

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

RECEIVED  
AUG 24 2012  
OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

PRINTED: 08/15/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185361	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  08/02/2012
NAME OF PROVIDER OR SUPPLIER  KINDRED HOSPITAL - LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205		
(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 standard health survey was conducted 07/30/12 through 08/02/12 and a Life Safety Code Survey was conducted and concluded on 07/31/12. Deficiencies were cited with the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	08/24/2012	
F 225 SS=D	This was a Nursing Home Initiative with entrance to the facility at 6:05 PM on 07/30/12. 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged	F 225	<b>How Corrective Action will be accomplished for those affected:</b> Resident # 13 has been discharged.  <b>How Corrective action will be accomplished for those residents having potential to be affected:</b> A head to toe skin assessment has been completed for all residents. Review of event reports over the last couple of months revealed no injury of unknown origin was identified.  <b>What measures will be put in place/ systematic changes made to ensure correction:</b> DNS will in-service all staff on the facilities' Policy and Procedures regarding abuse including injuries of unknown source, investigation and State agency reporting requirements.  During the Licensed nurses' weekly head to toe skin assessments of the residents, any new or areas identified as "unknown origin" will be reported and investigated.  All injuries of unknown origin will be promptly reported to the DNS/Supervisor	08/24/2012	

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

TITLE

(X6) DATE

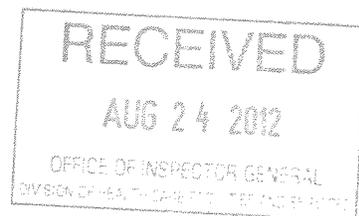
*X* *Amel Bull* *X ED* *8-22-12*

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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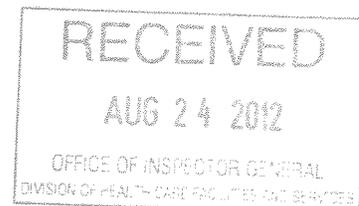
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F 225	<p>Continued From page 1</p> <p>violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to identify an injury of unknown origin and ensure it was reported immediately for one (1) of thirteen (13) sampled residents, Resident #13.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Abuse Prevention, revised 04/28/09, revealed staff were to identify residents most at risk for neglect and abuse.</p> <p>Review of the facility's policy regarding Reporting Suspicion of a Crime, dated 08/05/11, revealed injuries that are not of a serious nature shall be reported not later than 24 hours after forming a suspicion.</p> <p>Review of the facility's policy regarding Protection of Resident During An Investigation, revised 04/28/09, revealed reasonable measures are</p>	F 225	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>upon discovery of the injury. The DNS, Clinical Coordinator or Social Worker will initiate a complete investigation of the occurrence utilizing the facility investigation guidelines.</p> <p><b>How the facility plans to monitor its performance to make sure that solutions are sustained:</b></p> <p>The DNS/Administrator will track and trend all injuries of unknown origin, and subsequent investigations, to ensure completions and appropriateness of actions taken. Results will be reported to the Quality / Performance Improvement Committee monthly for 3 months than at least quarterly to determine progress and identify and additional educational needs. This will be reviewed at the Quality / Performance Improvement Committee with subsequent plan of correction developed and implemented as necessary.</p> <p>The Administrator is responsible for ensuring compliance with this standard.</p>		



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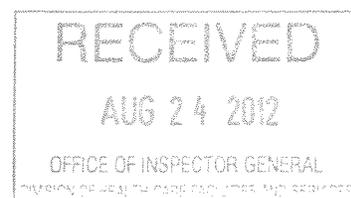
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F 225	<p>Continued From page 2</p> <p>taken to protect a resident during an investigation of abuse, neglect, or misappropriation of resident property, this includes injuries of unknown origin.</p> <p>Review of the facility's policy regarding Conducting an Investigation, revised 06/30/06, revealed Federal regulations requires a facility to have evidence that all allegations of abuse, neglect, and exploitation/misappropriation, including injuries of unknown source, are thoroughly investigated. In addition, the center must take action to prevent further potential abuse while the investigation is in progress.</p> <p>Review of the clinical record for Resident #13 revealed a Patient Transfer Form, dated 06/05/12, which stated Resident #13 was transferred from the Hospital with a dressing and bandages to the right shin for a skin tear. It further identified the resident's bottom as very red. Further record review of the Patient Transfer Form revealed no other skin issues.</p> <p>Continued review of the clinical record revealed the admitting nursing notes on 06/05/12 at 5:10 PM, revealed Resident #13 arrived on the unit asleep. The resident was restless last night and asleep earlier in the shift. The nurse reported the resident was pleasantly confused and hard of hearing. The resident was very content when up in the chair, but often wiggly in bed. The nurse recommend the resident not be up in the chair over 3 hours due to excoriated skin. Further record review revealed no documentation of any bruises or an injury to the right eye.</p> <p>Review of the initial skin assessment completed</p>	F 225		



