Resident #2's bedside table and the tray ticket was dated 03/25/14. Resident #2 was in bed with her/his eyes closed. Interview on 03/26/14 at 9:15 AM with Registered Nurse (RN) #1 who was assigned to the resident, revealed the supper tray should have been removed from the room last evening.</p> <p>Continued interview on 03/27/14 at 11:35 PM with the Infection Control Nurse revealed she was unaware if there was a written policy, but the meal trays were to be removed from the resident rooms after each meal and indicated old food left in the rooms could promote insects.</p> <p>5. Observation on 03/26/14 at 3:40 PM revealed Licensed Practical Nurse (LPN) #2 completed Foley catheter care for Resident #7, then placed the soiled wash cloths and soiled towels on the counter by the sink in the resident's room. Interview with LPN #2 revealed she should have placed the soiled washcloths and towels in a plastic bag, and indicated she contaminated the sink counter which was shared with the resident's roommate.</p> <p>Interview on 03/26/14 at 4:15 PM with the Infection Control Nurse, revealed soiled wash cloths/towels and any soiled linens should be placed in a plastic bag prior to taking the items out of the room, and should not be placed directly</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069		
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F 441	Continued From page 22 on the sink counter due to this was an infection control issue. 6. Review of the " Medication Administration" Policy, undated revealed administer oral medication, remain with the resident until all medication is taken, assist the resident to a comfortable position, wash hands, and proceed to the next resident. Observation on 03/27/14 at 10:30 AM, revealed RN #1 entered Unsampled Resident B's room and administered the resident's medications, handing the resident a medicine cup of medications and a cup of water. The nurse did not wash or sanitize her hands prior to exiting the room and signing out the medications on the Medication Administration Record (MAR). Interview with RN #1 at the time of the observation, revealed she should have washed her hands after administration of the medications. Interview on 03/27/14 at 11:35 AM with the Infection Control Nurse revealed the nurses should wash or sanitize their hands after administration of medications and before exiting the room.	F 441			
F 492 SS=C	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.	F 492	1. A new form has been added to the admission packet which contains information about Human Immunodeficiency Virus (HIV) and Auto Immune Deficiency Syndrome (AIDS) including		

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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069
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F 492	<p>Continued From page 23</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to comply with all Federal, State, and local laws, regulations and codes. Information about Human Immunodeficiency Virus (HIV) and Auto Immune Deficiency Syndrome (AIDS) provided by the facility did not meet the statutory requirements of KRS 214.620 (4) which states information on the HIV infection shall be presented to any person who receives treatment in a skilled nursing facility. The information shall include, but not be limited to methods of prevention.</p> <p>The findings include:</p> <p>Review of the Checklist for Compliance with KRS 214.620(4) HIV/AIDS Patient Information revealed information provided by each facility must include methods of prevention.</p> <p>Review of the facility's form "Important Information About HIV and AIDS, effective 07/01/12, revealed no documented evidence the form included methods of prevention.</p> <p>Interview with the Administrator, on 03/27/14 at 4:25 PM, revealed the form needed to be revised to meet statutory requirements and he was unaware the information which was included in the Admissions Packet did not have methods of preventions for HIV/AIDS.</p> <p>F 520 483.75(o)(1) QAA SS=E COMMITTEE-MEMBERS/MEET</p>	F 492	<p>prevention by Admission's Director on 4/21/2014.</p> <p>2. The Admissions Coordinator conducted an audit of all current resident files to determine if their charts contain information about prevention of HIV and AIDS on 4/18/2014. All current residents were informed and a copy of the new form was placed in the chart by the Admission's Director on 4/18/2014.</p> <p>3. The old forms without information about prevention of HIV and AIDS were all discarded by the Admission's Director and the new forms will be used from here on. The Admissions Director was re-educated by the Administrator on 3/27/2014 on what specific contents that are required in the Admission's packet</p> <p>4. The Interdisciplinary Team will report all findings to QA Committee for review</p>	
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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40089		
(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 520	<p>Continued From page 24 QUARTERLY/PLANS</p> <p>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.</p> <p>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.</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 observation, interview, and record review, it was determined the facility failed to maintain a Quality Assessment and Assurance Program that developed and implemented appropriate plans of action to correct quality deficiencies. This was evidenced by repeated deficiencies related to the facility's failure to ensure the Comprehensive Plan of Care was revised, and failure to ensure there was an</p>	F 520	<p>Members of the Quality Assurance Committee met on 5/2/2014 and discussed the Care plan revision process and Infection Control Program to ensure all care plans will be revised when appropriate and that Infection Control practices are followed throughout the facility. All residents have the potential to be affected if their Plan of Care is not updated when required or the Infection Control Process is broken. Processes and guidelines were reviewed by the committee with education being developed and audits discussed and created to be monitored and brought back to the Quality Assurance Committee for any further directions or recommendations required.</p>		

