

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

PRINTED: 01/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/05/2012
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NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 905 HWY 127 NORTH OWENTON, KY 40369
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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
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1977</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system</p> <p>GENERATOR: Type II generator installed in 1991. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 01/05/12. Owenton Manor was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred (100) beds with a census of ninety five (95) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Owenton Manor Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *2-27-12*

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

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NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 905 HWY 127 NORTH OWENTON, KY 40359		
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K 000 K 025 SS=E	Continued From page 1 Deficiencies were cited with the highest deficiency identified at "F" level. 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 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds with a census of ninety five (95) on the day of the survey. The findings include: Observation, on 01/06/12 at 4:15 PM, with the Maintenance Director revealed the fire wall extending above the ceiling in all the Front Hall to be penetrated by wires. The spaces around the	K 000 K 025	K025 1. The Maintenance Director sealed the identified penetrations in the smoke barrier wall above the ceiling in the front hall with smoke resistive caulk on 1/9/12. 2. Other smoke barrier walls were visually inspected by the Maintenance Director and the Life Safety Inspector on 1/5/12 to determine proper requirements are met regarding smoke barrier walls in accordance with NFPA Standards. In addition, the Maintenance Director re-checked smoke barrier walls on 1/9/12. 3. The Maintenance Director was re-educated on Life Safety Code Standards regarding smoke barrier walls by 2/5/12 by the Administrator. 4. The Maintenance Director will audit smoke barrier walls monthly for six (6) months to determine that smoke barrier walls have not been penetrated and smoke compartments are not compromised. The Maintenance Director will also monitor any contractor doing work in the attic to determine smoke barrier walls have not been penetrated and smoke compartments are not compromised. Identified issues will be addressed immediately. The		



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K 025	Continued From page 2 penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. Interview, on 01/05/12 at 4:15 PM, with the Maintenance Director revealed they were not aware of the penetrations. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. NFPA 101 LIFE SAFETY CODE STANDARD	K 025	Maintenance Director will report on the finding of his audit monthly for six (6) months to the Performance Improvement Committee for further review and recommendation. <i>2/24/12 2-19-12 per plan by PB 3-13-12</i>	
K 027 SS=F		K 027		

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K 027	<p>Continued From page 3</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5; 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure access doors in smoke barriers were installed in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred (100) beds with a census of ninety five (95) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 01/05/12 at 4:10 PM, with the Maintenance Director revealed two (2) unrated homemade smoke barrier access doors located in the attic above the cross corridor doors in the 100, and 200 Long Hall.</p> <p>Interview, on 01/05/12 at 4:10 PM, with the Maintenance Director revealed he was not aware</p>	K 027	<p>K027</p> <ol style="list-style-type: none"> 1. The Maintenance Director installed two fire rated smoke barrier access doors in accordance with NFPA Standards located in the attic above the cross corridor doors in the 100 and 200 long hall on 1/11/12. 2. Residents residing in the center benefit with fire rated smoke barrier access doors being placed in the attic. 3. The Maintenance Director was re-educated by the Administrator by 2/5/12 regarding fire rated smoke barrier access doors in accordance with NFPA standards. 4. The Maintenance Director will audit smoke barrier walls monthly for six (6) months to ensure smoke barrier access doors are in accordance with NFPA Standards. The Maintenance Director will also monitor any contractor doing work in the attic to determine that smoke barrier access doors have not been compromised. Identified issues will be addressed immediately. The Maintenance Director will report on the finding of his audit monthly for six (6) months to the Performance Improvement Committee for further review and recommendation. 5. 2/24/12 2-19-12 by John John PB 3-13-12 	
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K 027	Continued From page 4 the doors in the attic must be rated for use. Reference: NFPA 101 (2000 Edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Reference: NFPA 101 (2000 Edition) Continuity 8.3.2 Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.	K 027		
K 029 SS=D	Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. 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	K 029		

