

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

PRINTED: 09/05/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/21/2014
NAME OF PROVIDER OR SUPPLIER  PIONEER TRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 115 PIONEER TRACE FLEMINGSBURG, KY 41041	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  A Recertification Survey was initiated on 08/19/14 and concluded on 08/21/14. Deficiencies were cited with the highest Scope and Severity of a "F".	F 000	Room #33, #34, and #37 bathrooms were cleaned immediately by housekeeping staff on 8/21/14.	
F 253 SS=D	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 and interview, it was determined the facility failed to maintain sanitary conditions for residents residing in the facility's room #33, room #34, and room #37. Observation revealed a brown substance was observed on the commode chairs and floor in the resident shared bathrooms of these rooms.  The findings include:  Interview with the Director of Nursing (DON) 08/21/14 at 9:41 AM, revealed there was no facility policy with regard to cleaning residents' bathrooms; however, it was her expectation for staff to clean and sanitize the bathrooms after resident use.  Observation during the initial tour of the facility on 08/19/14 at 10:35 AM, of the shared bathroom for residents residing in room #37, and at 11:00 AM for residents sharing the bathroom for room #33 and room #34, revealed a brown substance on the commode chairs. In addition, room #37 had a	F 253	All bathrooms in the facility were inspected on 8/21/14, for cleanliness by housekeepers Brenda Luman and Patricia Hunt and any area requiring attention was addressed.  CNAs were in-serviced on cleaning and sanitizing bathrooms after each resident use on 9/9/14 by Michelle Marshall, RN, and on 9/10/14, by Susan Fulton, LPN.  Weekly audits to verify staff cleaning and sanitizing of bathrooms after use is being conducted by the Quality Assurance team. The QA team is composed of all employees in the facility, organized into teams, that rotate various responsibilities, including "safety observation."	

SEP 26 2014

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

*Michelle Cox*

TITLE (X6) DATE

ADMINISTRATOR 9/26/14

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

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F 253 Continued From page 1  
brown substance on the floor around the toilet.

Interview with Certified Nursing Assistant (CNA) #1 on 08/19/14 at 11:08 AM, revealed residents' bathroom areas were cleaned immediately following resident use by the CNA assisting the resident or by housekeeping staff.

Interview with Registered Nurse (RN) #2 on 08/19/14 at 11:00 AM, revealed the cleaning of the residents' bathrooms was the responsibility of the facility housekeeping staff and nursing assistants who assisted residents to the bathroom. She stated failure to clean the bathrooms would strongly affect incontinent residents, as they would have to wait longer, due to delayed cleaning, before each use. Therefore, it was her expectation the CNAs clean residents' bathrooms after each use as there was a potential for harm to residents due to the possible spread of infection.

Continued interview with the DON on 08/21/14 at 9:41 AM, revealed she expected her staff to ensure bathrooms were cleaned and sanitized after each use with Sani-wipes (disinfecting wipes). The DON stated the CNAs should clean the commode seat and gait belts after each use with the Sani-wipes.

F 253

F 253 Cont.

Continued compliance will be monitored by the QA Committee in monthly meetings.  
Completed 9/11/14

F 253

F 279 483.20(d), 483.20(k)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable

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objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review and review of facility policy, it was determined the facility failed to ensure a Comprehensive Care Plan was developed for two (2) of fifteen (15) sampled residents (Resident #1 and #4).

Resident #1's care plan was not developed to include the resident's communication and cognitive loss, although these areas triggered on the comprehensive assessment.

In addition, Resident #4's care plan was not developed to include the tab alarm in use.

The findings include:

Review of the facility's, "Resident Care Plan" Policy, dated 05/01/09, revealed residents' care plans were to reflect the specific physical, social, and emotional problems and concerns identified.

F 279 The Care Plan of Resident #1 was updated on 8/27/14 by Kim Breeze, RN, to include communication and cognitive loss.

The Care Plan of Resident #4 was updated on 9/3/14, by Kim Breeze, RN, to include use of pull tab alarms

100% of resident Comprehensive Assessments and Care Plans were audited by Sandy Mitchell, DON, Michelle Marshall, RN, Kim Breeze, RN, and Susan Fulton, LPN, between 9/3/14, and 9/12/14.

Sandy, Michelle, Kim and Susan each received training on updating Comprehensive Care Plans on 9/23/13 by Point Click Care webinar. Susan Fulton received MDS 3.0 Basic Training on 2/12/14.

All Care Plans will be monitored by Sandy Mitchell, DON, Michelle Marshall, RN, and Kim Breeze, RN, the week prior to submission of the MDS, for accuracy and completeness, for

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F 279	<p>Continued From page 3</p> <p>1. Review of Resident #1's medical record revealed the facility re-admitted the resident on 05/22/14, with diagnoses which included Dementia and Parkinson's Disease. Review of the Annual Minimum Data Set (MDS) Assessment dated 01/28/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of a three (3) indicating severe cognitive impairment. Further review of the MDS revealed the facility assessed the resident as having clear speech, as understanding others, as sometimes understood, and as having adequate hearing.</p> <p>Review of the Care Area Assessment Summary (CAAS) dated 02/01/14, revealed Resident #1's BIMS score was less than thirteen (13) and cognitive loss would be addressed in the Comprehensive Care Plan. Continued review of the CAAS revealed the resident had impaired ability to make self understood through verbal and non-verbal expression of ideas/wants and was sometimes understood. The CAAS stated communication would also be addressed in the Comprehensive Care Plan.</p> <p>Review of the current Comprehensive Plan of Care, dated 02/18/13, and reviewed 07/18/14, revealed no documented evidence the care plan addressed Resident #1's impaired communication and cognitive status.</p> <p>Observation of Resident #1 on 08/19/14 at 4:00 PM, revealed the resident was in bed lying on the right side. Continued observation revealed Resident #1 was attempting to speak to the Surveyor; however, the resident spoke very quietly with mumbling speech and the Surveyor could not understand what he/she was saying.</p>	F 279	<p><b>F 279 Cont.</b></p> <p>time the Care Plans will be reviewed monthly.</p> <p>Compliance will be monitored by the QA Committee in their monthly meetings.</p> <p><b>Completed 9/13/14</b></p>	

