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

PRINTED: 06/24/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185396	A. BUILDING _____ B. WING _____	06/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TRANSITIONAL CARE CENTER OF OWENSBORO	811 EAST PARRISH AVENUE OWENSBORO, KY 42303

(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 initiated on 06/07/11. Immediate Jeopardy was determined to exist on 06/07/11 and identified on 06/08/11. A partial extended survey was initiated on 06/09/11 and concluded on 06/10/11. A nurse was observed not cleaning the glucometer after obtaining blood glucose levels on two (2) (Residents #1 and #11) of the eleven (11) sampled residents. Deficiencies were cited at 483.65, F441, Infection Control, at a scope and severity of an "J", 483.25, F309, Care and Services, at a scope and severity of a "D", and 483.35, F371, Dietary Sanitation, at a scope and severity of an "E". The facility provided an acceptable Allegation of Compliance on 06/09/11. The state agency verified Immediate Jeopardy was removed on 06/10/11 as alleged. The deficiency 483.65, F441, Infection Control was lowered to a scope and severity of an "D", while the facility's Quality Assurance monitors glucometer testing and disinfecting.	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309	F309 Resident #5 was potentially affected due to inconsistent documentation of fistula output which impacted MD's ability to accurately calculate residents NPO status. Physician was notified at the time issue of incorrect documentation of drain output was identified. Physician was given opportunity to make any needed changes to patient treatment plan at that time. Clinical Supervisor educated nurses caring	7-4-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

X Joy Everly MSN MPA Administrator x Director Extended Care x 7-12-11

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 309	Continued From page 1 Based on observation, interview, record review and policy review regarding intake and output directions, it was determined the facility failed to ensure physician orders were followed for one (1) of eleven (11) sampled residents. Resident #5's fistula drainage was not consistently recorded by the nursing staff. The findings include: The facility policy on intake and output directions with a revision date of 02/09/10, revealed intake and output is collected and reported every four (4) hours unless otherwise ordered. Example of device related intake/output include but are not limited to a feeding pump, intravenous pump, Jackson Pratt drain, Hemovac, gastrointestinal suction, chest tube, and Foley catheter. Record review for Resident #5 revealed the resident was admitted by the facility on 04/06/11 with the diagnoses of a Jejunostomy (J-tube) tube site infection, Malnutrition, Failure to Thrive, and Chronic Pancreatitis. A physician order dated 04/06/11 stated intake/output should be recorded every eight (8) hours. The resident was NPO (nothing to eat or drink) and was receiving TPN (total parental nutrition). Review of the intake/output sheet dated 05/29/11 recorded revealed two different amounts for the fistula drainage on the night shift. The intake /output sheet dated 05/31/11 and 06/02/11 did not have the fistula output recorded for the day and/or evening shift. Observation of Resident #5, on 06/07/11 at 10:30am, revealed the resident sitting in a chair with the fistula draining into a collection device.	F 309	for resident #5 immediately. Education included correct policy/procedure for measuring and recording patient output (including drain outputs). Documentation audit was performed by Clinical Supervisor to determine compliance to policy for documentation of I & O. Audit results reported to Manager for review/action. Clinical Supervisor addressed non-compliant audit results with staff identified. Clinical Supervisor will perform I & O documentation audits monthly x 4 or until sustained compliance and report audit findings to Manager. Manager will review audit results for further performance issues/further educational needs. TCC Manager will then report results to TCC QA Committee and OMHS Performance Improvement Oversight Committee.	

