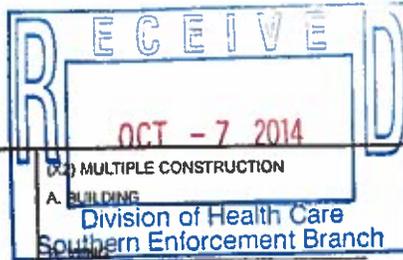


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 09/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185273	(X2) MULTIPLE CONSTRUCTION A. BUILDING Division of Health Care Southern Enforcement Branch	(X3) DATE SURVEY COMPLETED 09/04/2014
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NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11 BOONEVILLE, KY 41314
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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
F 000	INITIAL COMMENTS	F 000	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.	
F 323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of the facility's policies, it was determined the facility failed to maintain safe water temperatures below 110 degrees Fahrenheit in eight (8) of fifty-one (51) resident rooms and one (1) of two (2) shower rooms.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Resident Water Temperature Monitoring," (not dated) revealed the facility would provide residents' water at an appropriate temperature and according to the recommendations of state and federal guidelines.</p> <p>Review of the Kentucky Administrative Regulation (KAR) 902 KAR 20:046 revealed "maximum water temperature of 110 degrees Fahrenheit" was required.</p>	F 323	<p><u>F 323 (SS=E) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</u></p> <p><i>Corrective Action for Residents Found to Have Been Affected:</i></p> <p>All hot water temperatures are routinely maintained between 106-110 degrees Fahrenheit in resident rooms 119, 115, 114, 127, 219, 108, 217, 216, West Wing shower room, and men's restroom located near Administrator's office. The Circulating Pump was replaced on 9/4/2014 and maintains the hot water temperatures between 106-109 degrees Fahrenheit.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Whitney Lyatts* TITLE: *Administrator* (X5) DATE: *10/7/14*

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

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NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11 BOONEVILLE, KY 41314		
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F 323	Continued From page 1 Observations conducted on 09/02/14 at 4:14 PM revealed the hot water temperature in resident room 108 was 122 degrees Fahrenheit (F) (12 degrees higher than the acceptable maximum temperature of 110 degrees Fahrenheit). Further observation on 09/02/14 from 4:26 PM through 4:47 PM revealed the water temperature at resident room sinks were as follows: resident room 119 was 112 degrees F; resident room 115 was 116 degrees F; resident room 114 was 118 degrees F; resident room 127 was 116 degrees F; resident room 219 was 114 degrees F; resident room 217 was 116 degrees F; and resident room 216 was 116 degrees F. Observation on 09/02/14 at 4:48 PM revealed the mixing valve at the hot water heater read at 134 degrees F. Further observations with the Maintenance Director on 09/02/14 at 4:53 PM revealed the hot water in the men's restroom located near the Administrator's office was 118 degrees F and the water at the sink in resident room 102 at 4:55 PM was 118 degrees F; resident room 108 at 4:57 PM was 118 degrees F; and at 4:59 PM, the water in the Shower Room sink on West Wing was 112 degrees F. Review of the facility's "Water Temperature Log Check Daily" sheet completed in 2014 in June, July, August, and 09/01/14 thru 09/02/14 revealed the facility documented the hot water temperatures had been within normal range of 100 to 110 degrees F. Interview conducted with the Maintenance Director on 9/02/14 at 5:05 PM, revealed the Maintenance Director "was not aware the water temperatures were too high," and stated he had	F 323	Identification of Other Residents Having the Potential to be Affected: All residents have the potential to be affected. On 9/5/2014, the Maintenance Director checked hot water temperatures in all resident rooms, all resident bathrooms, and any area that residents have access to. The hot water temperatures are maintained at 106-109 degrees Fahrenheit, the Circulating Pump was replaced on 9/4/2014 and maintains the hot water temperatures between 106-109 degrees Fahrenheit. Measures or Systemic Changes Made to Avoid Reoccurrence: The Circulating Pump on the hot water heater was replaced on 9/4/2014 and maintains the hot water temperatures between 106-109 degrees Fahrenheit. On 9/5/2014, staff was educated on water temperatures and how to immediately report any observed changes in water temperatures. The Maintenance Department		