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Interview on 08/21/14 at 2:05 PM with Licensed Practical Nurse (LPN) #3, revealed the MDS Coordinator who completed the MDS and care plan for Resident #1 was on vacation and unavailable for interview. She stated the MDS nurse completed the MDS Assessment for the facility with her assistance if needed. According to LPN #3, the MDS Coordinator developed residents' Comprehensive Care Plans after completion of the Admission, Significant Change and Annual MDS Assessments, and revised care plans with the Quarterly MDS Assessments. She stated Resident #1 spoke very quietly and mumbled. Further interview with LPN #3, revealed Resident #1's Annual MDS Assessment dated 01/28/14, triggered for cognitive loss and communication and a care plan should have been developed in those areas due to the resident's cognitive loss and poor communication.

Interview on 08/21/14 at 9:41 AM with the Director of Nursing (DON), revealed she was unaware of any concerns noted with the development of residents' Comprehensive Care Plans. She stated LPN #3 had trained the current MDS Coordinator; however, she indicated she was unaware of anyone auditing the care plans to ensure they were developed and revised as necessary.

2. Review of Resident #4's medical record revealed the facility admitted him/her on 02/25/14, with diagnoses which included Cerebrovascular Accident (CVA), Rehabilitation, Abnormality of Gait and Unspecified Cerebral Artery Occlusion.

Review of the Physician's Orders dated 02/26/14

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F 279	Continued From page 5  revealed an order for Resident #4 to have a pull tab alarm at all times. However, review of Resident #4's Comprehensive Care Plan dated 02/25/14, revealed no documented evidence it had been developed to include the intervention for a pull tab alarm at all times.  Interview with Registered Nurse (RN) #2 on 08/21/14 at 3:45 PM, revealed she verified there was not an intervention of pull tab alarm on Resident #4's care plan dated 02/25/14. She further stated if there was a Physician's Order for the pull tab alarm then it should have been placed on the care plan.  Interview with the Director of Nursing, on 08/21/14 at 7:01 PM, revealed Resident #4's Comprehensive Care Plan should have been developed to reflect the pull tab alarm intervention.	F 279		
F 280 SS=E	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	F 280		

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legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:

Based on interview, record review and review of facility policy, it was determined the facility failed to ensure the Comprehensive Care Plans were reviewed and revised for three (3) of fifteen (15) sampled residents (Residents #1, #9, and #13).

Resident #1's care plan was not revised to indicate significant weight loss, nor was it updated to indicate the resident's anticoagulant and anti-anxiety medications had been discontinued.

Resident #9's care plan was not revised to indicate his/her anticoagulant medications had been discontinued.

In addition, Resident #13's care plan was not revised to related to a Urinary Tract Infection (UTI).

The findings include:

Review of the facility's, "Resident Care Plan" Policy, initiated 05/01/09, revealed residents' care plans were to reflect a resident's specific needs regarding physical, social, and emotional problems and concerns. The Policy noted a care plan goal was to be established and the means to reach the goal was noted. According to the Policy, each discipline would make initial and

F 280 The Care Plan for Resident #7 was revised to indicate significant weight loss, anticoagulant, and anti-anxiety medication discontinued on 8/21/14, by Kim Breeze, RN.

The Care Plan for Resident #9 was revised to indicate discontinuation of anticoagulant medication on 8/20/14, by Kim Breeze, RN.

The Care Plan of Resident #13 was revised to indicate diagnosis of Urinary Tract Infection on 9/3/14, by Kim Breeze, RN.

100% of resident Care Plans were audited by Sandy Mitchell, DON, Michelle Marshall, RN, Kim Breeze, RN, and Susan Fulton, LPN, between 9/3/14, and 9/12/14. Any errors noted have been corrected.

All Care Plans will be monitored by Sandy Mitchell, DON, Michelle Marshall, RN, and Kim Breeze, RN, the week prior to submission of the MDS, for accuracy and completeness, for a period of 60 days. After that time the Care Plans will be reviewed monthly.

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F 280	<p>Continued From page 7</p> <p>regular assessments on the resident's chart at least quarterly and more frequently if a resident's condition warranted. Review of the Policy addendum titled, "Acute Plan of Care (APOC), undated, revealed an acute plan of care must be initiated for any change which qualified as acute, such as a UTI, respiratory infection, skin tear, and any new symptom in which a resident did not already have a long term chronic care plan.</p> <p>1. Review of Resident #1's medical record revealed the facility re-admitted the resident on 05/22/14, with diagnoses which included Dementia, Parkinson's Disease, Adult Failure to Thrive, Esophageal Reflux, and Intertrochanteric Left Hip Fracture. Review of Resident #1's Quarterly Minimum Data Set (MDS) dated 07/16/14, revealed the facility assessed the resident as having a five percent (5%) weight loss in the last month or loss of ten percent (10%) or more in the last six (6) months, and as having an altered diet.</p> <p>Review of the Physician's Orders, active orders as of 07/31/14, revealed Resident #1 had orders for a pureed texture regular diet, Mighty Shakes (liquid nutritional supplement) three (3) times a day, and Sugar free Prostat (high protein supplement) thirty (30) milliliters (mls) every day.</p> <p>Review of the "Weights and Vitals Summary", revealed Resident #1's weight on 08/31/14 was 99.1 pounds, and weight on 07/16/14 was 106.3 pounds, which was a 7.26 % significant weight loss in a month. Further review revealed the resident's weight on 05/15/14 was 115.6 which was a 16.64 % significant weight loss in three (3) months.</p>	F 280	<p><b>F 280 Cont.</b> Compliance will be monitored by the QA Committee in their monthly meetings.</p> <p><b>F 280 Completed 9/13/14</b></p>	