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F 309	Continued From page 2 Interview with Licensed Practical Nurse (LPN), on 06/08/11 at 1:00pm, revealed the nurse was responsible for emptying and recording the fistula drainage. No explanation was provided as to why the fistula output was not recorded consistently. Interview with the Clinical Supervisor, on 06/07/11 at 3:00pm, revealed the fistula drainage was not consistently or accurately recorded. She stated the output information was important because the physician used this information to determine the intake for Resident #5. Interview with the Physician, on 06/08/11 at 1:00pm, revealed she was concerned the output of the fistula was neither recorded correctly or not at all. She stated she used the output of the fistula to calculate the compliance of the resident's NPO status. The Physician stated if the resident was not compliant, the fistula would be more difficult to heal.	F 309		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371	F371 - None of the 25 residents were found to be affected. To address the deficient sanitary food practice the following corrective action was taken by the Assistant Director/Patient Service and Executive Chef: all production staff received a training/inservice via lecture and visual printed material on correct procedures for storing food. This training included proper covering, labeling, dating of food and the food service policy 8052-208 which addresses "Using Leftover Foods". Policy "Using Leftover Foods" (8052-208) was revised to include more detailed procedures for labeling, dating and discarding expired foods as	7-4-11

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F 371	Continued From page 3 Based on observation and interview, it was determined the facility failed to store food properly, and failed to maintain sanitary conditions when serving food and operating the dishwasher at the required temperature. The facility had expired food and food not covered properly in the refrigerator. The dietary staff did not have their hair completely covered when serving food. The dishwasher was not at the proper temperature during a washing cycle. The findings include: Observation of the kitchen, on 06/07/11 at 9:00am, revealed expired bread pudding dated 05/29/11 and expired orange fluff dated 05/26/11. The bake shop freezer contained a cake under the freezer fan that was partially covered with plastic wrap. Interview with the Dietary Supervisor, on 06/07/11 at 9:30am, revealed the kitchen bake shop staff should have removed the expired food. The cake should have been covered securely. She stated expired food could pose a health hazard. Observation, on 06/08/11 at 11:30am, revealed two (2) employees serving food on the tray line with hair not completely covered. The Assistant Dietary Manager witnessed one employee with their hair not completely covered and did not ask the employee to cover their hair. Interview with the Assistant Director of Food Services, on 06/08/11 at 11:45am, revealed staff should completely cover their hair while in the kitchen.	F 371	F 371 CONTINUED well as storing, reheating, and use of unused Portions of Food. Policy 8052-208 revision was approved by Food Service Director and Executive Chef. A daily log was created to monitor proper storage and handling of leftover food. A food service staff member is assigned daily to monitor compliance, discard expired food, and complete the log. Audit of log is done monthly per executive chef for compliance of process/policy. All production staff has been educated. All staff completed the education and competency was validated by passing a post test. Staff will be tested bi-annually and newly hired employees will be educated and required to pass the post test before beginning their first scheduled shift. To address the deficient dishwasher practice corrective action was taken by the Assistant Director/Patient Service, Executive Chef, Retail Manager and Patient Service Supervisor. Inservice/training was provided via discussion, printed material and opportunity for question/answer to all staff on the requirement for hair covering (including beards) for all staff working in areas where food is prepared/served. Food Service policy 8052-502 addresses "Hair Covering in Food Service Area" and was approved by Food Service Director and Assistant Director/Patient Service. A log was developed for Supervisor to monitor via observation and document policy compliance on a daily basis.	

