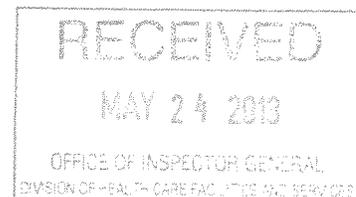


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER WESTERN STATE NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 RUSSELLVILLE ROAD HOPKINSVILLE, KY 42240		
(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 03/19/13 and concluded on 03/21/13 with deficiencies cited at the highest scope and severity of an "F". A Life Safety Code survey was initiated on 03/20/13 and concluded on 03/21/13 with deficiencies cited at the highest scope and severity of an "F" with the facility having the opportunity to correct deficiencies before remedies would be recommended for imposition. This was a Nursing Home Initiative survey with entrance to the facility on Tuesday, 03/19/13 at 7:00 AM. After consultation with the Centers for Medicare/Medicaid Services (CMS), the standard health survey was re-opened on 04/15/13 for further investigation, and concluded on 04/17/13. One additional regulatory violation was cited at F514 with a scope and severity of an "E".	F 000			
F 371 SS=F	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: Based on observation, interview, and review of	F 371	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Dietary Staff #8 was verbally re-educated by the Assistant Director of Food & Nutrition Services on proper food handling guidelines on 3/20/2013. Trash-can with removable lid was removed from the kitchen. On 3/20/2013: the Assistant Director of Food & Nutrition Services and the Clinical Nutrition Manager verbally re-educated associates (Dietary Staff #8, #9, and the Dietary Manager) on proper hand washing, glove changing methodology and proper food handling to prevent cross-contamination.		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>John Sumner</i>			TITLE NHA		(X6) DATE 5/10/13

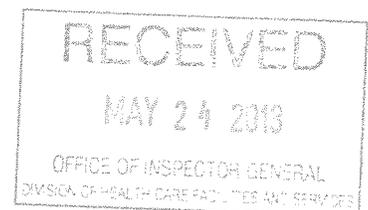
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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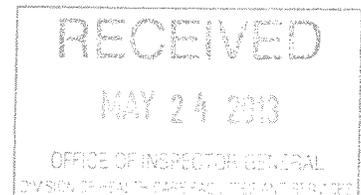
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F 371	<p>Continued From page 1</p> <p>the facility's policy and procedure, it was determined the facility failed to store, prepare and serve food under sanitary conditions. Observations revealed three (3) of five (5) staff failed to practice correct hand hygiene and prevent contamination of food during a meal service on 03/20/13.</p> <p>The findings to include:</p> <p>Review of the facility's policy and procedure regarding Hand Hygiene, dated 11/09, revealed all employees handling food shall wash hands with soap and water, before putting on gloves and after removing gloves.</p> <p>Review of the facility's policy and procedure regarding Food Handling Guidelines, dated 01/12, revealed gloves are to be placed over clean hands. Gloves are changed between tasks and hands are washed after gloves are removed.</p> <p>A review of the facility's policy and procedure regarding Solid Waste Disposal, dated 07/07, revealed garbage containers are clean, lined and covered at all times.</p> <p>Observation of the meal trayline, on 03/20/13 at 11:15 AM, revealed a large trash can placed next to the staff handwashing area with a lid which was not securely closed.</p> <p>Interview with the Dietary Manager, on 03/20/13 at 12:45 PM, revealed having the lid off of the trash can would be an infection control issue. The lid should be on at all times.</p> <p>Interview with the Clinical Dietitian, on 03/20/13 at</p>	F 371	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>Re-education on policies, F007 Hand Hygiene, F011 Solid Waste Disposal, and B017 Food Handling Guidelines for all Food & Nutrition Services associates will be completed by 5/15/2013. Associates on extended leave will be re-educated upon return. (Attachment A, B, and C)</p> <p>What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice will not recur?</p> <p>The Director of Food & Nutrition Services/Assistant Director of Food & Nutrition/Clinical Dietitian will complete a minimum of thirteen (13) random hand washing and glove changing tray-line audits weekly beginning the week of 5/13/2013. This will be conducted for a period of four (4) weeks. Each Supervisor and trayline associate will be randomly audited and additional corrective action will be taken if any issues are identified. The Hand Hygiene/Glove Changing Compliance Audit will then be completed on trayline staff quarterly. (Attachment D)</p>	



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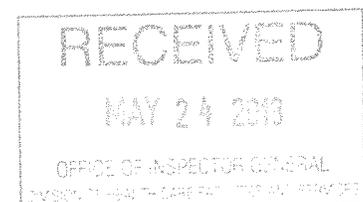
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F 371	<p>Continued From page 2 12:46 PM, revealed having the trash can lid off could lead to cross contamination.</p> <p>Observation of the meal trayline, on 03/20/13 at 11:20 AM, revealed the Dietary Manager, while obtaining trayline food temperatures, dropped a probe wipe onto the floor, reached down to pick the probe wipe from the floor, changed her glove and continued to obtain food temperatures without washing her hands.</p> <p>Further observation of the meal trayline revealed Dietary Staff #8 pulled mashed potatoes out of a warmer and pushed them back into the warmer with her foot, touched the side of the metal steam table and then placed her fingers in a white Styrofoam serving bowl of residents' food, touched the handle of a plate warmer with her gloved hand, then used the same gloved hand to pick up a piece of toast and place it on a resident's plate. She continued to place an oven mit over her vinyl glove, removed the mit and touched food on a resident's plate. In addition, she passed a box of gloves over the food on the steam table to the Dietary Manager and held a resident's plate of food up against her apron.</p> <p>Continued observation revealed Dietary Staff #8 was observed leaning over the steam table causing her apron to touch two bowls of corn sitting on the edge of the counter and green pureed food on the steam table. She used a divided plate for a resident's food which had been holding an empty plastic bag.</p> <p>Further observation of the trayline revealed Dietary Staff #9 touched a plate warmer handle with her gloved hand and then proceeded to</p>	F 371	<p>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place?</p> <p>The Director of Food & Nutrition Services/Assistant Director of Food & Nutrition Services will monitor and report audit findings quarterly to the Quality Assurance (QA) Committee for review of trends and for the need to change the plan according to the audit findings.</p>	5/15/13	