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K 029	Continued From page 5 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 NFPA Standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds with a census of ninety five (95) on the day of the survey. The findings include: Observation, on 01/05/12 at 3:45 PM, with the Maintenance Director revealed the door to the Janitor Closet located in the Kitchen did not have a self closing device. Interview, on 01/05/12 at 3:45 PM, with the Maintenance Director revealed they were not aware the self closing device was required. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in	K 029	K029 1. The janitor closet room door lock located in the kitchen was replaced with a self-closing device on 1/10/12 by the Maintenance Director. 2. Other doors were visually inspected throughout the facility by the Maintenance Director and the Life Safety Code Surveyor on 1/5/12 to determine that center meets the requirements for protection of hazards in accordance with NFPA Standards. In addition, the Maintenance Director re-checked center doors on 1/30/12. 3. The Maintenance Director was re-educated on Life Safety Code Standards regarding protection of hazards in accordance with NFPA Standards by 2/5/12 by the Administrator. 4. The Maintenance Director will audit doors of the facility monthly for six (6) months to determine proper protection of hazards in accordance with NFPA Standards to include self-closing door devices are in place and in working order in areas that could be hazardous. Identified issues will be addressed/corrected immediately. The Maintenance Director will report findings of audit to the Performance Improvement Committee monthly for six (6) months for further review and recommendation. 5. 2/24/12 2-19-12 per John by PO 3-13-12	



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K 029	Continued From page 6 accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.6.4. 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: (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. NFPA 101 LIFE SAFETY CODE STANDARD	K 029			
K 038 SS=D	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038			



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K 038	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiencies had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred (100) beds with a census of ninety five (95) on the day of the survey. The findings include: Observation, on 01/05/12 at 3:38 PM, with the Maintenance Director revealed the delayed egress doors located at the Front Entry; did not have the required signage stating the door was equipped with a fifteen (15) second delay before opening. Interview, on 01/05/12 at 3:38 PM, with the Maintenance Director revealed they were not aware the delayed egress signage was to be on the exit doors. Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings	K 038	K038 1. The Maintenance Director posted the required signage on the front entry to inform the door is equipped with a fifteen (15) second delay before opening on 1/23/12. 2. The Maintenance Director reviewed other center doors on 1/30/12 to determine the need for delayed egress signage. 3. The Maintenance Director was re-educated on Life Safety Code as it relates to delayed egress doors and exits in accordance with NFPA standards by 2/5/12 by the Administrator. 4. The Maintenance Director will review center doors monthly for six (6) months to determine that the required signage remains in place for doors with delayed egress. Identified issues will be addressed/corrected immediately. The Maintenance Director will report findings of review to the Performance Improvement Committee monthly for six (6) months for further review and recommendation. 5. 2/21/12 2:29:12 pm by OS 3-13-12	



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K 038 Continued From page 8
protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.

K 038

(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.
NFPA 101 LIFE SAFETY CODE STANDARD

K 050

K 050 SS=F
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

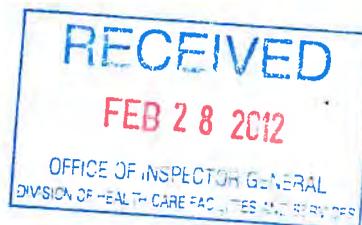
This STANDARD is not met as evidenced by:
Based on interview and fire drill review it was