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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069		
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F 520	<p>Continued From page 25 effective Infection Control Program.</p> <p>The findings include:</p> <p>Review of the facility "Quality Assessment and Assurance Committee Summary", dated 09/20/12, revealed the goals of the committee included; monitoring and evaluating the appropriateness and quality of care provided, overseeing facility systems and processes related to improving quality of care and services, promoting consistent facility systems and processes and appropriate practices in resident care, helping to identify negative outcomes related to resident care and resolving them, and coordinating the development, implementation, monitoring, and evaluation of action plans to achieve specified goals.</p> <p>1. Based on observation, interview, and record review, it was determined the facility failed to ensure the Comprehensive Plan of Care was revised. This was a repeat deficiency for the facility which was cited 12/20/13 related to the care plan not being revised after a resident underwent a Hemicolectomy and after a resident received repeated Kidneys Ureters Bladder X-Ray (KUB's) and Soap Suds Enemas for recurrent Ileus.</p> <p>Review of the facility's Plan of Correction, with a 01/21/14 compliance date, revealed the use of the Twenty-Four Hour Report and the Physician Telephone orders were being used in an attempt to capture all events occurring for individual residents. In addition, three (3) random care plans would be reviewed per the Director of Nursing (DON) or designee weekly for updates and would be kept for discussion in the QA</p>	F 520	<p>All residents have the potential to be affected by improper food handling, poor handwashing and improper glove changing while handling food. The Dietary Manager will monitor and observe daily the meal preparations for all meals for one week to ensure all dietary staff have been monitored preparing and serving meals and are able to competently complete a return demonstration checklist by 5/8/2014.</p> <p>The Quality Assurance Committee reviewed the Care Plan Process and Infection Control Program along with the educational sessions for updating the care plan and following the infection control program for any recommendations on when 5/2/2014. The QA Committee reviewed the employee roster and compared with the education required set forth</p>		

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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069
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F 520	<p>Continued From page 26 meetings.</p> <p>Record review during this survey revealed the Care Plan was not revised related to Resident #2 having the indwelling urinary catheter changed every two (2) weeks as per Physician's Orders.</p> <p>Interview on 03/27/14 at 7:50 PM with the Administrator and DON, revealed the care plans were being reviewed and revised in the morning meetings Monday through Friday according to new Physician's Orders and each morning a complete care plan audit was done for one resident in the meeting to ensure the care plan was accurate. Further Interview revealed the Physician's Order for the indwelling urinary catheter to be changed every two (2) weeks should have been transcribed to the care plan during the morning meeting and this was missed.</p> <p>2. Based on observation, interview, and record review, it was determined the facility failed to maintain an effective infection control program in order to prevent the development and transmission of disease and Infection within the facility. This was a repeat deficiency for the facility which was cited 01/11/13 for deficiencies related to poor infection control with perineal care, staff failing to utilize Personal Protective Equipment (PPE) and failing to wash hands before exiting a room for a resident who was in contact isolation. This was also a repeat deficiency for the facility which was cited 12/20/13 for deficiencies related to poor infection control with perineal/incontinence care, staff failing to wash hands prior to exiting an isolation room, and volunteer staff entering an isolation room without PPE and failing to wash hands after touching items in the room.</p>	F 520	<p>in this plan of correction that all employees received the appropriate education and signed the educational requirement. The QA Committee also determined that all new employees would be inserviced on the Infection Control Program and any new licensed nurse hired would receive education on updating careplans prior to their start of work.</p> <p>The Administrator, Director of Nursing and/or Staff Development Coordinator will bring all educational in-services along with signature logs and all audits pertaining to this plan of correction to each Quality Assurance meeting for review and recommendations monthly for the next 6 months and then quarterly for the following 6 months for further recommendations.</p>	5/11/2014
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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069		
(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 520	Continued From page 27 Review of the Plan of Correction, with a compliance date of 02/15/13, revealed the Education Manager would re-educate staff regarding the procedure for perineal care and monitor at least three (3) staff providing care on each shift to ensure competency by 02/12/13. According to the POC, the Education Manager was to re-educate all staff regarding isolation type and procedure by 02/11/13. The DON and Assistant Director of Nursing (ADON) was to audit staff providing care for ten (10) residents weekly for eight (8) weeks to ensure hands were washed per the Infection Control Policy and staff were able to perform care without the spread of infection. The DON and the ADON were to monitor a total of the next five (5) residents requiring isolation to ensure isolation policy was followed and handwashing occurred per the policy. The QA Team was to meet weekly for four (4) weeks beginning the week of 02/04/13, then two (2) times a month for two (2) months, then monthly to review all audit findings which would be ongoing until corrected. Review of the Plan of Correction, with a compliance date of 01/24/14 revealed an Infection Control Inservice was conducted per the Education Training Nurse, and random observations highlighting the infection control practices such as hand washing, peri-care observations, and donning and taking off PPE equipment would be conducted by the Education Training Nurse or designee for four (4) weeks then monthly and as needed. Further review revealed on hire new employees would review the handwashing/isolation precautions with the Education Training Nurse. The QA Team was to meet weekly for four weeks starting the week of	F 520			