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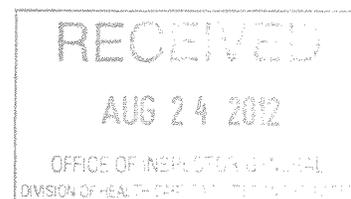
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F 225	<p>Continued From page 3</p> <p>by the Registered Nurse for Resident #13, on 06/05/12, revealed no documentation about the right eye being bruised.</p> <p>Review of the skin assessment completed by the Wound Care Nurse, on 06/07/12 two days after admission, revealed multiple bruised and reddened areas on Resident #13's arms, abdomen, legs, buttocks and right eye. The bruises were noted to be in different stages of healing.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 08/02/12 at 4:23 PM, revealed when she received report from the transferring facility. The nurse talked about Resident #13's bottom could get easily irritated. LPN #3 further stated she did not remember the transferring nurse talking about any other skin issues. LPN #3 stated she could not recall any bruises on the resident or that Resident #13 had a bruise to her right eye. She could only remember the resident laying in bed asleep.</p> <p>Interview with the Wound Nurse, on 08/02/12 at 5:21 PM, revealed she had followed Resident #13 when he/she was admitted to the hospital. The Wound Nurse stated she had not seen the wounds to Res #13's leg before she had taken the pictures on 06/07/12. She further stated no one from the nursing facility had come to her to talk about Resident #13 and any skin issues including bruises or the injury to the right eye.</p> <p>Interview with the Director of Nursing (DON), on 08/02/12 at 2:45 PM, revealed the staff were trained to report bruises or new bruises to the DON, Doctor and Wound Care Nurse. In</p>	F 225			



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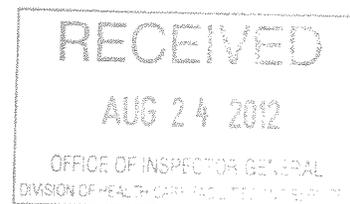
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F 225	Continued From page 4 addition, the Wound Nurse sees all residents upon admission. She stated she was not aware of the pictures taken by the Wound Nurse on 06/07/12 until today. The DON further stated she was not aware of the resident's right eye being bruised or the potential cause; therefore, did not suspect abuse.  Interview with the Administrator, on 08/02/12 at 5:40 PM, revealed she was not made aware of Resident #13's skin concerns until today. The Administrator stated her process was to look at the documentation, and report the condition of the resident on admission to the family and Doctor. She further voiced she would report the findings to the State Agency. The Administrator indicated more harm could have occurred to Res #13, if it was abuse, and they did not complete an investigation.	F 225	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, it was determined the facility failed to implement written policies on abuse as it related to identifying, reporting and investigating injuries of unknown origin for one (1) of thirteen (13) residents, Resident #13.	F 226	<b>How Corrective Action will be accomplished for those affected:</b> Resident # 13 has been discharged.  <b>How Corrective action will be accomplished for those residents having potential to be affected:</b> Any injury of unknown origin and allegations of abuse will be reviewed through the morning report process to ensure that the investigation and reporting process are completed and appropriate interventions have been implemented. The Administrator, or her designee, will review investigations conducted over the past two months to assure full implementation of the facility's policies was achieved. Counseling and in-servicing will be conducted on any	08/24/2012	