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F 371	Continued From page 3 Based on observation and interview, it was determined the facility failed to store food properly, and failed to maintain sanitary conditions when serving food and operating the dishwasher at the required temperature. The facility had expired food and food not covered properly in the refrigerator. The dietary staff did not have their hair completely covered when serving food. The dishwasher was not at the proper temperature during a washing cycle. The findings include: Observation of the kitchen, on 06/07/11 at 9:00am, revealed expired bread pudding dated 05/29/11 and expired orange fluff dated 05/26/11. The bake shop freezer contained a cake under the freezer fan that was partially covered with plastic wrap. Interview with the Dietary Supervisor, on 06/07/11 at 9:30am, revealed the kitchen bake shop staff should have removed the expired food. The cake should have been covered securely. She stated expired food could pose a health hazard. Observation, on 06/08/11 at 11:30am, revealed two (2) employees serving food on the tray line with hair not completely covered. The Assistant Dietary Manager witnessed one employee with their hair not completely covered and did not ask the employee to cover their hair. Interview with the Assistant Director of Food Services, on 06/08/11 at 11:45am, revealed staff should completely cover their hair while in the kitchen.	F 371	F 371 CONTINUED Non-compliance will be immediately addressed when observed. All staff completed the inservice/training and competency was validated by passing a post test. All staff signed a roster indicating competency. Staff will be tested bi-annually. Inservice/training was added to the new hire orientation agenda. Audit results will be submitted weekly To Patient Service Supervisor for review/analysis of compliance. 6/9/11 None of the 25 residents were found to be affected. To address the deficiency corrective action was implemented by the Assistant Director/Patient Service, Executive Chef, and Patient Service Supervisor. Inservice/training was provided to all staff with dishwasher responsibility via discussion, printed material and opportunity for question/answer. The inservice/training agenda included "Quality Control Measure Policy: Dishwasher Temperature" #8052-504 review, ensuring correct temperature for safely sending dishware through dishwasher, and a step by step dishwasher operation. Step by step dishwasher operational information was posted for reviewing as needed to operate the dishwasher. This information contains pictures and identifies area to fill, temperature gauges and run buttons. Return demonstration was utilized to ensure staff could correctly set dishwasher temperature within the required	

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F 371	Continued From page 4 Observation of the dishwasher, on 06/08/11 at 12:00pm, revealed the dishwasher did not reach the required temperature during the start of a washing cycle. The gauge was marked for the required temperature. Interview with the Dietary Worker, who was starting the dishwasher, on 06/08/11 at 12:00pm, revealed he was not aware the dishwasher should reach a required temperature. He stated he had been operating the dishwasher for eight (8) months and had not received training regarding the operation of the dishwasher. Interview with the Assistant Director of Food Services, on 06/08/11 at 12:00pm, revealed she did not have training records for the employee who was operating the dishwasher. She acknowledged running the dishwasher at a lower temperature could result in the dishes etc. not being properly sanitized and potentially causing food borne illnesses.	F 371	F 371 CONTINUED range. All staff completed the Inservice/training and competency was validated by passing a post test. This training/inservice has been added to the new hire orientation agenda. Food Service policy for "Quality Control Measure Policy: Dishwasher Temperature" 8052-504 was approved by Food Service Director and Assistant Director/Patient Service. To sustain compliance all staff will review policies and successfully pass post test on a quarterly basis. Supervisor will perform random observation monitoring to ensure dishwasher temperature is within required range. If temperature is found out of range immediate corrective action will be taken. Immediate feedback/review of correct procedure will be provided.	
F 441 SS=J	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	F441 – Residents #1 and #11 had potential to be affected due to the possible transmission of infection. Both identified residents were assessed by clinical supervisor and presented with stable v/s and no s/s of infection that might be related to non-cleaning of the glucometer. As a result of these findings, Residents #1 and #11 were found not to be affected. All residents identified to have orders for chemstrips were assessed by clinical supervisor and presented with stable v/s and no s/s of infection that might be related to non-cleaning of the glucometer. All residents identified were assessed every shift	7/4/11

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F 441	Continued From page 5 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the Glucometer and the Reusable Equipment policy, it was determined the facility failed to have an effective system to ensure infection control policies were implemented for two (2) (Residents #1 and #11) of the eleven (11) sampled residents. The glucometer was not cleaned after blood glucose levels were obtained on Resident #1 and #11. Immediate Jeopardy was determined to exist on 06/07/11 and identified on 06/08/11. The facility's failure to	F 441	per nursing staff with any abnormal vital signs / signs & symptoms of infection reported to MD for appropriate follow-up. Documentation audits performed by Clinical Supervisors on residents with potential to have been affected by deficient practice to ensure residents had no documented signs / symptoms of infection during their stay on the Transitional Care Center (TCC). Audit findings reported to Manager for review/follow-up. Audit results then submitted to TCC QA committee and OMHS performance improvement oversight committee for review/follow-up. Staff have been educated on policy. • Staff have read newly revised policy with proper cleaning instructions including the lens, test strip holder with 10% bleach solution (example: Dispatch) and exterior surface with hospital approved disinfectant (examples: Sani-wipes/Cavi-wipes). • Competency testing was performed with all Transitional Care Center Staff who perform blood glucose monitoring • Competency testing tool has been developed and includes: • Gloves will be worn during cleaning processes	