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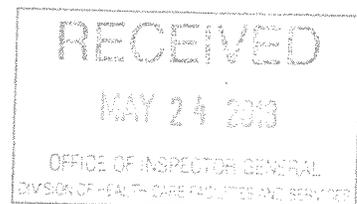
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F 371	<p>Continued From page 3</p> <p>touch some toast for the residents. She did not remove her gloves, wash her hands or change gloves after touching the handle of the plate warmer. The Dietary Manager and Dietary Staff #9 were observed removing gloves and regloving without washing their hands.</p> <p>Interview with Dietary Staff #9, on 03/21/13 at 1:00 PM, revealed before putting on a new pair of gloves they were supposed to wash their hands. To open the plate warmer they were supposed to use the white disposable cloths. The lid on the trash can should not have been left open, because it could cause infection. She stated staff are supposed to place their fingers and hands on the edge or bottom of the plates and bowls, never putting their fingers in the foodware. When touching the toast, after touching the food warmer handle, she should have changed her gloves or used tongs.</p> <p>Interview with the Dietary Manager, on 03/21/13 at 1:10 PM, revealed staff should wash their hands every time they change their gloves. They are supposed to hold the foodware by the edge not placing their fingers into the foodware. They should lean to the side of the steam table not directly over the table, so they don't take the chance of touching the food with their aprons. She stated if there was a food item in the warmer area, that was on the bottom shelf and something was above it, it should be covered to prevent spillage from the rack above.</p> <p>An interview with the Clinical Dietitian, on 03/21/13 at 1:30 PM, revealed staff should wash their hands every time they change their gloves, they should use gloves or tongs to place toast on</p>	F 371			



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F 371	Continued From page 4 plates, but they do not have to put on a new clean glove for each piece of toast. She stated staff should never place their fingers in bowls, but should hold them from underneath. She also stated staff should not lean over the steam table having their aprons touching any food items, food stored under the warmer on the bottom shelf should be covered to prevent spillage from items on the top shelf, no staff should use his/her foot to place food back in the warmer and staff should not use gloves to touch food on plates once they have used gloves to touch other items.	F 371	What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologcals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431	The narcotic record of Residents #1, A, B and C were all reviewed and the counts were made correct by subtracting the administered 9:00 AM doses. This was completed on 03/21/13 at 11:00 AM by Certified Medication Technician (CMT) #14. On 3/23/13, CMT #14, was removed from medication administration assignment and re-trained and re-in-serviced on Medication Administration on 3/23/13, Policy # IV-9G, "Psychobiological/ Pharmacological Interventions Controlled Substance Scheduled II-V Drugs" (Attachment E) by the assigned Shift Facility Charge Nurse. Additionally, disciplinary action was conducted with the CMT by the assigned administrative nurse on 03/23/13. A Pharmacy and Therapeutic committee (Pharmacy Director, Facility Pharmacist, Director of Nursing, ADON, and APRN) meeting was held on 5/6/13 to discuss accurate reconciliation of narcotics. No changes were recommended.	



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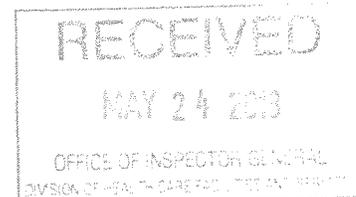
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F 431	<p>Continued From page 5</p> <p>permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and procedure, it was determined the facility failed to ensure narcotic records were accurately maintained for one (1) resident (Resident #1), in the selected sample of twenty residents and three (3) unsampled residents (Residents A, B, and C), during an observation of a narcotic count with Certified Medication Technician (CMT) #14 at 9:30 AM on 03/21/13.</p> <p>The findings include:</p> <p>A review of the facility's policy and procedure, Controlled Substances, dated May 2011, revealed the narcotic count form would be maintained on the unit medication cart. Documentation on the narcotic count form would include the remaining balance of the scheduled drug after each dose administered. The Controlled Substances policy also stated a Scheduled II and Scheduled III-IV drug count would be verified by the off-going and on-coming licensed nurses and/or any time there was a change in assignment. Verification of the count would be recorded on the Scheduled II and</p>	F 431	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>On 3/22/13, all residents within the facility who were on any type of controlled substance had the potential to be affected by this practice. Each unit's administrative nurse reviewed each controlled substance sign out sheet versus the on-coming and off-going shift count sheet versus the actual narcotics present in the narcotics box. There were no discrepancies noted on any unit. An in-service was conducted with all Licensed Nurses and Certified Medication Technicians on 03/25/13 by the Director of Nursing (DON) and completed on 03/28/13 by the assigned Facility Charge Nurse to ensure all staff who administer medications were re-educated on the importance of documentation of the scheduled substance on the sign-out sheet immediately after it is administered. A reminder of the importance of documenting the administration of all medications after they are given was discussed as well. This in-service also included re-education on the importance of comparison of the actual medication from pharmacy with the order on the MARS.</p>		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XRG511