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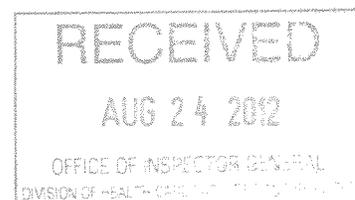
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F 226	Continued From page 5 The findings include:  Review of the facility's policy regarding Abuse Prevention, revised 04/28/09, revealed staff were to identify residents most at risk for neglect and abuse.  Review of the facility's policy regarding Reporting Suspicion of a Crime, dated 08/05/11, revealed injuries that are not of a serious nature shall be reported not later than 24 hours after forming a suspicion.  Review of the facility's policy regarding Protection of Resident During An Investigation, revised 04/28/09, revealed reasonable measures are taken to protect a resident during an investigation of abuse, neglect, or misappropriation of resident property.  Review of the facility's policy regarding Conducting an Investigation, revised 06/30/06, revealed the facility was required to have evidence that all allegations of abuse, neglect, and injuries of unknown origin are thoroughly investigated. The facility was to determine the type of abuse and document the details. The resident was to be evaluated for emotional distress and the impact on psychosocial functioning identified. The description of any injuries; size, color, appearance and location, etc are to be documented. Upon the conclusion of the investigation, a summary report of the findings and conclusions was to be completed and the findings submitted to the State Survey Agency within 5 working days of the initial incident or per state regulations, if applicable.	F 226	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  noted discrepancies.  <b>What measures will be put in place/ systematic changes made to ensure correction:</b> The Administrator, DNS or their designee, will in-service the facility staff on the Abuse Policy with an emphasis on the prevention, intervention and reporting components. The Nurse Education Coordinator will include information on the Abuse Policy with an emphasis on the prevention, intervention and reporting components tin the orientation of new personnel and annual credentialing. The Administrator, or her designee, will review each investigation, at least daily, while it is being conducted to assure full implementation of the policy. Corrective action will be taken for elements found not to be fully implemented.  <b>How the facility plans to monitor its performance to make sure that solutions are sustained:</b> The DNS/Administrator will provide the Quality / Performance Improvement		



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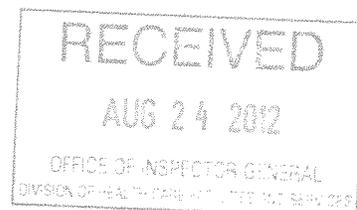
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F 226	Continued From page 6 Review of the clinical record for Resident #13 revealed a Patient Transfer Form, dated 06/05/12, that indicated Resident #13 was transferred from the Hospital with a right shin skin tear and a very red bottom. Further review of the Patient Transfer Form, revealed no other skin issues.  Record review of the Skin assessment completed by the Wound Care Nurse, on 06/07/12 two days after admission, revealed multiple bruised and reddened areas on Res #13's arms, abdomen, legs, buttocks and right eye. The bruises were noted to be in different stages of healing.  Interview with the Director of Nursing (DON), on 08/02/12 at 2:45 PM, revealed the resident had an injury to the eye and there was no documentation of that in the clinical record. She voiced concern that all bruises are investigated; however the staff did not tell her about the bruised eye. They did not witness the cause of the bruised eye nor did the information from the transferring facility identify or explain the bruised eye. If anyone would have told her about the injured right eye she would have completed an investigation. There was no investigation completed to determined if abuse was the cause of the injury to the right eye.  Interview with the Administrator, on 08/02/12 at 5:40 PM, revealed the injury of unknown origin was a reportable incident and she was not aware of the incident until today.	F 226	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  Committee with a monthly report on the audit process of the reporting and investigation of events. The Quality / Performance Improvement Committee will review and recommend actions if necessary.  The Administrator is responsible for ensuring compliance with this standard.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged	F 280	<b>How Corrective Action will be accomplished for those affected:</b> Resident # 13 has been discharged.	8/24/2012