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F 441	Continued From page 6 provide adequate cleaning of the glucometers placed residents at risk for infection and placed residents in a situation that is likely to cause serious injury, harm, impairment, or death to a resident. The facility provided an acceptable Allegation of Compliance (AOC) on 06/09/11. The state agency verified Immediate Jeopardy was removed on 06/10/11. The deficiency 483.65, F441, Infection Control was lowered to a scope and severity of an "D". The findings include: The facility policy on reusable equipment with a revision date of 02/01/11, stated patient care reusable items shall be decontaminated between each resident use with a hospital disinfectant. The facility policy on the SureStepFlexx Whole Blood Glucose Testing, with a revision date of 07/13/10, stated the glucose monitor shall be cleaned at least once every twenty four (24) hours. The monitor will be cleaned according to manufacturer's recommendation in the operator's manual. Keypoint: Use a moist cloth to wipe the machine clean. A cloth with ten percent 10% bleach solution may be used when indicated. To clean the test strip holder, remove from the machine and clean with ten percent (10%) bleach solution and cotton swab. The test strip holder should stay moist for one (1) minute. The SureStepFlexx Whole Blood Glucose Testing manual, dated 2002, stated clean the meter if dirt, blood, or lint is present, when an error message appears indicating the meter may need to be	F 441	• The bedside blood glucose device shall be decontaminated between each patient use • Proper cleaning will be demonstrated by Educator/Supervisor, Manager Transitional Care Center in collaboration with Clinical Supervisors Transitional Care Center/Extended Care Educator • Staff successfully completed (score 100%) written competency test • Staff returned demonstration of cleaning bedside blood glucose device per policy for trainer • Staff successfully completed the post-test and demonstration signed a roster indicating competency • Staff remediated until competency was proven • Staff who are unable to demonstrate competency were not allowed to work • Staff completed the required competency validation by 06/09/2011 or before next scheduled shift for those on current FMLA/vacation monitoring and Evaluation Method	

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F 441	Continued From page 7 cleaned, and as defined by your institution's infection control policies. The manual stated, clean the outside of the meter with a cloth dampened with a ten percent (10%) bleach solution. Follow with a cloth moistened with water to remove residual bleach. Dry the meter thoroughly. Refer to cleaning agents listed in the manual for other solutions that can be used to clean the outside of the meter. Clinical record review for Resident #11, revealed the facility admitted the resident on 06/02/11 with the diagnoses of Peripheral Vascular Disease, Hypertension, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Insulin Dependent Diabetes Mellitus and a recent amputation of the right lower extremity. The resident was ordered Humalog Insulin per sliding scale (adjusted dose to cover elevated blood sugars). Clinical record review for Resident #1, revealed the resident was admitted by the facility on 04/08/11 with diagnoses of a Compression Fracture of the Lumbar Spine, Chronic Obstructive Pulmonary Disease, and Insulin Dependent Diabetes Mellitus. The resident was ordered Humalog Insulin via sliding scale (dose is adjusted to cover elevated blood sugars). Observation of Registered Nurse (RN #7), on 06/07/11 at 6:30am, revealed the nurse entered Resident #11's room and performed the blood glucose test. She identified the resident, scanned the meter to her badge and the resident's identification bracelet, wiped off the resident's finger with alcohol, donned gloves, did the finger stick, and placed a drop of blood onto the strip.	F 441	• Observation audit tool was developed and included the following monitoring and evaluation method: • Transitional Care Center Clinical Supervisors/Extended Care Educator will perform 20 observations (divided among all shifts) per week X 4 weeks, then 20 observations per month X 3 months for a sustained compliance of 100% • Audit results will be submitted weekly to department manager of Transitional Care Center in collaboration with Transitional Care Center Clinical Supervisors/Extended Care Educator. Manager will report audit results to Transitional Care Center QA Committee and to OMHS Performance Improvement Oversight Committee. • Observations of any staff non-compliance will result in appropriate disciplinary action	