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Review of the Comprehensive Care Plan dated 02/15/13, revealed the resident was care planned for a potential nutritional problem related to the need for extensive assist with feeding and advanced Parkinson's Disease. Continued review of the care plan revealed a goal which stated Resident #1 would maintain adequate nutritional status as evidenced by maintaining weight within ten percent (10%) of baseline, no signs and symptoms of malnutrition, and consuming at least fifty percent (50%) of at least two (2) meals daily. However, further review revealed no documented evidence the care plan was revised to include the information regarding Resident #1's actual significant weight loss.

Interview on 08/21/14 at 1:00 PM with the Registered Dietician (RD), revealed Resident #1 received whole milk, and supplements including Mighty Shakes three (3) times a day and ate fairly well. She stated Resident #1 had consumed sixty-eight percent (68%) of meals over the past week; however, the resident continued to lose weight and had experienced significant weight loss over the past several months. She stated she did not complete or revise the Comprehensive Care Plans as this was the nurse's responsibility. The RD stated however, the nutritional care plan should have been updated to reflect Resident #1's actual weight loss.

Interview with Licensed Practical Nurse (LPN) #3 on 08/21/14 at 2:05 PM, revealed the MDS Coordinator was on vacation and unavailable for interview. She stated she assisted the MDS Coordinator with residents' MDS Assessments and Comprehensive Care Plans. Continued interview revealed the MDS Coordinator

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completed the MDS Assessments, and also updated the Comprehensive Care Plans after completing the Admission, Annual, Quarterly, and Significant Change MDS's. LPN #3 stated the nurses on the floor updated the care plans related to acute changes in residents' conditions and with Physician's Orders. After reviewing Resident #1's MDS dated 07/16/14, his/her Comprehensive Care Plan, and the resident's weights, LPN #3 acknowledged the care plan should have been revised to indicate this resident's significant weight loss. She further stated the Care Plan should have been revised to indicate the Lovenox and antianxiety medication had been discontinued.

2. Continued review of Resident #1's Quarterly MDS dated 07/16/14, revealed the facility assessed the resident as receiving no antianxiety medications or anticoagulant medications during the last seven (7) days.

Continued review of his/her Comprehensive Care Plan dated 04/23/14, revealed the resident was care planned to be on anticoagulant therapy-Lovenox Injections and antiplatelet therapy-Aspirin, related to a Left Hip Fracture. Continued review of this care plan revealed the goal stated Resident #1 would be free from discomfort or adverse reactions related to anticoagulant and antiplatelet use.

Review of the Physician's Orders, active orders as of 07/31/14, revealed orders for Aspirin (antiplatelet) 81 milligrams (mg) every day for Deep Vein Thrombosis (blood clot) prophylaxis (action taken to prevent a disease); however, there was no documented evidence of an order for Lovenox Injections (anticoagulant).

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Further review of the Comprehensive Plan of Care dated 03/05/13, revealed the resident used anti-anxiety medications with a goal stating the resident would be free from discomfort or adverse reactions related to anti-anxiety therapy.

However, review of the Physician's Orders (Active Orders as of 07/31/14), revealed no documented evidence of orders for anti-anxiety medications.

Continued interview with LPN #3 on 08/21/14 at 2:05 PM, revealed Resident #1's Comprehensive Care Plan should have been revised to indicate the discontinuation of the resident's Lovenox and antianxiety medication.

Interview with the Director of Nursing (DON) on 08/21/14 at 7:01 PM, revealed she acknowledged Resident #1's care plans should have been revised to indicate the resident's actual weight loss and related to the discontinuation of the Lovenox and the antianxiety medication.

3. Review of Resident #9's medical record revealed diagnoses which included Dementia, Diabetes Mellitus, Hypertension, Long Term Use of Anticoagulants, Long Term Use of Insulin, Coronary Atherosclerosis, Abnormal Posture, Vitamin D Deficiency, Esophageal Reflux, Dysphagia, Muscle Weakness, Alzheimers Disease and Transient Cerebral Ischemias. Review of the Physician's Orders dated 06/29/14 revealed Resident #9's Plavix and Aspirin medications had been discontinued.