Facility ID: 100490

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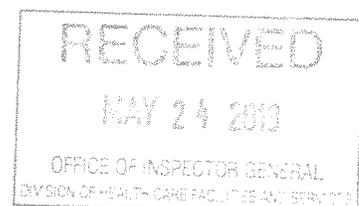
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F 431	<p>Continued From page 6</p> <p>Scheduled III-IV monthly count sheet. Any discrepancy in the count would be reported to the Unit Charge Person, an investigation into the discrepancy would be started, and the discrepancy report forwarded to the Director of Nursing (DON).</p> <p>Observation of a narcotic count with CMT #14, on 03/21/13 at 9:30 AM, revealed she had not signed out the morning narcotics for the following residents:</p> <p>A review of Resident #1's Tramadol 50 mg medication card revealed there were 36 pills; however, a review of Resident #1's Tramadol 50 mg scheduled III-V Drug Administration form revealed there were 38 pills.</p> <p>A review of Unsampled Resident A's, Ativan 1 mg medication card revealed there were 46 pills; however, a review of Resident A's Ativan 1 mg scheduled III-V Drug Administration form revealed there were 47 pills.</p> <p>A review of Unsampled Resident B's Ativan 0.5 mg medication card revealed there were 12 pills; however, a review of Resident B's Ativan 0.5 mg scheduled III-V Drug Administration form revealed there were 13 pills.</p> <p>A review of Unsampled Resident C's, Clonazepam 1 mg medication card revealed there were 69 pills; however, a review of Resident C's Clonazepam 1 mg scheduled III-V Drug Administration form revealed there were 70 pills.</p> <p>Interview with Certified Medication Technician (CMT) #14, on 03/21/13 at 10:00 AM and</p>	F 431	<p>Additionally, on 03/25/13, the narcotic sign-out sheets were combined with the Medication Administration Record (MAR) to accurately maintain the balance of the administered doses of the narcotics after each dose is administered. Reorganization of this system was completed by the assigned ward clerk of each unit on 03/25/13.</p> <p>What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice will not recur?</p> <p>On 4/5/13, the charge nurses on each unit have begun completing a Scheduled Narcotic Accuracy Monitoring Form. This monitoring form compares the actual number of narcotics available in the double-locked controlled substance drawer, versus the individual resident sign out sheet versus the beginning and end of shift count off sheet</p>	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XRG611

Facility ID: 100490

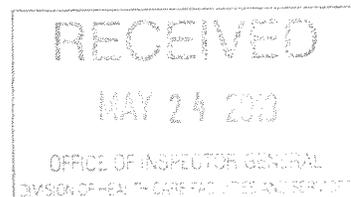
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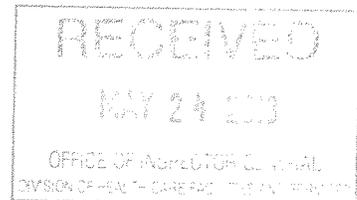
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F 431	<p>Continued From page 7</p> <p>04/17/13 at 10:05 AM, revealed she was assigned to pass medications for Resident #1 and Unsampled Resident's A, B and C on 03/21/13. She stated every resident on that medication cart received a narcotic in the morning, except for one resident, and she was able to remember all the narcotics she gave without signing them out after each narcotic was given. She further stated she did not sign out their Scheduled III-V narcotics when she pulled them because she was taking a shortcut. CMT #14 revealed this was not the correct thing to do and she had been trained in the CMT program and at the facility to sign-out narcotics when pulling them. She also stated it was the facility's practice for the off-going and the on-coming nursing staff to count the narcotics and make sure they were reconciled to the count in the monthly count sheet kept on each medication cart.</p> <p>Interview with CMT #13 and CMT #15, on 04/16/13 at 8:20 AM and 2:00 PM, revealed they always signed out narcotics when they pulled them because that's the way they were trained.</p> <p>Interview with Registered Nurse (RN) #1, on 03/21/13 at 1:55 PM, revealed she would have expected each narcotic to be signed out after each one was given according to the facility's policy. She revealed it was the practice and policy of the facility to have each off-going nursing staff count all narcotics with the on-coming nursing staff assigned to pass medications and if there was a discrepancy it was to be reported immediately to the unit charge nurse and the DON.</p> <p>Interview with RN #12, on 4/16/13 at 3:50 PM,</p>	F 431	<p>This form (Attachment F) will continue to be completed three (3) times a week on all three shifts for two (2) months. After two (2) months a total of three (3) residents will be monitored weekly. If there are no discrepancies, then one (1) resident on each shift will be monitored for two (2) months. After two (2) months a total of three (3) residents will be monitored weekly. If there are no issues found, then one (1) resident on each shift will be monitored for two (2) months. Thereafter, a total of two (2) residents a month will be monitored on a random unit and random shift. The completed Scheduled Narcotic Accuracy Monitor Form will be sent to the Administrative Nurse on each unit after completion. If at any time the charge nurse who completed the monitor notes a discrepancy in count, the Staff Facility Charge Nurse (SFCN) will be notified immediately. An investigation will immediately be initiated by the SFCN to find where the discrepancy occurred. If the cause of the discrepancy cannot be located the SFCN will contact the Director of Nursing (DON). Any nurse or CMT who is responsible for a discrepancy in count or an error will be immediately pulled from the medication cart and education will be provided prior to being assigned a medication cart.</p>		