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K 050	<p>Continued From page 9</p> <p>determined the facility failed to ensure fire drills were conducted at unexpected times under varied conditions. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds with a census of ninety five (95) on the day of the survey.</p> <p>The findings include:</p> <p>Fire Drill review, on 01/05/12 at 3:15 PM, with the Maintenance Director revealed the fire drills were not being conducted at unexpected times under varied conditions. Fire drills were being conducted as follows:</p> <p>First Shift 10/30/11 @ 1:25 PM 07/28/11 @ 9:45 AM 04/26/11 @ 11:16 AM 01/26/11 @ 10:17 AM</p> <p>Second Shift 11/28/11 @ 8:40 PM 08/29/11 @ 3:35 PM 05/23/11 @ 4:15 PM 2/22/11 @ 4:15 PM</p> <p>Thlrd Shift 12/21/11 @ 11:14 PM 09/21/11 @ 8:40 AM 06/08/11 @ 6:45 AM 03/29/11 @ 6:30 AM</p> <p>Interview, on 01/05/12 at 3:15 PM, with the</p>	K 050	<p>K050</p> <ol style="list-style-type: none"> The Maintenance Director conducted a fire drill on 1/30/12 at 12:26pm. The Maintenance Director conducted a fire drill on 1/31/12 at 8:02 p.m.. The Maintenance Director conducted a fire drill on 2/1/12at 2:00 a.m. The Maintenance Director will continue to conduct fire drills at unexpected times, under varying conditions, at least quarterly on each shift. The center recognizes that residents and staff benefit by conducting fire drills at unexpected times, under varying conditions. The Maintenance Director was re-educated on Life Safety Code Standards regarding holding fire drills at unexpected times under varying conditions, at least quarterly on each shift by the Administrator by 2/5/12. The Maintenance Director will conduct fire drills at unexpected times three (3) times monthly for three (3) months, then monthly for three (3) months. The Administrator will review planned dates/times of fire drills before the drill to determine drills are being conducted at random for six (6) months. The Maintenance Director will report dates and times of fire drills to the Performance Improvement Committee monthly for six (6) months for further review and recommendation. <p>5. 2/24/12 2:19:12 per adm on 03.13.12</p>	



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NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 806 HWY 127 NORTH OWENTON, KY 40358	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 10 Maintenance Director revealed they were unaware the fire drills were not being conducted as required. Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts. NFPA 101 LIFE SAFETY CODE STANDARD	K 050	K056 1. Sprinkler protection was installed by the contractor on the 100 long and short hall, and the 200 long and short hall on 1/31/12. 2. The Maintenance Director and Life Safety Inspector visually inspected the center to determine that other porches located outside exit doors throughout the facility to extend out four (4) foot or greater, made of combustible materials, are sprinkler protected on 1/5/12. Equipping the 100/200 porch areas with a sprinkler system will meet this requirement. 3. The Maintenance Director was re-educated by the Administrator by 2/5/12 on Life Safety Code requirements for a complete sprinkler system in accordance with NFPA Standards. 4. The Maintenance Director will inspect the center sprinkler system, to include the porch-area sprinklers monthly for six (6) months to determine that they are properly in place. Identified issues will be addressed/corrected immediately. The Maintenance Director will report findings of this inspection to the Performance Improvement Committee monthly for six (6) months for further review and recommendation. 5. 2/21/12 2:15:12 pm by PB 3-13-12	
K 056 SS=E	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred (100) beds with a census of ninety five (95) on			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/05/2012
NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 HWY 127 NORTH OWENTON, KY 40388	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 11 the day of the survey. The findings include: Observation, on 01/05/12 at 2:40 PM, with the Maintenance Director revealed four (4) porches located outside exit doors throughout the facility to extend out four (4) foot or greater, made of combustible materials, and were not sprinkler protected. The porches are located in the 100 Long and Short Hall, and the 200 Long and Short Hall. Interview, on 01/05/12 at 2:40 PM, with the Maintenance Director revealed they were not aware the porches needed to be sprinkler protected. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056		
K 062 SS=D	Reference: NFPA 13 (1999 Edition) 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, 9.7.5	K 062		