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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069		
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F 520	<p>Continued From page 28 01/12/14, then monthly and as needed related to infection control issues.</p> <p>Observation during this survey revealed a resident entered another resident's isolation room and obtained a soda, was handed a cup by the nurse, and then exited the room without washing hands with no education done by the nurse.</p> <p>Observation also revealed a nurse entered a resident's room and did not wash or sanitize her hands prior to flushing an intravenous access with 0.9 Normal Saline ten (10) milliliters, and prior to starting an intravenous antibiotic.</p> <p>Observation revealed a nurse obtained an accucheck for a resident, then removed her soiled gloves and exited the room without performing hand hygiene. The nurse then obtained a lancet from the medication cart and obtained another accucheck for the same resident and again exited the room without performing hand hygiene. The same nurse then re-entered the room and administered insulin to the resident, then removed the soiled gloves and exited the room without performing hand hygiene.</p> <p>Observation revealed a nurse administered medication to a resident and did not wash her hands prior to exiting the room and signing out the medications.</p> <p>Observation on 03/26/14 revealed the supper tray dated 03/25/14 was left in a resident's room on the bedside table.</p> <p>Observation revealed a nurse performed Foley catheter care, then placed the soiled wash cloths and towels on the resident's sink counter.</p>	F 520			

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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069	

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F 520	Continued From page 29 Interview on 03/27/14 at 7:50 PM with the Administrator and the DON, revealed per the POC, with a compliance date of 01/24/14 observations of Infection control procedures including handwashing, pericare, and donning and removing PPE was done weekly for four (4) weeks, then monthly until 02/14. However, currently observations related to infection control procedures were being done randomly. Further interview revealed the QA Meeting was still being held monthly and infection control issues were being discussed in these meetings.	F 520		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185336	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 05/08/2014
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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069
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{K 000}	INITIAL COMMENTS A desk review of the facility's Plan of Correction (POC) was completed on 05/08/14 with the facility's POC found to be acceptable. The facility was found to be in compliance 05/07/14 as alleged, and meeting the minimum requirements for participation in the Medicare and Medicaid program.	{K 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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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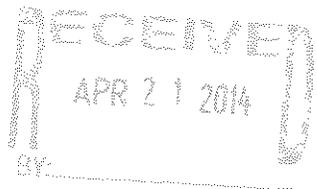
PRINTED: 04/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185336	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2014
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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1968 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type (111) SMOKE COMPARTMENTS: Three (3) smoke compartments FIRE ALARM: Complete fire alarm system with smoke detectors. SPRINKLER SYSTEM: Complete automatic dry sprinkler system. GENERATOR: New Installation 01-01-14 Generac Type II Diesel A standard Life Safety Code survey was conducted on 03/26/14 and the facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for seventy (70) beds with a census of fifty-five (55) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire) Deficiencies were cited with the highest	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>M. I. [Signature]</i>	TITLE ADMINISTRATOR	(X6) DATE 4-21-14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000

Continued From page 1
deficiency identified at "F" level.

K 000

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 heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

K 025

1. Proper smoke barriers have been put in place by the Maintenance Director on 4/15/2014. Maintenance Director removed the existing barriers and replaced them with barriers designed to resist the passage of smoke

2. All areas of the building have the potential to be affected. Maintenance Director inspected the attic area on 4/18/2014, to determine if there are other barriers that needed to be replaced. No other barriers were identified.

3. When contractors do work in the building, Maintenance Director will educate the contractors and assure all barriers installed or replaced will be designed to resist the passage of smoke.

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 the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility was certified for seventy (70) beds with a census of fifty-five (55) on the day of the survey.