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F 323	Continued From page 2 not identified any problems. According to the Maintenance Director, "apparently" the mixing valve had gone bad.	F 323	completes daily checks to assure that water temperatures are maintained according to (KAR) 902 KAR 20:046.		
F 456 SS=E	<p>An interview conducted with the Administrator and Director of Nursing (DON) on 09/02/14 at 5:14 PM revealed they were unaware of any concerns with elevated water temperatures.</p> <p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to ensure one (1) of two (2) freezers was in safe operating condition. Observation on 09/02/14 revealed a buildup of ice on the ceiling and fan unit of the walk-in freezer located in the kitchen.</p> <p>The findings include:</p> <p>Review of the policy, "Frozen Food," (not dated) revealed frozen food would be stored in a manner that would allow cold air to circulate around the products.</p> <p>Review of the policy, "Facility Maintenance Work Order Policy," (not dated) revealed employees were responsible to complete work orders for any equipment or maintenance concern.</p> <p>Review of the policy, "Cleaning Schedules,"</p>	F 456	<p><i>Plans to Monitor Performance for Sustained Solutions</i></p> <p>The Administrator will check the water temperature log completed by the Maintenance Department on Monday of each week. The Administrator will review these audits with the Quality Assurance Committee that meets monthly for recommendations and follow-up.</p> <p><u>F 456 (SS=E) 483.70 (c) (2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</u></p> <p><i>Corrective Action for Residents Found to Have Been Affected:</i></p> <p>On 9/23/2014 the freezer gasket was replaced. The installation of this freezer gasket eliminated the ice build-up cited in F 456.</p>	10-3-2014	

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F 456	<p>Continued From page 3</p> <p>(dated 11/15/00) revealed the employee would initial the cleaning schedule to indicate the cleaning was completed and the Dietary Manager or designee would initial that the cleaning was completed.</p> <p>Observation during the kitchen tour on 09/02/14 at 12:30 PM revealed the walk-in freezer had a buildup of ice on the ceiling and the fan unit. There was an icicle on the freezer's fan unit approximately 3 inches in length, and ice buildup on the ceiling above the fan unit. Observation revealed the temperature of the walk-in freezer was 0 degrees Fahrenheit.</p> <p>Observation of the facility's cleaning schedule revealed staff was to clean the walk-in freezer every other day to remove ice buildup. Review of the schedule was conducted and revealed the walk-in freezer had been cleaned, and the ice buildup removed, on 09/01/14 (one day prior to the observation conducted on 09/02/14) by Dietary Employees #2 and #3.</p> <p>Interview with Dietary Workers #1, #2, and #3 on 09/04/14 at 1:12 PM revealed the staff cleaned the walk-in freezer every other day to remove the ice buildup on the ceiling of the freezer. According to Dietary Workers #1, #2, and #3, the removal of the ice was on the routine cleaning schedule for the freezer.</p> <p>Interview with the Dietary Manager (DM) on 09/02/14 at 6:00 PM revealed the buildup of ice on the ceiling and the fan of the walk-in freezer unit had occurred for "a while," and a cleaning schedule to remove the ice every other day had been developed and implemented by facility staff. The Dietary Manager stated the temperature of</p>	F 456	<p>Identification of Other Residents Having the Potential to be Affected:</p> <p>All residents have the potential to be affected. (See the corrective action for residents found to have been affected above.)</p> <p>Measures or Systemic Changes Made to Avoid Reoccurrence:</p> <p>On 9/23/2014 the freezer gasket was replaced. On 9/9/2014 Dietary staff was educated related to the reporting of repairs. The Maintenance Department checks all freezers in dietary department daily to assure that the freezers are working correctly and there is no ice build-up.</p>	