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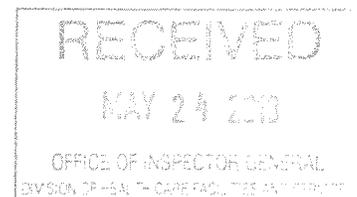
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F 431	<p>Continued From page 8</p> <p>revealed he always signed out the narcotics as he pulled them out of the box because that was the way he was trained in nursing school and it was the facility's policy. He also stated he would count all narcotics on his assigned unit at the beginning and end of each shift with the on-coming nursing staff to ensure the count was correct. He stated any discrepancy would be reported immediately to the Unit Charge Nurse and the DON.</p> <p>Interview with the DON, on 03/21/13 at 2:25 PM, revealed staff should immediately sign-out a narcotic as soon as it was given to make sure the count was accurate according to the facility's policy. The DON stated it was the policy of the facility to have each off-going nursing staff count all narcotics with the on-coming nursing staff assigned to pass medications and if there was a discrepancy it was to be reported immediately to the Unit Charge Nurse and the DON.</p> <p>Interview with the facility's Pharmacist, on 04/15/13 at 3:30 PM, revealed he had not identified any concerns with narcotics at the Nursing facility. The Pharmacist stated pharmacy staff provided inservice's for the nursing facility staff and were involved in creating policies and reviewing /revising policies, as necessary.</p> <p>Interview with the facility's Administrator, on 04/16/13 at 3:00 PM, revealed the Quality Assurance (QA) Committee had not identified any pharmacy or medication error concerns in the past year. He stated the facility's medication errors were reported quarterly to the governing body and if the facility identified a concern they would invite the Pharmacist to QA.</p>	F 431	<p>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place?</p> <p>On 4/5/13, the Administrative Nurse began completing a weekly Administrative Narcotic Accuracy Completion Form monitor (Attachment G) on their assigned unit and forward the form to the DON or Assistant Director of Nursing (ADON) as another check of completion of the monitors and that the narcotic counts are accurately maintained in all aspects (See Attachment B). Should a discrepancy be noted, the administrative nurses will complete training and in-servicing with the nurse/CMT who is not accurately maintaining the narcotic records. This will be initiated immediately upon discovery of the inaccurate monitoring. The results of all monitors will be reported to the Quality Assurance Committee by the DON/ADON on a quarterly basis with action plans developed for any issues of non-compliance.</p>	5/7/13	



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F 463 SS=E	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide an accessible emergency call system in two (2) of three (3) men's bathroom stalls and two (2) of three (3) women's bathroom stalls on unit 331.</p> <p>The findings include:</p> <p>Observation, on 03/20/13 at 10:10 AM, revealed emergency call cords which were less than five (5) inches in length in two (2) of three (3) women's bathroom stalls and in two (2) of three (3) men's bathroom stalls on unit 331.</p> <p>Interview with Registered Nurse (RN) #2, on 03/20/13 at 4:05 PM, revealed all bathroom stalls should have emergency pull cords accessible to the residents, but if it was a handicap toilet the residents using the restroom would never be left alone. He stated he did not know what had happened to the pull cords that were there. He stated staff should have made out a work ticket and submitted it to the Maintenance Department for repairs to the emergency pull cords.</p> <p>Interview with the Maintenance Director, on 03/20/13 at 4:30 PM, revealed the facility was currently out of long pull cords so he was</p>	F 463	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>On 3/22/13, call light cords were replaced with temporary cords to ensure proper length until new cords were received. On 4/3/13, new emergency call light cords greater than 5" in length were installed in each resident bathroom stall on unit 331.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>As all facility residents and staff have the potential to be affected by the same deficient practice, on 4/3/13, all restrooms were checked and new emergency call light cords greater than 5" in length were installed in each resident bathroom stall on units 311, 312, and 332. On 5/14/13, an in-service will be held for all staff in regards to installation of new bathroom stall call lights in resident bathrooms with all in-servicing to be completed by 5/21/13. (All employees on extended leave at the time of in-servicing will be in-serviced upon return to work.) On 5/14/13, all residents with cognition to understand will be provided education during Resident Council meeting in regards to bathroom call lights in resident bathrooms.</p>		