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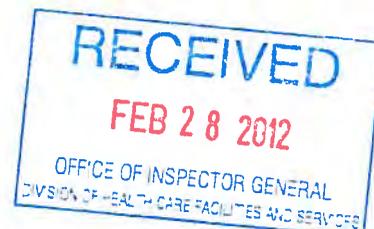
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/05/2012
NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 905 HWY 127 NORTH OWENTON, KY 40369		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 062	Continued From page 12 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect one (1) of the four (4) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (10) beds with a census of ninety five (95) on the day of the survey. The findings include: Observation, on 01/05/12 at 3:40 PM, with the Maintenance Director revealed corrosion on the sprinkler head in the Dish Room, located in the Kitchen. Interview, on 01/05/12 at 3:40 PM, with the Maintenance Director revealed they were not aware of the corrosion on the sprinkler head. Reference: NFPA 25 (1998 Edition). 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062	K062 1. The sprinkler head in the dish room was replaced by the contractor on 1/31/12. 2. The Maintenance Director and Life Safety Inspector visually inspected the center to determine that other sprinklers are free of corrosion, foreign materials, paint, and physical damage and installed in the proper orientation. There were no additional sprinkler heads identified that needed to be replaced. 3. The Maintenance Director was re-educated by the Administrator by 2/5/12 on Life Safety Code requirements that all sprinklers are free of corrosion, foreign materials, paint, and physical damage and installed in the proper orientation. 4. The Maintenance Director will inspect the center monthly for six (6) months to determine that all sprinklers are free of corrosion, foreign materials, paint, and physical damage and installed in the proper orientation. Identified issues will be addressed/corrected immediately. The Maintenance Director will report the findings of sprinkler head audit to the Performance Improvement Committee monthly for six (6) months for further review and recommendation. 5. 2/24/12 - 2-19-12 per ATR by P9 3-13-12		
K 070	NFPA 101 LIFE SAFETY CODE STANDARD	K 070			



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NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 HWY 127 NORTH OWENTON, KY 40358	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 070 SS=D	Continued From page 13 Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds with a census of ninety five (95) on the day of the survey. The findings include: Observation, on 01/06/12 at 4:47 PM, with the Maintenance Director revealed a portable space heater located in the Beauty Shop. Interview, on 01/06/12 at 4:47 PM, with the Maintenance Director revealed they were aware the heaters were not permitted in patient care areas, but not aware the heating element could not exceed, 212°F (100°C) when used in non-sleeping staff and employee areas.	K 070	K070 1. The Maintenance Director removed the portable space heater located in the beauty shop on 1/5/12. 2. The Maintenance Director and Life Safety Inspector visually inspected the center on 1/5/12 and did not determine there to be any other portable space heaters in use. In addition, the Maintenance Director completed rounds on 1/30/12 and did not identify any portable space heaters. 3. Administrative, Nursing, Housekeeping, Maintenance, Therapy, and Dietary staff will be re-educated by the Administrator, Director of Nursing Services and/or Staff Development Coordinator regarding not using portable space heaters in the center. 4. The Maintenance Director will complete center rounds monthly for six (6) months to determine that there are no portable space heaters available for use in the center. Any identified portable space heaters will be removed from the center immediately. The Maintenance Director will report findings of rounds for portable space heaters to the Performance Improvement Committee monthly for six (6) months for further review and recommendation.	2-5-12 date by KH training by PB 3-1-12
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No	K 072	5. 2/24/12 2-15-12 per ADR by PB 3-13-12	



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NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 905 HWY 127 NORTH OWENTON, KY 40358
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K 072 Continued From page 14
furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred (100) beds with a census of ninety five (95) on the day of the survey.

The findings include:

Observation, on 01/05/12 between 2:40 PM and 5:30 PM, with the Maintenance Director revealed linen carts, wheelchairs, lifts, and Med carts were being stored in the 100 Long and Short Halls, and the 200 Long and Short Halls.

Interview, on 01/05/12 between 2:40 PM and 5:30 PM, with the Maintenance Director revealed the facility routinely stored linen carts, wheelchairs, lifts, and Med carts in these halls.

Reference: NFPA 101 (2000 Edition)
Means of Egress Reliability 7.1.10.1
Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.