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F 441	Continued From page 8 She obtained the reading of one hundred (100) and placed the needle in the sharps container. RN #7 placed the glucometer in her uniform pocket until she entered the medication room where she placed the glucometer directly onto the charger base. Observation of RN #7, on 06/07/11 at 7:00am, revealed she entered the medication room and retrieved the glucometer. She proceeded into the room of Resident #1 and performed a blood glucose level. She then proceeded to the medication room and placed the glucometer onto the charger base. Interview with RN #7, on 06/07/11 at 7:10am, revealed she did not clean the glucometer before placing it in the charger. She stated she cleaned the glucometer between some residents, however not between each resident. The RN stated the policy of the facility was to clean the glucometer between each resident with the facility disinfectant. She acknowledged the glucometer could potentially spread infection if not cleaned properly between residents. Interview with the Unit Manager, on 06/07/11 at 7:35am, revealed her expectation would be the glucometer would be cleaned after obtaining a blood glucose level. She stated the nurse should not have placed the glucometer in her pocket after obtaining the blood glucose. The Unit Manager explained it was the facility policy to clean the glucometer after obtaining the blood glucose sample. An interview conducted with the Infection Preventionist, on 06/06/11 at 7:50am, revealed	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185396	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 06/10/2011
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 811 EAST PARRISH AVENUE OWENSBORO, KY 42303	

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F 441	Continued From page 9 the glucometer was to be cleaned every shift unless contaminated. She admitted there was a discrepancy between the glucometer cleaning policy and the reusable equipment policy. Her expectation would be the glucometer should be cleaned after obtaining the blood glucose sample, because all residents could potentially carry an organism. She stated the reusable equipment policy indicated the equipment should be decontaminated after each resident use and the glucometer would be considered reusable equipment. The facility's AOC included the following and was verified by the state agency: 1. Review of the revised policy, dated 06/08/11, on the SureStepFlexx Whole Blood Glucose Testing included: the exterior surface shall be decontaminated between each resident use with a hospital approved disinfectant, example "Sani-Cloth Plus or Cavi Wipes" (for C-diff residents, must use ten percent (10%) bleach solution example "Dispatch" towelette. Gloves shall be worn during the cleaning policy. 2. Review of the staff education records revealed all staff who perform blood glucose testing were inserviced on the revised cleaning policy, dated 06/08/11, and competency tests were completed on 06/09/11. 3. Continued review of the education records revealed staff performed a return glucometer cleaning demonstration on 06/08/11. 4. An audit tool was developed for exterior and interior glucometer cleaning to be completed	F 441		

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F 441	Continued From page 10 using a random sample of staff. The facility completed ten (10) random observations with 100% compliance, on 06/09/11. 5. All diabetic residents were assessed from 06/07/11 through 06/09/11 for any conditions/diseases that would compromise their immune system and for any signs or symptoms of infection that may be related to non-cleaning of the glucometer. Interviews with staff on 06/09/11 revealed they were knowledgeable regarding the revised cleaning policy. The staff, which included Licensed Practical Nurse #2 and #3, Registered Nurse #4, #5, #7 and #9, and Nursing Assistant #1 and #3 stated the glucometer was to be cleaned after each resident use with Sani-wipes or Cavi cloths unless the resident has C-diff which requires a ten percent (10%) bleach solution. Observations on 06/09/11 revealed staff Licensed Practical Nurse #2 and #3, Registered Nurse #4, #5, #7 and #9, and Nursing Assistant #1 and #3 did clean the glucometer after each resident use according to the new policy. The state agency reviewed the revised cleaning policy and the audit tool that was developed to ensure staff compliance. Record review revealed the facility completed ten (10) random observations with 100% compliance. Interview with the Unit Manager on 06/09/11 revealed no diabetic residents had been adversely affected by the glucometer not being cleaned.	F 441		