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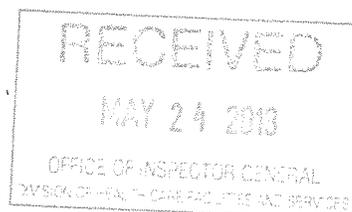
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F 463	Continued From page 10 improvising with other cords till the original cords come in. He stated there should have been long emergency pull cords in every bathroom.	F 463	Continued on Page 14	
F 514 SS=E	483.75(j)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure narcotic records were accurately maintained for one (1) resident (Resident #1) in the selected sample of twenty (20) residents and three (3) unsampled residents (Unsampled Residents A, B, and C) during an observation of a narcotic count with Certified Medication Technician (CMT) #14 at 9:30 AM on 03/21/13. The findings include: Review of the facility's policy and procedure regarding Medication Administration and	F 514	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #14, # A, #B, and #C were reviewed and the administered narcotics were subtracted on the narcotics sign out sheet. The residents had received their scheduled medication; therefore there was no harm to the residents related to failure to sign out the narcotic immediately after administration. On 3/23/13, the next assigned working day, the Certified Medication Technician (CMT), #14 was relieved of her assigned duty on the medication cart and was not allowed to pass medications until in-servicing and re-training had been completed. On 3/23/13, CMT #14 was in-serviced on Policy #IV-9 G, "The Psychobiological/Pharmacological Interventions Controlled Substance Scheduled II-V Drugs". (Attachment E) by the assigned Staff Facility Charge Nurse. Additionally, disciplinary action was conducted with the CMT by the Administrative nurse assigned to that unit on 03/23/13.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XRG511

Facility ID: 100490

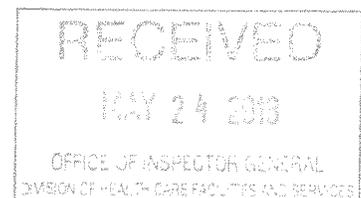
If continuation sheet Page 11 of 15



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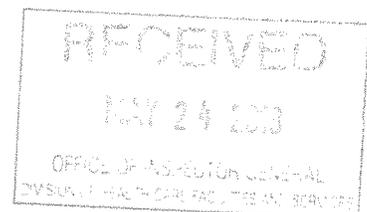
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F 514	<p>Continued From page 11</p> <p>Documentation, dated February 2013, revealed the Licensed Nurse or assigned Medication Aide should record the administration of all Scheduled III-V drugs on the Resident Scheduled III-V Administration Record and on the Medication Administration Record.</p> <p>Observation of a narcotic count with CMT #14, on 03/21/13 at 9:30 AM, revealed she had not signed out the morning narcotics for the following residents:</p> <p>A review of the narcotic count sheets for Resident #1, Unsampld Residents A, B and C revealed the counts documented did not reflect the actual pill count in the blister packs for Resident #1's Tramadol 50 mg, Unsampld Resident A's Ativan 1 mg, Unsampld Resident B's Ativan 0.5 mg, and Unsampld Resident C's Clonazepam 1 mg.</p> <p>Review of the narcotic count sheet revealed Resident #1 had 38 Tramadol pills and the blister pack had 36. Unsampld Resident A's narcotic count sheet revealed a count of 47 Ativan, when the blister pack had 46 pills. Unsampld Resident B's narcotic count sheet stated a count of 70 Clonazepams and the blister pack had 69 pills.</p> <p>Interview with Certified Medication Technician (CMT) #14, on 03/21/13 at 10:00 AM, revealed she should have signed the narcotics out at the time the narcotic was given.</p> <p>Interview with Registered Nurse (RN) #1, on 03/21/13 at 1:45 PM, revealed she would have expected each narcotic to be signed out after each one was given according to the facility policy.</p>	F 514	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents who have a controlled medication have the potential to be affected by this practice. On 03/22/13, the administrative nurse for each assigned unit reviewed the controlled substance counts of all residents with no discrepancies noted. On 03/25/13, all of the controlled substance records were combined with the Medication Administration Record (MAR) to make it more convenient for staff to accurately maintain the balance of the administered doses of the controlled substance after each dose is administered. (Previously, the controlled substance sheet was in a different binder). This was completed by the ward clerk assigned on each unit.</p> <p>What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice will not recur?</p> <p>On 3/25/13, an In-service on SOP Section IV 9G (Attachment E) was conducted with all Licensed Nurses and Certified Medication Technicians on 3/25/13 by the Director of Nursing, and completed on 3/28/13 by the Shift Facility Charge Nurse, to ensure all staff who administer medications were re-educated on the importance of documentation of the scheduled substance</p>		



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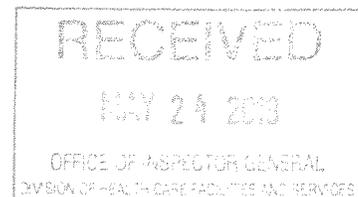
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F 514	Continued From page 12 Interview with the Director of Nursing (DON), on 03/21/13 at 2:25 PM, revealed staff should immediately sign out a narcotic as soon as it was given to make sure the narcotic count was accurate according to the facility's policy.	F 514	<p>on the sign-out sheet immediately after it is administered. A reminder of the importance of documenting the administration of all medications after they are given was discussed as well. This in-service also included re-education on the importance of comparison of the actual medication from pharmacy with the order on the MARS. The combining of the controlled substance binder into the MARS binder to ensure all of the sheets were in one place and to eliminate the use of a separate binder was presented in the in-service as well.</p> <p>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place?</p> <p>On 4/5/13, the Unit Charge Nurse on each unit began to complete a Scheduled Narcotic Accuracy Monitor Form of the scheduled narcotic count three (3) times a week on all three shifts for two (2) months. After the initial two month period if no discrepancies are encountered then a total of three (3) residents will be monitored weekly times two months. Again, if no problems are identified, one (1) resident on each shift will be monitored times two (2) months. A total of two (2) residents a month will be monitored on a random unit and random shift thereafter (Attachment F).</p> <p>Continued on Page 15</p>		