However, review of Resident #9's Comprehensive Care Plans, dated 05/14/14, revealed care plans indicating the resident was still care planned for

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F 280	<p>Continued From page 11</p> <p>Antiplatelet Therapy related to use of Plavix and Aspirin. Continued review of the care plans revealed no documented evidence of the care plans being revised, even though the Plavix and Aspirin medications had been discontinued.</p> <p>Interview with LPN #3 on 08/20/14 at 3:17 PM, revealed Resident #9's care plans should have been updated by nursing staff when the Plavix and Aspirin were discontinued.</p> <p>Interview with Registered Nurse (RN) #2 on 08/21/14 at 3:45 PM, revealed Resident #9's care plan should have been updated after receipt of the Physician's Order to discontinue the Plavix and Aspirin. RN #2 stated failure to update the care plans could have affected the resident's care needs.</p> <p>4. Review of Resident #13's medical record revealed Resident #13 was admitted to the facility on 12/23/13, with diagnoses which included UTIs, Chronic Kidney Disease and Carcinoma in Situ of Bladder (Bladder Cancer). Further review of Resident #13's medical record revealed a laboratory (lab) report printed on 06/22/14 at 11:03 PM of a urinalysis (U/A) which indicated the resident had a UTI involving the bacterial organisms Enterococcus Faecalis and Klebsiella Oxtoca.</p> <p>Review of Resident #13's Comprehensive Care Plan with a review date of 07/30/14, revealed no documented evidence the resident's UTIs had been care planned.</p> <p>Interview with the Unit Coordinator (UC) on 08/20/14 at 5:16 PM, revealed nurses were responsible for updating resident care plans</p>	F 280	

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F 280 Continued From page 12  
whenever resident condition changes occurred.  
The UC stated Resident #13 would have received an order for antibiotics on 06/23/14, and the resident's care plan should have been updated on 06/24/14 to reflect the UTI status and ongoing treatment. The UC stated, however she had no explanation regarding why Resident #13's care plan was not updated.

F 280

Continued interview with the DON on 08/21/14 at 7:01 PM, revealed she was unaware of anyone auditing the Care Plans for accuracy at this time, and LPN #3 had trained the current MDS Coordinator. She stated the nurses on the floor were to update residents' care plans with new interventions from Physician's Orders and with acute changes in their condition. According to the DON stated there was also a copy of the Physician's Orders put in the UC's mailbox and the UC was to check and make sure the interventions had been placed on the care plans. The DON indicated the residents' care plans should have been updated by nurses or the UC.

F 282  
SS=D 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

F 282

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review and review of facility policy, it was determined the facility failed to follow care plan interventions for one (1) of fifteen (15) sampled residents (Resident #10).

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F 282	Continued From page 13 Resident #10 was care planned for risk for injury related to smoking with interventions which included monitoring for smoking materials in the resident's room and ensuring the materials were in a locked area. However, observation revealed Resident #10 had cigarettes lying on his/her bed during the initial tour of the facility.  The findings include:  Review of the facility's, "Tobacco Policy", revised 01/02/14, revealed residents could not keep tobacco products, such as cigarettes in their rooms. The Policy revealed cigarettes were kept by the nursing staff in an area designated by the Director of Nursing (DON), and smoking was not permitted in any area where oxygen was in use.  Review of the "Tobacco Policy" signed by Resident #10 and dated 07/24/14, revealed by signing it the resident indicated he/she understood the facility's "Tobacco Policy".  Review of Resident #10's medical record revealed diagnoses which included Chronic Airway Obstruction and Congestive Heart Failure. Review of the Admission Minimum Data Set (MDS) dated 08/04/14, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of fifteen (15) of fifteen (15), indicating Resident #10 was cognitively intact. Further review of the MDS Assessment revealed the facility assessed Resident #10 to be able to make himself/herself understood, to understand others and to require oxygen therapy.  Review of Resident #10's Comprehensive Care Plan initiated on 07/25/14, revealed the resident		F 282 Smoking materials were removed from room of Resident #10 on 8/21/14, by RN #2 and materials were placed in storage in locked area.  All staff was in-serviced on 9/9/14 and 9/10/14, by Maintenance Supervisor, Charles Ginn, Kim Breeze, RN, and Michelle Marshall, RN with regard to handling of harmful materials in resident rooms.  All resident rooms were inspected for inappropriate materials on 8/19/14 by Housekeeping staff. None found.  All Housekeeping staff has been instructed to inspect all resident rooms on a daily basis while performing routine cleaning duties. This task has been added to the checklist housekeeping staff must sign off the completed. Housekeeping will visually check resident rooms as part of routine daily cleaning checklist. Clinical staff will check residents' bedside drawers daily for any harmful materials/objects. Housekeeping staff was educated as to inspection and recordkeeping requirements on 9/10/14, by Susan Fulton, LPN.		

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F 282 Continued From page 14

was care planned for shortness of breath related to Chronic Obstructive Pulmonary Disease (COPD) with interventions which included oxygen use. Continued review of the Comprehensive Care Plan revealed Resident #10 was care planned for risk for injury related to smoking activity with interventions which included monitoring the resident's room for smoking materials and removing the smoking materials immediately from the room if found. Continued review of the risk for injury care plan revealed if smoking material was found in the resident's room staff were to report it to the Charge Nurse. Additionally, the risk for injury care plan included an interventions to keep smoking materials in a locked location.

Observation during the initial tour of the facility on 08/19/14 at 11:25 AM, revealed Resident #10 had oxygen in the room available for use. Resident #10 was observed to be lying on his/her bed with a pack of cigarettes lying on the bed next to the resident's pillow. Observation revealed Registered Nurse (RN) #2 removed the cigarettes from the resident's bed and room after the Surveyor's observation.

Interview with RN #2 on 08/19/14 at 11:25 AM, revealed Resident #10 should not have had the cigarettes in his/her room as the cigarettes should have been stored in the laundry area which had a locked compartment. She stated Resident #10 was care planned for smoking activity and staff was to monitor the resident daily for smoking material. She stated it was a safety concern if a resident had smoking material in the their room.

Interview with the Director of Nursing (DON) on

**F 282 Cont.**

F 282 Compliance will be monitored monthly in the Safety Committee meeting.