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	185396		06/10/2011

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F 441	Continued From page 11 The facility provided an acceptable Allegation of Compliance (AOC) on 06/09/11. The state agency verified the Immediate Jeopardy had been removed prior to exit on 06/10/11. The deficiency 483.65, F441, Infection Control was lowered to a scope and severity of an "D" while the facility's Quality Assurance monitors glucometer testing and disinfecting.	F 441		

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	185396	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/07/2011

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K 000	INITIAL COMMENTS A Life Safety Code Survey was initiated and concluded on 06/07/2011. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".	K 000		
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 interview and record review it was determined the facility failed to ensure fire drills were conducted at unexpected times under varied conditions. The deficiency had the potential to affect all smoke compartments, staff and residents. The facility is licensed for thirty (30) beds with a census of twenty five (25) residents on the day of the survey. The findings include: Record review on 06/07/11 at 11:20 AM with the Safety and Security Representative revealed the fire drills were not being conducted at unexpected times under varied conditions.	K 050	**K050** None of the 25 residents were found to be affected. 1. The Corporate Safety and Security Manager in-serviced (read and sign) the Facility Supervisors (who conduct the fire drills) on NFPA Standard 101 19.7.1.2. Which states, "fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts" For this unit varied conditions are times such as meal times, activity times, etc. 2. Monthly logs are kept which document fire drill times/locations and critiques of drills. These logs are submitted to the Corporate Safety and Security Manager who then reviews log data monthly to ensure drills occur at unexpected times and are under varied conditions on all shifts. This data is then reported to the OMHS Environment of Care Committee for further review and to ensure sustained regulatory compliance.	7/4/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

X [signature] NSMNPA Administrator X Director Extended Care 7-12-11

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	Continued From page 1 Interview, on 06/07/11 at 11:20 AM, with the Safety and Security Representative revealed that he was unaware that 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.	K 050		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system according to NFPA standards. The deficiency had the potential to affect all smoke compartments, residents, staff and visitors. The facility is licensed for thirty (30) beds with a census of twenty five (25) the day of the survey. The Findings Include: Observation on 06/07/11 at 10:35 AM, with the Construction Coordinator revealed that the facility failed to provide a sprinkler head wrench per	K 062	**K062** 1. There were no residents affected by this finding. A sprinkler head wrench was placed in the cabinet on 6/8/2011 by the biomed department. 2. There were no residents affected by this finding. A sprinkler head wrench was placed in the cabinet on 6/8/2011 by the biomed department. 3. The biomed manager and maintenance manager will in-service (read and sign) their respective staffs by July 4th, 2011 on NFPA Standard 13, 6.2.9.6. Which states, "A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. One	7-4-11

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K 062	Continued From page 2 NFPA requirements. Interview, on 06/07/11 at 10:35 AM, with the Construction Coordinator confirmed the observation. Reference: NFPA 13 6.2.9.6 A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. One sprinkler wrench shall be provided for each type of sprinkler installed.	K 062	sprinkler wrench shall be provided for each type of sprinkler installed". 4. Quarterly inspections will be conducted to assure that the wrench remains in the cabinet. Results will be reported to the Environment of Care Committee Meetings.	
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the installed fire extinguishers to be free of obstructions. The deficient practice affected one (1) smoke compartment, staff and all residents. The facility is licensed for thirty beds (30) with a census of twenty five (25) the day of the survey. Findings include: Observation on 06/07/11 at 10:15 AM with the Safety and Security Representative revealed that the portable fire extinguisher located in the 3-3 Hall Nurses Station was mounted over a work	K 064	**K064** 1. There were no residents affected by this finding. The fire extinguisher will be relocated, by July 4th, 2011, to an area that complies with the unimpeded access requirement. 2. There were no residents affected by this finding. All other extinguishers were checked and were found to be in compliance. 3. The Security Department conducts monthly inspections of fire extinguishers. The Security Staff will be in-serviced (read and sign) by the Security Supervisor to ensure that installed fire extinguishers are free from obstruction. It will be noted that if staff find an	7-4-11