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F 456	<p>Continued From page 4</p> <p>the freezer had been maintained at acceptable temperatures and, therefore, the DM had not reported the buildup of ice to the Maintenance Department.</p> <p>Interview with the Maintenance Supervisor on 09/04/14 at 1:30 PM revealed an "outside" company performed maintenance for the walk-in freezer. According to the Maintenance Supervisor, staff monitored the temperatures of the walk-in freezer on a daily basis, had not reported any problems with the freezer and, as a result, maintenance staff had not contacted the "outside" company related to the need for repairs of the walk-in freezer. The Maintenance Supervisor notified the "outside" company to evaluate the walk-in freezer on 09/02/14 and the company identified the gasket around the door of the walk-in freezer was cracked and needed to be replaced.</p> <p>Interview with the Administrator on 09/04/14 at 1:50 PM revealed the dietary staff was required to report any problems with the freezer and had not reported any problems related to the buildup of ice on the ceiling and fan of the walk-in freezer. The Administrator stated staff should have reported the problem related to the buildup of ice in order for the necessary repairs to be made.</p>	F 456	<p>Plans to Monitor Performance for Sustained Solutions:</p> <p>The Administrator will review monthly the Maintenance Department daily freezer log. The Administrator will take the daily freezer log audit to the Quality Assurance Committee that meets monthly for recommendations and follow-up.</p>	10-3-2014	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185273	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	RECEIVED SEP 26 2014	(X3) DATE SURVEY COMPLETED 09/04/2014
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NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11 BOONEVILLE, KY 41314
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K 000	INITIAL COMMENTS Building: 01 Survey under: NFPA 101 (2000 Edition) existing Plan approval: 1980, 1999 Facility type: SNF/NF Type of structure: One story, Type V (unprotected) Smoke Compartments: 6 Fire Alarm: Complete fire alarm smoke detectors in corridors and dining room, heat detectors in kitchen and laundry room. Sprinkler System: Complete sprinkler system (dry). Generator: Type 2 generator powered by diesel installed 2011. A standard Life Safety Code survey was conducted on 09/04/14. Owsley County Health Care Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "D" level.	K 000	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Whitney Grouts* TITLE: Administrator (X6) DATE: 9/26/14

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

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K 029	<p>Continued From page 1</p> <p>the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors to hazardous areas were equipped with door-closing devices as required. This condition affected three (3) of six (6) smoke compartments and approximately twenty-four (24) residents, staff, and other occupants of the building. The facility has the capacity for 91 beds and had a census of 74 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 09/04/14 at 10:20 AM with the Director of Maintenance (DOM), a corridor door to the Medical Records room was observed not to be equipped with a door-closing device as required. Rooms that are considered to be hazardous areas are required to have a door-closing device.</p> <p>An interview on 09/04/14 at 10:20 AM with the DOM revealed he was not aware the door required a door-closing device. During the survey the 103 storage room, 107 storage room, and the Milk Room doors were also observed not to be self-closing.</p>	K 029	<p><u>K 029 (SS=D) NFPA 101 LIFE SAFETY CODE STANDARD</u></p> <p><i>Corrective Action for Residents Found to Have Been Affected:</i></p> <p>The Maintenance Department installed door closures on 9/4/2014 on storage rooms 103 & 107, and the Milk Room door.</p> <p><i>Identification of Other Residents Having the Potential to be Affected:</i></p> <p>All residents have the potential to be affected. (Please see corrective action for residents found to have been affected above.) On 9/5/2014 the Maintenance Department checked all facility doors to assure that self-closures were installed on doors according to K 029.</p> <p><i>Measures or Systemic Changes Made to Avoid Reoccurrence:</i></p>		

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K 029	Continued From page 2 The findings were revealed to the Administrator upon exit.	K 029	<p>On 9/5/2014 the Administrator educated the Maintenance Department on the importance of self-closing doors under NFPA guidelines. The Maintenance Department will check facility self-closing doors monthly to assure compliance with K 029.</p> <p><i>Plans to Monitor Performance for Sustained Solutions:</i></p> <p>The Administrator will review the self-closing door records completed by the Maintenance Department each month.</p>	10-3-2014	