**F 282 Completed 9/11/14**

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F 282	Continued From page 15 08/21/14 at 9:41 AM, revealed all residents were given the facility's smoking policy on admission, and staff were to educate residents and their families on the tobacco-smoking policy. She stated she was unsure if Resident #10's family was educated because the resident was cognitively intact and able to make his/her own decisions. The DON stated her expectations were for staff to ensure smoking materials were not in residents' rooms by closely monitoring and observing for the materials. She indicated she expected staff to follow residents' care plans however, there was no system in place to routinely check or search for smoking materials in residents' room.	F 282		
F 411 SS=E	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS  The facility must assist residents in obtaining routine and 24-hour emergency dental care.  A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide or obtain	F 411		

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F 411 Continued From page 16  
from an outside resource routine dental services or an annual inspection of residents' oral cavity for signs of disease or diagnoses of dental disease for seven (7) of fifteen (15) sampled residents. (Residents #1, #2, #3, #5, #7, #8 and #9). Record review revealed there was no documented evidence these residents had been seen by a dentist for routine annual dental services.

The findings include:

1. Review of the medical record revealed the facility admitted Resident #1 to the facility on 02/15/13, with diagnoses which included Dementia, Parkinson's Disease, and Adult Failure to Thrive. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/16/14, revealed the facility assessed the resident as having short and long term memory loss. Further review of the MDS Assessment revealed the facility assessed Resident #1 to have no concerns with dentures or mouth or facial pain, or discomfort or difficulty with chewing.

Review of the Comprehensive Care Plan, dated 04/24/14, revealed Resident #1 had the potential for chewing/swallowing difficulties related to having full dentures. Continued review of the CCP revealed interventions included upper and lower dentures, staff to assess oral status weekly and as needed, and consult dentistry as ordered.

Further review of the medical record, revealed no documented evidence a dentist had seen the resident for routine dental care and services since admission to the facility.

Interview on 08/21/14 at 1:30 PM with Registered

F 411 Resident #1 continues to receive routine oral care by nursing staff daily. There has not been any change in the resident's dental status, and no complaints have been made. Resident will be evaluated and examined by a dentist from On Healthcare, providing dental services per signed agreement as indicated below.

Resident #2 continues to receive routine oral care by nursing staff daily. There has not been any change in the resident's dental status, and no complaints have been made. Resident will be evaluated and examined by a dentist from On Healthcare, providing dental services per signed agreement as indicated below.

Resident #3 continues to receive routine oral care by nursing staff daily. There has not been any change in the resident's dental status, and no complaints have been made. Resident will be evaluated and examined by a dentist from On Healthcare, providing dental services per signed agreement as indicated below.

Resident #5 continues to receive routine oral care by nursing staff daily. There

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F 411 Continued From page 17

Nurse (RN) #1/Unit Coordinator (UC), revealed the resident still wore dentures and there was no concern with the way they fit; however, she was unable to find evidence the resident had been seen by dental for a routine screening to ensure the denture fit.

2. Review of Resident #2's medical record revealed the facility admitted him/her on 05/29/13, with diagnoses which included Congestive Heart Failure, Diabetes, Hypertension and Gastroesophageal Reflux Disease (GERD). Review of the Significant Change MDS Assessment dated 04/28/14, revealed a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated no cognitive impairment. Further review of the MDS Assessment revealed the facility assessed Resident #2 to have no dental problems.

Review of the CCP, initiated 06/10/13, revealed Resident #2 was care planned to be edentulous, and to have the potential for oral/dental health problems related to the edentulous status. Continued review of the CCP revealed Resident #2 required weekly mouth inspections, and for staff to coordinate arrangements for dental care.

However, further record review revealed no documented evidence the facility had obtained or assisted the resident to see a dentist for routine dental care and services since admission to the facility.

3. Review of Resident #3's medical record revealed the facility admitted him/her on 09/06/13, with diagnoses which included Pacemaker, Diabetes, Dementia, GERD, Dysphagia (difficulty swallowing) and Renal

F 411 cont.

F 411 has not been any change in the resident's dental status, and no complaints have been made. Resident will be evaluated and examined by a dentist from On Healthcare, providing dental services per signed agreement as indicated below.

Resident #7 continues to receive routine oral care by nursing staff daily. There has not been any change in the resident's dental status, and no complaints have been made. Resident will be evaluated and examined by a dentist from On Healthcare, providing dental services per signed agreement as indicated below.

Resident #8 continues to receive routine oral care by nursing staff daily. There has not been any change in the resident's dental status, and no complaints have been made. Resident will be evaluated and examined by a dentist from On Healthcare, providing dental services per signed agreement as indicated below.

Resident #9 continues to receive routine oral care by nursing staff daily. There has not been any change in the resident's dental status, and no

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F 411 Continued From page 18

Failure. Review of the Annual MDS Assessment dated 08/11/14, revealed the facility assessed Resident #3 to have a BIMS score of eleven (11) which indicated moderate cognitive impairment. Continued review of the MDS Assessment revealed the facility assessed Resident #3 to have no dental problems.

Review of the CCP, initiated 09/17/13, revealed Resident #3 was care planned to have a full set of dentures and for staff to provide oral care every shift and as needed. Additionally, the CCP revealed Resident #3 was care planned to have dental consults scheduled as needed.

However, further record review revealed no documented evidence the facility had obtained or assisted the resident to see a dentist for routine dental care and services since admission to the facility.