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K 064	Continued From page 3 counter. Interview, on 06/07/11 at 10:15 AM, with the Safety and Security Representative revealed that he was not sure why the portable fire extinguisher had been mounted over the work counter. Reference: NFPA 10 6.2.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected, manually or by electronic monitoring, at more frequent intervals when circumstances require. 6.2.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Operating instructions on nameplate legible and facing outward (4)* Safety seals and tamper indicators not broken or missing (5) Fullness determined by weighing or " hefting " (6) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (7) Pressure gauge reading or indicator in the operable range or position (8) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (9) HMIS label in plac Reference NFPA 10 (1998 Edition).	K 064	extinguisher obstructed, they must remove the obstruction immediately. 4. Security Staff will continue to conduct monthly inspections of the fire extinguishers. The inspections will be reported to the Environment of Care Committee.	

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K 064	Continued From page 4 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064		
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 according to NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, residents, staff and visitors. The facility is licensed for thirty (30) beds with a census of twenty five (25) on the day of the survey. Observation on 06/07/11 at 9:37 AM, with the Safety and Security Representative, revealed a space heater being used in the MDS Coordinator	K 070	K070 1. There were no residents affected by this finding. During the tour on 6/7/2011, a portable space heater was found in the MDS office. The facility had no specific documentation that this specific heater complied with OMHS policy #8060-508, requiring that the "Maximum temperature of space heaters must not exceed 212 degrees F. The space heater was immediately removed from the office. 2. There were no residents affected by this finding. A thorough inspection of the unit followed verifying no other non-compliant space heaters.	7-4-11

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K 070	Continued From page 5 Office. Interview, on 06/07/11 at 9:37 AM, with the Safety and Security Representative revealed he was unaware that portable heaters could not exceed 212 degrees. The facility had no documentation for the heater, listing its temperature range. The space heater was immediately removed from the office. Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).	K 070	3. Policy #8060-508 (Basic Electrical Equipment Safety Guidelines will be reviewed and read by all applicable (office staff) TCC staff, by July 4th, 2011. An emphasis was placed on the section "Guidelines for Use of Personal Electrical Heaters. 4. The Transitional Care Manager or designee will conduct rounds weekly to monitor for the use of electronic space heaters to ensure they are in compliance.	
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the generator sets by NFPA standards. This deficient practice has the potential to affect all smoke compartments, staff, and all the residents. The facility is licensed for thirty (30) beds with a census of twenty five (25)	K 130	**K130** 1. There were no residents affected by this finding. The identified corrosion was cleaned on 6/7/2011. 2. There were no residents affected by this finding. The identified corrosion was cleaned on 6/7/2011. 3. The maintenance staff currently conduct preventive maintenance work orders every month on the generators. One of the tasks is to "check the batteries for fluid level and excessive corrosion". The	7-4-11