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F463	Continued from page 10	F463	<p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Effective 5/22/13, the Unit Charge Nurse on each unit will monitor the call lights every shift for two weeks. The Safety Specialist /Maintenance Superintendent will monitor the call lights daily (for two weeks), weekly (for two months), then quarterly (for one year) for function ability and proper tab length and will report findings to MHMR Facility Superintendent. (Refer to Attachments H, I, J, and K)</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained?</p> <p>Effective 5/22/13, the MHMR Facility Superintendent will supervise the corrective actions by reviewing the monitors and ensuring the call cords are installed and report findings to the QA Committee and the Safety Risk Management Committee on a quarterly basis for one year with action plans developed for any issues of noncompliance.</p>	5/30/13	



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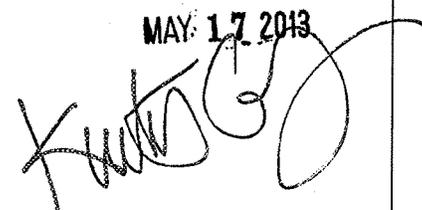
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F 514	Continued from page 13	F 514	<p>A Pharmacy and Therapeutic committee (Pharmacy Director, Facility Pharmacist, Director of Nursing, ADON, and APRN) meeting was held on 5/6/13 to discuss accurate reconciliation of narcotics. No changes were recommended.</p> <p>If at any time a problem is identified, the frequency and number of residents will be increased for more extensive monitoring. Upon completion of the Scheduled Narcotic Accuracy Monitor Form, should any discrepancy be noted the Staff Facility Charge Nurse (SFCN) will be immediately notified. An investigation will be initiated to locate the source of the discrepancy. If the source is not immediately discovered, the SFCN will notify the Director of Nursing (DON). Any staff member who is responsible for a discrepancy will be immediately pulled off of the medication cart and re-training initiated. This will be completed by the Administrative Nurse for that unit. Should this occur on a weekend or off shift, the SFCN will complete the education. Disciplinary Action will be conducted with any noted medication error and/or failure to document. Completed Narcotic Accuracy Monitor Forms will be routed to the DON or ADON for review. (Attachment G). The results of the monitoring will be reported to the Quality Assurance (QA) Committee by the DON/ADON on a quarterly basis with action plans developed for any issues of non-compliance.</p>	5/7/13



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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1958</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Three (3) story, Type II (222)</p> <p>SMOKE COMPARTMENTS: Ten (10) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Installation in progress but not operational.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was initiated on 03/20/13 and concluded on 03/21/13. Western State Nursing Facility was found to be not in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire). The facility is certified for one hundred forty four (144) beds with a census of ninety eight (98) on the day of the survey.</p> <p>The findings that follow demonstrate</p>		<p>POC ACCEPTED</p> <p>MAY 17 2013</p> 	

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

[Handwritten Signature]

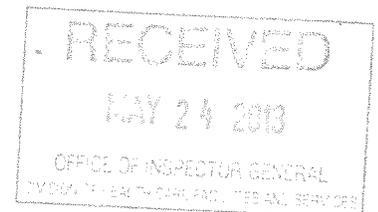
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NHA

(X6) DATE

5/10/13

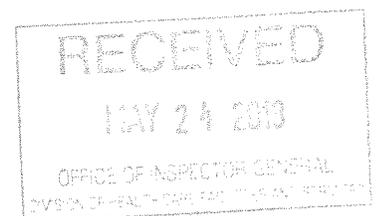
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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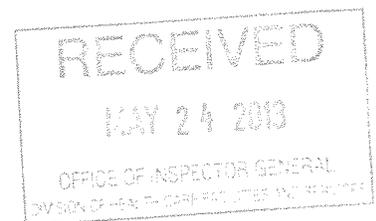
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K 000	Continued From page 1 noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000		
K 027 SS-D	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect four (4) of ten (10) smoke compartments, residents, staff and visitors. The facility is certified for one hundred forty four (144) beds with a census of ninety eight (98) on the day of the survey. The findings include: Observation, on 03/21/13 at 9:15 AM, with the Maintenance Superintendent revealed the cross	K 027	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Metal striping was installed on April 11, 2013 and fire rated smoke striping on May 7, 2013 to the cross corridor doors located in the 331 and 313 Hall, to ensure the corridor doors resist the passage of smoke in accordance with NFPA standards. How the facility will identify other residents having the potential to be affected by the same deficient practice? As all residents, staff and visitors have the potential to be affected, in order to identify the same deficient practice, the Maintenance Superintendent inspected all cross corridor doors to ensure they resist the passage of smoke on 3/22/13. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On May 9, 2013, the Safety Specialist, in-serviced all Western State Nursing Facility staff in accordance with NFPA standards of a smoke	