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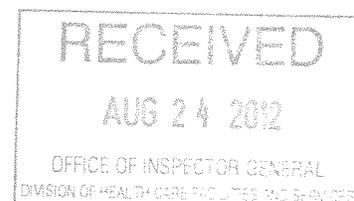
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F 280	<p>Continued From page 7</p> <p>incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, it was determined the facility failed to revise and update the care plan with care cues as it related to restraint use for one (1) of thirteen (13) residents, Resident #13.</p> <p>The findings include:</p> <p>Review of the facility's Restraint Policy, revised 04/28/09, revealed the staff were to assess and care plan for restraint use on an ongoing basis and design interventions to minimize or eliminate the medical symptom and to identify and address any underlying problems causing the medical symptom.</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>How Corrective action will be accomplished for those residents having potential to be affected:</b> The DNS, or her designee, will review the comprehensive care plans of restrained residents and assure that specific needs related to assessment of the skin around the restraint area and removal of restraints every 2 hours to improve circulation and provide range of motion are a component of the care plan interventions.</p> <p><b>What measures will be put in place/systematic changes made to ensure correction:</b> The DNS will in-service the Interdisciplinary Care Team and Nurses on development and updating of comprehensive care plans with an emphasis on the specific needs of restrained residents. The DNS, or her designee, will include this education to the orientation process of newly hired nursing staff.</p> <p><b>How the facility plans to monitor its performance to make sure that solutions are sustained:</b> The DNS, or her designee, will monitor</p>		



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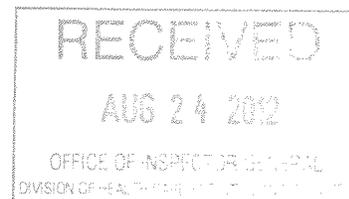
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F 280	<p>Continued From page 8</p> <p>Review of the facility's policy regarding the Comprehensive Plan of Care, revised 05/28/08, revealed a comprehensive plan of care was developed for each resident within seven (7) days after completing the comprehensive assessment. The care plan was re-evaluated and modified: as necessary to reflect changes in care, service and treatments: with significant change of condition assessment. Communication/Implementation; communicate new or changed care plans to members of the interdisciplinary team and to caregivers. Ensure that any care cues are placed appropriately to remind caregivers of the residents' special needs.</p> <p>Interview with the Director of Nursing (DON), on 08/02/12 at 2:45 PM, revealed the nursing staff were to update care plans as needed.</p> <p>Review of the clinical record for Resident #13 revealed the facility admitted the resident on 06/05/12 and a physician's order, dated 06/07/12, specified the staff were to apply mitts to the resident's bilateral hands to prevent pulling out tubes and appliances.</p> <p>Review of the nursing notes, dated 06/07/12 at 6:58 AM, revealed Res #13 was placed in restraints because he/she continued to pull at his/her trach. Review of the nursing notes dated 06/07/12 at 9:52 AM revealed the resident continued to pull on tubes and appliances. The Doctor was notified and ordered mitts to be applied to the resident's bilateral hands to prevent pulling out tubes and appliances.</p> <p>Review of the care plan for Resident #13</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>through resident record review, at least monthly for three months, then at least quarterly, to assure the special needs of restrained residents are addressed. Results of these audits will be reviewed at the Quality / Performance Improvement meeting with subsequent plan of correction developed and implemented as necessary.</p> <p>The Administrator is responsible for ensuring compliance with this standard.</p>	



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185361</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/02/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</b>		
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F 280	<p>Continued From page 9</p> <p>revealed a potential for injury was initiated on 06/07/12. The interventions directed the staff to make sure bilateral mittens were placed on the resident to divert attention away from pulling on lines and tubes. The resident was to be monitored for less restrictive alternative measures on a daily basis. During each round, the staff were to make sure the resident's fingers were guided through the slots appropriately. However, no care cues were added to the process of monitoring to direct the staff to check and assess the skin around the restraint area or to remove the restraints every 2 hours to improve circulation, and provide range of motion.</p> <p>Interview with the Clinical Coordinator, on 08/02/12 at 4:31 PM, revealed the MDS Coordinator was not available for interview. However, the nurses initiate and update the care plans. However, when it comes to the restraint care plans, the nurses must pull care plan items from the restraint section to put in the restraint care plan. She stated if the resident had skin issues, the nurse should have copy/pasted something in the care plan about monitoring of the skin, examples would be to ensure restraints were removed every 2 hours and to check for circulation.</p>	F 280			