K 147 SS=E NFPA 101 LIFE SAFETY CODE STANDARD

K 072 K072

1. Linen carts, wheelchairs and lifts were moved from center corridors by the Staff Development Coordinator and the Director of Nursing Services on 1/5/12. Medication carts were moved from center corridors on 2/1/12.
2. The Administrator completed center rounds on 2/1/12 to determine that each corridor is free of any obstruction. Any identified concerns were addressed.
3. Administrative, Nursing, Housekeeping, Maintenance, Therapy, and Dietary staff were re-educated by 2/5/12 by the Administrator, Director of Nursing Services, Staff Development Coordinator, Unit Managers and/or Nursing Supervisors regarding maintaining clear exit access in accordance with NFPA standards. The linens are now kept in the clean utility room on the 200 Unit and the clean linen room on the 100 Unit. Wheelchairs not in use are kept in an outside storage building and wheelchairs assigned to residents but not in use are kept in their individual rooms. When not in use lifts are stored in the shower rooms. Med carts are now stored in a designated room on each unit when not in use.
4. Rounds will be completed by the MDS Coordinator, Administrator, Director of Nursing Services, Director of Marketing and Admissions, Nutritional Services Director, Unit Managers, Receptionist,

K 147



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NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 905 HWY 127 NORTH OWENTON, KY 40359
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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 147	<p>Continued From page 15 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred (100) beds with a census of ninety five (95) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 01/05/12 between 2:30 PM and 5:30 PM, with the Maintenance Director revealed:</p> <ol style="list-style-type: none"> 1) Storage in front of unlocked electrical panels located in the Living Room. 2) A blender, bread toaster, and a food processor plugged into a power strip located in the Kitchen. 3) A freezer was plugged into an extension cord located in the Kitchen. 4) Heat tape was plugged into an extension cord in the walk-in freezer to keep the condensate line from freezing. 5) An oxygen concentrator and a resident bed were plugged into a power strip located in room #113. 6) A refrigerator was plugged into a power strip located in resident room #114. 	K 147	<p>Central Supply Clerk, Social Services Director, Activity Staff, Staff Development Coordinator, Health Information Manager, Payroll Coordinator and/or Housekeeping Supervisor three (3) times weekly for four (4) weeks, then weekly for two (2) months, then monthly for three (3) months to determine center maintains clear means of egress including linens, med carts, wheelchairs, and lifts are not stored in the hallways. Any concerns identified will be addressed/corrected immediately. The Administrator and/or Maintenance Director will report results of egress rounds to the Performance Improvement Committee monthly for six (6) months for further review and recommendation.</p> <p>5. 2/24/12 2:19:12 PM Adm by PB 3-13-12</p> <p>K147</p> <p>1. The ottoman was moved from the Living Room electrical panels on 1/5/12 by the Director of Nursing Services. The Maintenance Director installed locks for the Living Room electrical panels on 1/6/12.</p> <p>The Nutritional Services Manager plugged the blender, bread toaster, and a food processor into a standard electrical outlet on 1/5/12.</p> <p>The freezer that was plugged into an extension cord is no longer in use at the center as of 1/27/12 by the Nutritional Services Manager.</p> <p>The heat tape plugged into an extension</p>	
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NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 808 HWY 127 NORTH OWENTON, KY 40369	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 16 7) A refrigerator and a microwave were plugged into a power strip located in the 100 Charting Room. 8) A microwave and a paraffin wax warmer were plugged into a power strip located in the Therapy Room. 9) A refrigerator was plugged into a power strip located in room #204. 10) A refrigerator and a microwave were plugged into a power strip located in the 200 Charting Room. 11) A power strip was plugged into another power strip running through a doorway located in the Housekeeping Office. Interview, on 01/05/12 between 2:30 PM and 5:30 PM, with the Maintenance Director revealed they were not aware of the extension cords and power strips being misused. Further interview revealed they were also not aware of the storage in front of the electrical panels. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet	K 147	cord in the walk-in freezer to keep the condensate line from freezing is no longer in use at the center as of 1/30/12, a drain line heater was installed for this purpose by an electrician on 1/30/12. The oxygen concentrator and bed in room 113 were plugged into a standard electrical outlet on 1/5/12 by the Maintenance Director. The refrigerator in room 114 was plugged into a standard electrical outlet on 1/5/12 by the Maintenance Director. The refrigerator and microwave in the 100 charting room were plugged into a standard electrical outlet on 1/5/12 by the Maintenance Director. The microwave and paraffin wax warmer located in the therapy room were plugged into a standard electrical outlet on 1/5/12 by the Director of Nursing Services. The refrigerator in room 204 was plugged into a standard electrical outlet on 1/5/12 by the Maintenance Director. The refrigerator and microwave in the 200 charting room were plugged into a standard electrical outlet on 1/5/12 by the Maintenance Director. The Maintenance Director removed one of the power strips from the Housekeeping office computer on 1/5/12. 2. Rounds were completed on 2/1/12 by the Maintenance Director to determine there were no electrical code concerns regarding the use of power strips and storage in front of electrical panels.	