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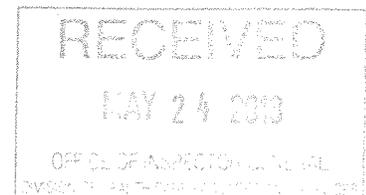
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K 027	Continued From page 2 corridor doors located in the 331. and 313 Hall had a gap too large and would not resist the passage of smoke. Interview, on 03/21/13 at 9:15 AM, with the Maintenance Superintendent revealed he was not aware the door had developed a gap that was too large to resist smoke. Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors. NFPA 101 LIFE SAFETY CODE STANDARD	K 027	barrier and how doors would resist the passage of smoke to ensure the deficient practice will not recur. Maintenance staff will be in-serviced on May 14, 2013. How the facility plans to monitor its performance to ensure that solutions are sustained? Effective May 15, 2013, the Safety Specialist/Maintenance Superintendent will conduct rounds to ensure corridor doors will resist the passage of smoke. A weekly monitoring system for three (3) months will be put into place requiring the Safety Specialist /Maintenance Superintendent to submit an inspection report. This will be submitted to the MHRM Facility Services Supervisor/ Superintendent for review. After monitoring for three (3) months, monitoring will change to monthly thereafter. The Safety Specialist monitoring report will be turned into the Performance Improvement Committee quarterly for review and follow up to ensure the inspections are being made and the smoke barrier doors are in accordance with NFPA standards. (Attachments A, B, and C)	6/30/13
K 029 SS=D	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Self-closing devices and rated doors to meet the requirements of Protection of Hazards in accordance with NFPA standards for the rooms identified as hazardous requiring a self-closing	



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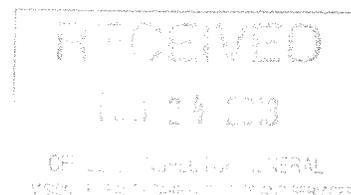
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K 029	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of ten (10) smoke compartments, residents, staff and visitors. The facility is certified for one hundred forty four (144) beds with a census of ninety eight (98) on the day of the survey. The facility failed to provide self-closing devices for doors protecting hazardous areas. The findings include: Observation, on 03/21/13 between 8:30 AM and 3:30 PM, with the Maintenance Superintendent revealed rooms required being self-closing or containing a hazardous amount of combustibles did not have self-closing device to keep the door closed. The rooms identified as hazardous requiring a self-closing device were located in the following areas: 1) Eight (8) storage closets, two (2) with unrated doors, located in the 333 Hall. 2) The smoking room located in the 332 Hall. 3) Treatment Room located in the 313 Hall. 4) Human Resources located in the 313 Hall. 5) Rooms 320A, and 320B located in the 313 Hall did not have a self-closer or a rated door.	K 029	device located in eight (8) storage closets, two (2) with unrated doors, located in the 333 Hall; the smoking room located in the 332 Hall; treatment room located in the 313 Hall; Human Resources located in the 313 Hall; and Rooms 320A, and 320B located in the 313 did not have a self-closer or a rated door. How the facility will identify other residents having the potential to be affected by the same deficient practice; and what corrective action will be taken. The deficiency had the potential to affect three (3) of ten (10) smoke compartments, residents, staff and visitors. On March 22, 2013, an inspection of all facility rooms was conducted by the Maintenance Superintendent, to identify other rooms with the same deficient practice. A purchase order and work order was submitted for the corrective action taken to purchase and install additional self-closing devices and rated doors. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On May 14, 2013, an In-service will be conducted by Safety Specialist with all staff regarding NFPA standards of Protection of Hazards to ensure the deficient practice will not recur. Effective May 15, 2013, rounds will be made on each unit, each week by the Safety Specialist/Maintenance Superintendent for room inspection to ensure self-closing devices and fire rated doors are on rooms protecting hazardous areas and working properly.	



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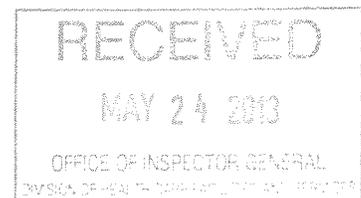
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K 029	Continued From page 4 Interview, on 03/21/13 between 8:30 AM and 3:30 PM, with the Maintenance Superintendent revealed he was not aware the doors to these rooms did not meet the requirements for protection from hazards. 8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ²	K 029	How the facility plans to monitor its performance to ensure that solutions are sustained; A weekly monitoring system for three (3) months and monthly thereafter for one (1) year, was put into place requiring the Safety Specialist/Maintenance Superintendent to complete a Protection of Hazards Inspection Monitor report to list the hall inspected, room, date, condition and date of repairs. (Attachments B, C, and D) The report will be submitted to the MHMR Facility Services Supervisor/ Superintendent for review. After monitoring for three (3) months, monitoring will change to monthly thereafter for one (1) year. The Safety Specialist will submit the monitoring report to the Performance Improvement committee quarterly for review and follow-up to ensure the inspections are being made and the doors protecting hazardous areas are in accordance with NFPA standards.	6/30/13	



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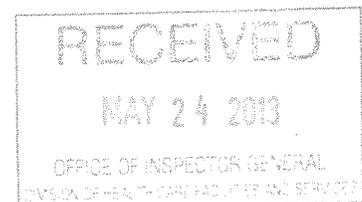
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K 029	Continued From page 5 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029		
K 045 SS=E	illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect six (6) of ten (10) smoke compartments, residents, staff and visitors. The facility is certified for one hundred forty four (144) beds with a census of ninety eight (98) on the day of the	K 045	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? On 4/4/13, two-bulb fixtures were installed at units 311 and 331 facility means of egress so that illumination shall be continuous and that failure of any single lighting unit does not result in a loss of illumination. How the facility will identify other residents having the potential to be affected by the same deficient practice? As all facility residents, staff, and visitors have the potential to be affected by the same deficient practice, on 4/4/13, two-bulb fixtures were installed at units 312, 332, and 321 facility means of egress so that illumination shall be continuous and that failure of any single lighting unit does not result in a loss of illumination.	