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K 130	Continued From page 6 the day of the survey. The findings include: Observation on 06/07/11 at 10:45 AM with the Safety and Security Representative and the Construction Coordinator revealed that three (3) of six (6) generator sets had batteries with corrosion on the battery terminals. Interview, on 06/07/11 at 10:45 AM, with the Safety and Security Representative and the Construction Coordinator revealed that they were unaware of the corrosion on the battery terminals. Reference: NFPA 110 (1999 Edition).	K 130	maintenance manager will re-educate applicable staff on the proper procedure on what to look for when they conduct preventive maintenance on the generators. 4. The Corporate Safety and Security Manager will monitor the reports, for three months, once completed to ensure compliance. The information will be reported to the Environment of Care Committee.	
K 141 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to properly mark areas that contained oxygen storage in the event of an emergency or a fire. The deficiency had the potential to affect all smoke compartments, staff and residents. The facility is licensed for thirty (30) beds with a census of twenty five (25) on the day of the survey.	K 141	K141 1. There were no residents affected by this finding. The two storage closets stored oxygen were found without a sign indicating oxygen was stored in the room. Signs indicating oxygen is being stored in the rooms were place on the doors on June 30, 2011. 2. There were no residents affected by this finding. During the tour on 6/7/2011, no other areas were found where oxygen was being stored. 3. The TCC staff will be educated on the need to only store oxygen in the	7-4-11

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K 141	Continued From page 7 The findings include: Observation during the Life Safety Code Inspection on 06/07/11 at 9:40 AM, with the Safety and Security Representative revealed two (2) storage closets with oxygen storage. The door to the storage room did not have a sign indicating oxygen was stored in the room. Interview, on 06/07/11 at 9:40 AM, with the Safety and Security Representative revealed he had not noticed the signs on the doors to the room where oxygen was stored, had been removed. NFPA: 99, 1999 8-6.4.1.7 All labeling shall be durable and withstand cleansing or disinfection. 8-6.4.2* Signs. Precautionary signs, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed wherever supplemental oxygen is in use, and in aisles and walkways leading to that area. They shall be attached to adjacent doorways or to building walls or be supported by other appropriate means.	K 141	two rooms designated to store oxygen. 4. The TCC Manager or designee will conduct weekly rounds of the department to ensure that oxygen cylinders are stored in the proper areas.	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	K147 1. There were no residents affected by this finding. The power strips found to be out of compliance were removed from the department on June 30, 2011.	7-4-11

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THE TRANSITIONAL CARE CENTER OF OWENSBORO	811 EAST PARRISH AVENUE OWENSBORO, KY 42303

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K 147	Continued From page 8 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 according to NFPA standards. This deficient practice affected all smoke compartments, including residents, staff, and visitors. The facility is licensed for thirty (30) beds with a census of twenty five (25) the day of the survey. The findings include: Observations on 06/07/11 between 9:30 AM and 11:30 AM with the Safety and Security Representative revealed: (1) Glucose Meters plugged into a power strip located in the Med Room listed as Staff Only in the 3-2 Hall. 2) A refrigerator plugged into a power strip located in the Managers Office located in 3-3 Hall. 3) A refrigerator, two (2) Med Cart chargers, and a Glucose Meter were plugged into a power strip located in the Med Room in the 3-3 Hall.	K 147	2. There were no residents affected by this finding. The entire department was inspected on June 30th, 2011, and no other areas were found to be out of compliance in regards to electrical standards. 3. The Maintenance Manager will in-service (read and sign) maintenance staff, by July 4th, 2011, on NFPA 99 3-3.2.1.2 D. This states "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 adapters". 4. The TCC manager or designee will conduct weekly rounds to monitor for improper use of power strips. If any strips are found to be non-compliant, they will be removed immediately.	
	4) Item were being stored in front of electrical panels located in the Med Room in the 3-3 Hall. 5) A Difibrillator, Crash Cart charger, and a suction pump, were plugged into a power strip located in the Nurses Station in the 3-3 Hall. 6) A bath bag warmer, and a DynaMap charger plugged into a power strip located in the clean			

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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 06/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185396	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 147	Continued From page 9 utility room, in the 3-3 Hall. Interview, on 056/07/11, with the Safety and Security Representative confirmed all observations. 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 adapters. Reference: NFPA 70 (1999 edition) 110-26. Spaces 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.	K 147		

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