The findings include:

Observations, on 03/26/14 between 10:20 AM and 11:00 AM, with the Maintenance Director revealed the smoke barriers, in the attic space had penetrations of pipes and wires. The penetrations were not filled with a material rated equal to the partition and could not resist the

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K 025	<p>Continued From page 2</p> <p>passage of smoke. The location of the smoke partition with the penetrations was in the East Hall by the Nurse's Station, West Hall by the Nurse's Station, and near the Physical Therapy Department.</p> <p>Interview, on 03/26/14 at 12:45 PM, with the Maintenance Director revealed he was not aware of the penetrations. He stated contractors had been in the attic running wires during the generator installation.</p> <p>Interview, on 03/26/14 at 12:50 PM, with the Administrator revealed he was unaware of the penetrations in the smoke barriers, but would get them repaired by the end of the week.</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"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <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"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration</p>	K 025	<p>4. Maintenance Director will report all findings to QA Committee for review.</p>	4/11/2014

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K 025	Continued From page 3 into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 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 National Fire Protection Association (NFPA) Standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, staff and visitors. The facility was certified for seventy (70) beds with a census of fifty-five (55) on the day of the survey. The facility failed to provide self-closing devices for doors protecting hazardous areas. The findings include: Observation, on 03/26/14 at 9:43 AM, with the	K 029	1. All files were removed from the beauty shop on 4/2/2014 by Maintenance Director. 2. The Maintenance Director inspected all identified storage areas on 4/18/2014, to ensure they all have self closing doors and safety barriers 3. The Maintenance Director was re-educated by the Administrator on 4/18/2014 that all storage areas are to have self closing doors. 4. The Maintenance Director will check storage rooms 5 times per week for 2 weeks, weekly for 4 weeks then monthly thereafter to assure doors are closing properly. The	

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K 029	<p>Continued From page 4</p> <p>Maintenance Director revealed the beauty shop did not have a self-closing device on the door and contained a hazardous amount of combustibles.</p> <p>Interview, on 03/26/14 at 12:15 PM, with the Maintenance Director revealed he was not aware the door to the beauty shop was required to be self-closing, but did admit the room was being used to store files.</p> <p>Interview, on 03/26/14 at 12:15 PM, with the Administrator revealed he was not aware the door to this room was required to be self-closing.</p> <p>NFPA Life Safety Code 101 8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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>results of these audits will be taken to the Quality Assurance Committee for further recommendations.</p> <p>4/11/2014</p>

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K 029	Continued From page 5 (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), 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 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.6 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the sprinkler system was inspected and maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff, and visitors.	K 062	1. Wires supported by sprinkler pipes have been secured with straps by the Maintenance Director on 4/18/2014 and are no longer on the pipes. Sprinkler heads in the three (3) areas will be converted to all quick response by Tri-State Fire Protection on 5/7/2014. 2. All areas of the building have the potential to be	

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K 062

Continued From page 6

The facility was licensed for seventy (70) beds and the census the day of survey was fifty-five (55).

The findings include:

1. Observation on 3/26/14 at 10:22 AM, revealed the sprinkler piping in the attic space facility wide was being used to support various wiring.

Interview, on 3/26/14 at 12:25 PM, with the Maintenance Director, revealed he was not aware of this code requirement.

Interview, on 3/26/14 at 12:30 PM, with the Administrator revealed he was unaware of the wiring, but would make the correction at once.

2. Observation on 03/26/14 at 10:18 AM, with the Maintenance Director revealed two (2) Quick Response sprinkler heads mixed in with regular compartment.

Interview on 3/26/14 at 12:35 PM, with the Maintenance Director revealed he was not aware of this code requirement.

Interview on 3/26/14 at 12:40 PM, with the Administrator revealed he was not aware of this requirement, but would get it corrected as soon as possible.

Reference: NFPA 25 (1998 edition)

2-2.2* Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and

K 062

affected. Maintenance Director inspected the attic area on 4/18/2014 to determine if there were other wires supported by pipes. No other wires were identified. Maintenance Director and Administrator inspected the other areas of the building on 4/18/2014 to determine if there were other mis-matched sprinkler heads.

3. When contractors do work in the building, Maintenance Director will assure all wires are properly secured and educate the contractors on how to install. If sprinkler heads are to be replaced, Maintenance Director will ascertain in advance which heads are to be used and assure sprinkler heads are of the same type.
4. Maintenance Director will report all findings to QA Committee for review.

4/11/2014

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K 062	Continued From page 7 fittings shall be in good condition and free of mechanical damage, leakage, corrosion, and misalignment. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. Exception No. 1: Pipe and fittings installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Pipe installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. Reference: NFPA 101 (2000 Edition) 19.3.5.3* Where this Code permits exceptions for fully sprinklered buildings or smoke compartments and specifically references this paragraph, the sprinkler system shall meet the following criteria: (1) It shall be installed throughout the building in accordance with Section 9.7. (2) It shall be electrically connected to the fire alarm system. (3) It shall be fully supervised. (4) It shall be equipped with listed quick-response or listed residential sprinklers throughout all smoke compartments containing patient sleeping rooms.	K 062			

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K 062	Continued From page 8 Exception No. 1: Standard response sprinklers shall be permitted to be continued to be used in existing approved sprinkler systems where quick-response and residential sprinklers were not listed for use in such locations at the time of installation. Exception No. 2: Standard response sprinklers shall be permitted for use in hazardous areas protected in accordance with 19.3.2.1.	K 062		
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