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

RECEIVED  
AUG 24 2012  
OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE POLICIES AND SERVICES

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NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL - LOUISVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1313 ST. ANTHONY PLACE LOUISVILLE, KY 40205</b>		
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Plan Approval: 1992</p> <p>Survey under: 2000 existing</p> <p>Facility type: SNF/NF on the third floor of a Hospital.</p> <p>Type of structure: Six (6) stories with Basement, Type II protected construction.</p> <p>Smoke Compartment: Five (5) smoke compartments.</p> <p>Fire Alarm: Complete fire alarm system with heat and smoke detectors..</p> <p>Sprinkler System: Complete automatic (wet and dry) sprinkler system.</p> <p>Generator: Two (2) Type I generators, fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 07/31/12. The skilled nursing facility located on the third floor of Kindred Hospital was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from</p>	K 000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>How Corrective Action will be accomplished for those affected:</b> Koorsen Fire &amp; Security performed the Sensitivity Testing on devices in December 2011, but the supplement paperwork has not been found.</p> <p><b>How Corrective action will be accomplished for those residents having potential to be affected:</b> Koorsen Fire &amp; Security will perform the sensitivity testing again in September 2012 when performing the quarterly fire alarm inspection at Kindred Hospital. All supplement paperwork to support the sensitivity testing will be completed at that time.</p> <p><b>What measures will be put in place/systematic changes made to ensure correction:</b> All supplement paperwork to support the sensitivity testing completed every 2 yrs will be completed at that time. The Director of Plant Operations will keep a copy of the sensitivity report with the quarterly fire alarm inspection forms.</p>	<p>08/06/12 -09/28/12 M3 per phone + email</p>	

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

TITLE

(X6) DATE

*X [Signature]*

*X EO*

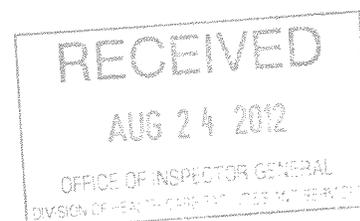
*X 8-22-12*

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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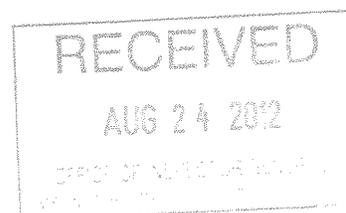
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K 000	Continued From page 1 Fire).	K 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
K 054 SS=F	<p>Deficiencies were cited with the highest deficiency identified at F level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure smoke detectors were inspected and tested according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the five (5) smoke compartments, residents, staff and visitors. The facility had forty-seven (47) certified beds and the census was forty-one (41) on the day of the survey.</p> <p>The findings include:</p> <p>Record review of the fire alarm inspection reports, on 07/31/12 at 11:00 AM, with the Director of Plant Operations revealed no documentation of a Smoke Detector Sensitivity Test being performed on the fire alarm smoke detectors within the time frame required by Code. Smoke detectors must be tested according to NFPA 72 (1999 edition) to ensure their reliability.</p>	K 054	<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>How the facility plans to monitor its performance to make sure that solutions are sustained:</b> The Director of Plant Operations will report results of the fire alarm inspections and the sensitivity testing quarterly to the at the Quality / Performance Improvement Committee.</p> <p>The Director of Plant Operations is responsible for ensuring compliance with this standard.</p>	



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K 054	Continued From page 2 Interview, on 07/31/12 at 11:00 AM, with the Director of Plant Operations, revealed he was unaware the facility did not have a current sensitivity test report on the fire alarm smoke detectors.  Reference: NFPA 72 (1999 edition)  7-3.2.1* Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method	K 054			



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K 054	<p>Continued From page 3</p> <p>(2) Manufacturer ' s calibrated sensitivity test instrument</p> <p>(3) Listed control equipment arranged for the purpose</p> <p>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range</p> <p>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</p> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced.</p> <p>Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced.</p> <p>Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.</p>	K 054			