4. Review of Resident #5's medical record revealed the facility admitted the resident to the facility on 04/20/12, with diagnoses which included CVA with Hemiplegia (paralysis of one side of the body), and Debility. The facility assessed Resident #5, in a Annual MDS dated 02/18/14, as requiring extensive assistance with daily hygiene, and to be edentulous.

Review of Resident #5's CCP, initiated 10/01/13, revealed the resident was at risk for chewing/swallowing problems related to being edentulous. Continued review of the CCP revealed interventions which included scheduling dental consults as needed and ordered by Physician, and provide oral care every shift and as needed.

F 411 cont.

F 411 complaints have been made. Resident will be evaluated and examined by a dentist from On Healthcare, providing dental services per signed agreement as indicated below.

Pioneer Trace has a signed emergency agreement in place since 11/28/2001 with Dr. Scott Perkins, who is a local dentist and has agreed to provide emergency care on an as-needed basis. He is unable to provide care to the entire resident population.

Pioneer Trace signed an agreement on 9/9/14 with On Healthcare to provide dental services to all residents in the facility. They have accelerated their normal sequencing in order to schedule our residents at the earliest possible date. One half of the residents in the facility will be evaluated and examined on 10/13/14, and the remainder will be evaluated and examined on 10/30/14, by a licensed dentist.

On Healthcare will continue to treat all residents as required, including an annual examination and evaluation.

They also will perform extractions, replacement dentures, filling of cavities,

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F 411	<p>Continued From page 19</p> <p>However, further record review revealed no documented evidence the facility had obtained or assisted the resident to see a dentist for routine dental care and services.</p> <p>5. Review of Resident #7's medical record revealed the facility admitted the resident on 04/18/13, with diagnoses which included Dementia and Alzheimer's Disease. Review of the Annual MDS Assessment, dated 03/24/14, revealed the facility assessed Resident #7 to be severely cognitively impaired, totally dependent upon staff for daily hygiene and to have no dental problems.</p> <p>Review of Resident #7's CCP, dated 06/19/14, revealed the resident was care planned with interventions which included to schedule dental consults as needed and ordered by the Physician.</p> <p>However, further record review revealed no documented evidence the facility had obtained or assisted the resident to see a dentist for routine dental care and services since admission to the facility.</p> <p>6. Review of Resident #8's medical record revealed the facility re-admitted the resident on 06/29/14 with diagnoses which included Dementia, Diabetes Mellitus and GERD. Review of Resident #8's Quarterly MDS Assessment dated 07/28/14, revealed the facility assessed Resident #8 to have denture with no dental problems noted.</p> <p>Review of the CCP, dated 10/01/13, revealed Resident #8 was care planned for risk of chewing and swallowing difficulties in regards to upper and lower denture use. Continued review of the CCP</p>	F 411	<p><b>F 411 cont.</b> etc. as required. This is a full service agreement.</p> <p>Compliance will be monitored by the QA committee on a monthly basis.</p> <p><b>F 411 Completed 9/10/14</b></p>	

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F 411	Continued From page 20 revealed interventions which included dental consults as ordered, and staff assistance with oral care daily and as needed.  However, further record review revealed no documented evidence the facility had obtained or assisted the resident to see a dentist for routine dental care and services since admission to the facility.  7. Review of Resident #9's medical record revealed the facility admitted the resident on 10/01/12, with diagnoses which included Alzheimer's Disease, Dysphagia, GERD, Dementia, Diabetes Mellitus and Long Term Use of Anticoagulants. Review of Resident #9's Annual MDS Assessment, dated 07/23/14, revealed the facility assessed Resident #9 to be severely cognitively impaired. Continued review of the MDS revealed the facility assessed Resident #9 to have upper and lower denture, and no dental problems identified.  Review of the CCP, dated 10/21/13, revealed Resident #9 was care planned for the potential for chewing and swallowing difficulties related to having upper and lower dentures. Continued review revealed interventions which included dental consult when ordered and weekly assessment of oral status and as needed.  However, further record review revealed no documented evidence the facility had obtained or assisted the resident to see a dentist for routine dental care and services since admission to the facility.  Interview with the Director of Nursing (DON) on 08/21/14 at 9:41 AM, revealed the facility had	F 411			

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F 411	Continued From page 21 consulted with a dental group for dental screenings for residents; however, the Primary Physicians were resistant to bringing in providers other than the "local" dentist. She stated nothing had been set up with the local dentist at this time, and there was no dental contract. She further stated right now the residents just received dental care as needed, and the nurses did assessments of the oral cavity with the weekly skin checks.  Interview with the Administrator on 08/21/14 at 8:50 PM, revealed the facility currently had no dental contract; however, the facility had recognized this as a concern and was in the process of trying to find a dentist who would provide the dental services needed at the facility.	F 411		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  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.  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.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431		

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F 431 Continued From page 22 controls, and permit only authorized personnel to have access to the keys.

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.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, and review of the facility's "Pharmacy Services and Procedures Manual", "Insulin and Injectable Diabetes Medication Chart", and "Injectable Medications" Guideline, it was determined the facility failed to ensure drugs and biologicals were dated when opened and were not expired for one (1) of two (2) medication rooms, and two (2) of two (2) medication carts. Observation revealed eye drops, insulin, and multidose injectable vials were not dated with an opened date. In addition, observation revealed purple top Vacutainers (a blood container tube) were expired; however, accessible and ready for use.