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NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 906 HWY 127 NORTH OWENTON, KY 40359
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K 147	Continued From page 17 adapters.	K 147	3. Administrative, Nursing, Housekeeping, Maintenance, Therapy, and Dietary will be re-educated regarding maintaining electrical wiring within accordance with NFPA Standards by the Administrator, Director of Nursing Services, Staff Development Coordinator, Unit Managers and/or Nursing Supervisors by 2/5/12.	
K 211 SS=D	<p>110-26. Spaces</p> <p>About Electrical Equipment, Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 8 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 480.72, 482.41, 483.70, 483.623, 485.623 	K 211	<p>4. The Maintenance Director will conduct weekly audits to determine compliance with electrical code to include the inappropriate use of power strips for four (4) weeks, then twice monthly for two (2) months and then monthly for three (3) months. Identified issues will be addressed immediately. The Maintenance Director will report findings of the audit to the Performance Improvement Committee monthly for six (6) months for further review and recommendations.</p> <p>5. 2/24/12 2-19-12 <i>midnight</i> by PB 3-13-12</p> <p>K211</p> <p>1. The Maintenance Director removed the alcohol based dispenser located adjacent to the light switch in the 100 shower on 1/5/12.</p> <p>2. The Maintenance Director and Life Safety Inspector visually inspected the center to determine that there were not any additional alcohol based dispenser installed over or adjacent to an ignition source in accordance with NFPA Standards on 1/5/12.</p>	



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NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 905 HWY 127 NORTH OWENTON, KY 40389
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K 211	<p>Continued From page 18</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that Alcohol Based Hand Rub dispensers were not installed over or adjacent to an ignition source in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds with a census of ninety five (95) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 01/05/12 at 5:20 PM, with the Maintenance Director revealed an Alcohol Based Hand Rub dispenser was installed over or adjacent to the light switch in the 100 Shower.</p> <p>Interview, on 01/05/12 at 5:20 PM, with the Maintenance Director revealed they were not aware the dispensers were not allowed to be mounted above an ignition source.</p> <p>Reference:</p> <p>Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft 	K 211	<p>3. The Maintenance Director was re-educated on Life Safety Code Standards regarding proper installation of alcohol based hand rub (ABHR) dispenser by the Administrator by 2/5/12.</p> <p>4. The Maintenance Director will audit proper installation of ABHR's in the entire facility weekly times four (4) weeks and then monthly for five (5) months. Identified issues will be addressed immediately. The Maintenance Director will report the results of the findings to the Performance Improvement Committee for further review and recommendations.</p> <p>5. 2/24/12 2:19:12 pm by PB 3-13-12</p>	
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NAME OF PROVIDER OR SUPPLIER OWENTON MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 908 HWY 127 NORTH OWENTON, KY 40369		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 211	Continued From page 19 from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211			