Additionally, observation revealed the facility failed to ensure prescribed medicated lotions and personal care items with warning labels were stored in a secure manner in residents' rooms and were inaccessible to other residents for one (1) of fifteen (15) sampled (Resident #10), and two (2) of three (3) unsampled residents

F 431 F 431 Two bottles of Artificial Tears Solution and one vial of Lidocaine HCL 1% 10mg/1ml (ten milligrams per milliliter) were removed and discarded from A unit medication cart on 8/20/14. The Artificial Tears solutions and vial of Lidocaine HCL 1% were discarded according to facility policy.

Fourteen purple top Vacutainers and one vial of Humalog 75/25 were removed and discarded from B unit Medication Room on 8/20/14. All Vacutainers and the vial of Humalog 75/25 were discarded according to facility policy.

One bottle of Systane Lubricant 0.3%-0.4% eye drops was removed and discarded from B unit medication cart on 8/20/14. The bottle of Systane Lubricant 0.3%-0.4% eye drops was discarded according to facility policy.

Housekeeping staff removed "Aloe Touch" Personal Cleansing Cloths from counter top of Resident B's room on 8/19/14. The Cloths were placed in Resident B's designated drawer on the B unit treatment cart. CNA removed Equate Oil Free Facial Moisturizer, Remedy with Olivamine, Calazime

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F 431	<p>Continued From page 23 (Unsampled Residents B and C).</p> <p>The findings include:</p> <p>Review of the facility's, "Storage and Expiration of Medications, Biologicals, Syringes and Needles" Policy, revised 01/01/13, revealed the facility should record the date opened on the medication container when the medication had a shortened expiration date once opened. Continued review revealed the facility should destroy or return all outdated/expired medications or biologicals in accordance with pharmacy guidelines.</p> <p>Review of the facility's, "Insulin and Injectables Diabetes Medication Chart", 7.0 Version, dated 2012, revealed Humalog 75/25 Insulin was to expire after being opened in twenty-eight (28) days.</p> <p>Review of the facility's, "Injectable Medications" Guideline, revised 03/31/14, revealed multidose vials for injection (non-insulin) were to be dated when opened and discarded after twenty-eight (28) days or in accordance with manufacturer's guidelines.</p> <p>A copy of the manufacturer's guidelines for Systane Lubricant 0.3%-0.4% eye drops, was requested; however, not received.</p> <p>1. Observation of the medication cart for the facility's A unit, on 08/20/14 at 9:00 AM, revealed two (2) bottles of Artificial Tears Solution was open, with no opened date, and a vial of Lidocaine HCL 1% 10 mg/1 ml (ten milligrams per milliliter) injectable was open with no opened date.</p>	F 431	<p><b>F 431 cont.</b> from Resident C's room. The Equate Oil Free Facial Moisturizer was placed in Resident C's toiletry container located in the B unit Shower Room. The Remedy with Olivamine and Calazime Skin Protectant Paste with Zinc Oxide were placed in Resident C's drawer on the B unit Treatment cart. CNA removed Eucerin Repair cream from Resident #10's bedside table and placed it in Resident #10's drawer on the B unit treatment cart.</p> <p>Michelle Marshal, RN inspected A unit Medication Room for any expired products and medications open needing open dates on 8/22/14. One 22 gauge needle for injection was found expired and discarded in sharps container. No other expired items found. No medications needing open dates found during inspection. Kim Breeze, RN inspected B unit Medication Room for any expired products and medications open needing open dates on 8/22/14. No expired products or medications needing open dates found during inspection. Sandy Mitchell, DON inspected Medication Carts on both A and B units for any expired products and medications open without open</p>
			<p>dates on 8/22/14. No expired items found.</p>

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F 431 Continued From page 24

Interview with Licensed Practical Nurse (LPN) #1 on 08/20/14 at 9:20 AM, revealed she was unsure how long the Artificial Tears Solution or Lidocaine HCL injectable was good for after opened, and stated staff who opened the bottles of artificial tears, and vial of Lidocaine should have written the opened date on the containers.

2. Observation of the Medication Room for the B Unit on 08/20/14 at 9:25 AM, revealed sixteen (16) purple top Vacutainers on the counter ready for use with an expiration date of June 2014. Interview with LPN #2, at the time of the observation, revealed she was unsure who checked the expiration dates for the Vacutainers. However, she stated the Vacutainers should have been removed from the medication room and not available for use because they were expired.

Further observation of the Medication Room for the B Unit, revealed the medication refrigerator contained a vial of Humalog 75/25 insulin which had been opened, with no opened date written on the bottle or the box. Interview with Registered Nurse (RN) #1, at the time of the observation, revealed the box or the vial should have been dated when opened, and she thought the insulin was good for thirty (30) days after opened. However, facility policy review revealed the insulin was to expire in twenty-eight days after being opened.

Observation of the B Unit Medication Cart on 08/20/14 at 9:50 AM, revealed a bottle of Systane Lubricant 0.3%-0.4% eye drops which was open with no opened date. Further interview with RN #1, at the time of the observation, revealed the eye drops should have been dated when opened.

F 431 **F 431 cont.** medications needing open dates found during inspection.

Nurses and Medication Aides were educated on proper procedures when opening medications requiring open dates by Susan Fulton, LPN on 9/9/14. Medication Aides will audit medication carts weekly for open medications with no open date.

Leanna Hunt, Medical Records will audit Medication Rooms and Medication Carts for expired products weekly.

Compliance will be monitored by QA committee monthly for 90 days and quarterly there after.

**F 431 Completed 9/10/14**

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F 431	<p>Continued From page 25</p> <p>Interview on 08/21/14 at 9:41 AM, with the Director of Nursing (DON), revealed lubricant eye drops, insulins, and Lidocaine injectable vials were to be dated when opened. She stated the Certified Medication Aides (CMAs) were to check the medication carts for expired medications to ensure medications had an opened date. She further stated the nurses were to check the medication rooms and the medication refrigerators for expired medications or biologicals and remove them from use, and ensure there was an opened date on the medications.</p> <p>3. Interview with the DON on 08/21/14 at 9:41 AM, revealed the facility did not have a policy with regard to the storage of prescribed bedside medications and toiletries, however her expectations were that the items be stored in a locked compartment.</p> <p>Observation during initial tour of the facility on 08/19/14 of Unsamped Resident B's room at 11:06 AM revealed "AloeTouch" Personal Cleansing Cloths lying on the resident's counter top unsecured; of Unsamped Resident C's room at 11:00 AM revealed Equate Oil Free Facial Moisturizer, Remedy with Olivamine, Calazime Skin Protectant Paste with Zinc Oxide all stored out in the open unsecured; and of Resident #10's room at 11:25 AM, revealed prescription "Eucerin Repair Cream" located on the tray next to the resident's bed. Review of the prescription label revealed no indication the resident could store the medication at bedside.</p> <p>Review of Unsamped Resident C's medical record revealed the resident had a diagnosis of Dementia.</p>	F 431
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F 431	<p>Continued From page 26</p> <p>Review of Unsampled Resident B's medical record revealed the facility assessed the resident as cognitively intact.</p> <p>Review of Resident #10's medical record revealed the facility assessed the resident as being cognitively intact.</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 08/19/14 at 11:08 AM, revealed personal items, such as the "AloeTouch" Personal Cleansing Cloths, Equate Oil Free Facial Moisturizer, Remedy with Olivamine, Calazime Skin Protectant Paste with Zinc Oxide and prescription "Eucerin Repair Cream" should not be stored out in the open available for wandering residents to access. She stated these items should be stored in a locked storage area to prevent resident use or ingestion.</p> <p>Interview with RN #2 on 08/19/14 at 11:25 AM, revealed prescription lotions, such as Resident #10's "Eucerin Repair Cream" should be stored on the medication cart and not in the resident's room. She stated, if there was a written Physician's Order which indicated the medication could be stored at bedside, it could be stored in a locked compartment at bedside to prevent wandering residents from accessing it. RN#2 also stated Resident #10's "Eucerin Repair Cream" would be stored on the medication cart until a Physician's Order was received for the resident to keep it at bedside.</p> <p>Continued interview with the DON on 08/21/14 at 9:41 AM, revealed her expectation with regard to bedside medications and personal items with warning labels to be stored in a secure manner to</p>	F 431		

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F 431	Continued From page 27 prevent wandering residents from accessing them. The DON stated medicated prescription creams and lotions should be stored on the treatment cart.	F 431		
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K 000	INITIAL COMMENTS	K 000		
	<p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Plan Approval: 1977</p> <p>Survey under: NFPA 101 (2000 edition)</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type V</p> <p>Smoke Compartment: Five (5)</p> <p>Fire Alarm: Complete fire alarm</p> <p>Sprinkler System: Complete sprinkler system</p> <p>Generator: Natural gas generator installed in 2009</p> <p>A standard Life Safety Code Survey was conducted on 08/20/14. The facility was found to not be in compliance with the requirements for participation in Medicare and Medicaid, Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). The census on the day of the survey was seventy-two (72). The facility was licensed for ninety-two (92) beds.</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> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p>			

SEP 26 2014

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

*Michael Cox*

TITLE

ADMINISTRATOR

(X6) DATE

9/26/14

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 050 SS=F** NFPA 101 LIFE SAFETY CODE STANDARD

Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2

This STANDARD is not met as evidenced by:  
Based on record review and interview, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the six (6) smoke compartments, residents, staff, and visitors. The facility had ninety-two (92) certified beds and the census was seventy-two (72) on the day of the survey.

The findings include:

Review of the facility's Fire Drill documentation, on 08/20/14 at 12:10 PM, with the Maintenance Director, revealed the 2nd Shift fire drills were not being conducted at random times on all shifts. All drills for 2nd shift were conducted at 3:15 PM. Further observation revealed a fire drill conducted on 3rd shift, dated 6/30/14, did not have the time the drill was conducted documented.

Interview, on 08/20/14 at 12:10 PM, with the

**K 050** Fire drills conducted in this facility will be conducted at unexpected times once per quarter per shift. Maintenance Supervisor, Charles Ginn, will coordinate all fire drills to ensure drills are conducted at random times.

All regular staff has been in-serviced pertaining to properly filling out fire drill forms to include actual time of fire drill, by Michelle Marshall, RN on 9/9/14, and by Charles Ginn on 9/9/14, and 9/10/14.

Several PRN staff and two employees on vacation have not been in-serviced, but this will be completed prior to their being placed back on the schedule.

Compliance will be monitored by the Safety Committee on a quarterly basis. Each Fire Drill Record form will be audited to ensure times are random and conducted on each shift by the Safety Committee. The Safety Committee consists of the Administrator, DON, Dietary Manager, Housekeeping/Laundry Manager, QA/Staff

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K 050 Continued From page 2  
Maintenance Director, revealed he was unaware the fire drills were not being conducted as required.  
Reference: NFPA 101 (2000 Edition)

4.7.5\* Simulated Conditions. Drills shall be held at expected and unexpected times and under varying conditions to simulate the unusual conditions that can occur in an actual emergency.

19.7.1.2\* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.

Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.

K 050 Cont.  
Development, Business Office Manager, and Maintenance Director.  
K 050 Completed 9/11/14