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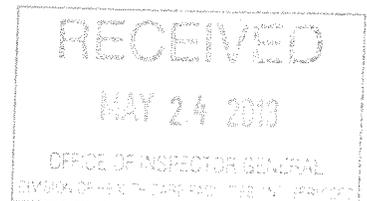
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K 045	Continued From page 6 survey. The facility failed to provide required illumination outside an exit for discharge. The findings include: Observation, on 03/21/13 at 3:00 PM, with the Maintenance Superintendent revealed the exits located in the stairwell of the 311, and 331 Hall did not have a light installed outside to provide the required illumination for exit discharge. The exits were equipped with a light fixture with only one bulb installed. Interview, on 03/21/13 at 3:00 PM, with the Maintenance Superintendent revealed he was not aware the exits did not have the required illumination for egress lighting. Reference: NFPA 101 (2000 Edition) 19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8. 7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and	K 045	What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 5/14/13, all facility staff will be in-serviced in regards to installing the two-bulb lighting fixtures with all in-servicing (All employees on in-servicing will be k.) Its ns are will eeks, thly to for mal. ne minimum criteri. replace the bulbs as needed. gs will be reported to MHMR Facility Services Superintendent/Supervisor. (Attachments E, F, and G) Effective May 15, 2013 the MHMR Facility Services Superintendent/Supervisor will review the monitors and ensure the two-bulb fixtures operate so that illumination shall be continuous. The Facility Services Superintendent/Supervisor will also ensure the monitors are completed and reported to the Quality Assurance Committee and the Safety Risk Management Committee on a quarterly basis for one (1) year. <i>5/21/13 K45 in-service 5/22/13 Compliance</i>	6/30/13



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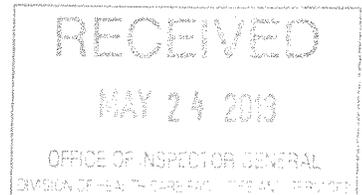
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K 045	Continued From page 7 passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not	K 045		



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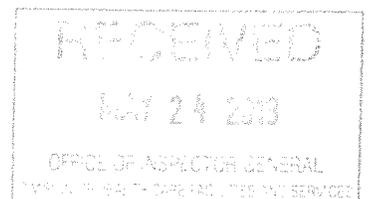
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K 045	Continued From page 8 result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045		
K 050 SS-F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least 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 fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect ten (10) of ten (10) smoke compartments, residents, staff and visitors. The facility is certified for one hundred forty four (144) beds with a census of ninety eight (98) on the day of the survey. The facility failed to ensure the fire drills were conducted at unexpected times on third shift. The findings include: Fire Drill review, on 03/20/13 at 2:51 PM, with the Maintenance Superintendent revealed the facility failed to conduct fire drills at unexpected times on third shift.	K 050	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The corrective action will be accomplished for those residents found to have been affected by the deficient practice by the MHMR Facility Services Supervisor reviewing the Western State Nursing Facility Monthly Fire Drill Report each month and completing a quarterly monitor to ensure that fire drills are at unexpected times on third (3 rd) shift. How the facility will identify other residents having the potential to be affected by the same deficient practice; and what corrective action will be taken? The deficiency had the potential to affect ten (10) of ten (10) smoke compartments, residents, staff and visitors. A Monthly Fire Drill Report will be completed by the Safety Specialist and in his absence, the Safety Coordinator, and submitted to the MHMR Facility Services Supervisor for review effective 5/15/13. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Effective May 14, 2013, the Safety Specialist/Safety Coordinator will conduct monthly fire drills at unexpected times on third shift.	



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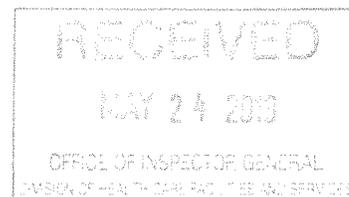
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K 050	Continued From page 9 Interview, on 03/20/13 at 2:51 PM, with the Maintenance Superintendent revealed he was not aware the fire drills were not being conducted as required. Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts. Reference: NFPA 101 Life Safety Code (2000 Edition). 19.7* OPERATING FEATURES 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator 's position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills	K 050	How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place? The MHMR Facility Services Supervisor/Superintendent will review the Monthly Fire Drill Report (Attachment H) each month and complete a quarterly monitor for one (1) year to ensure the fire drills are conducted at unexpected times on third (3 rd) shift. The Safety Specialist will submit a quarterly report to the Performance Improvement Committee for review and follow-up to ensure the fire drills are conducted at unexpected times on third shift.	6/30/13



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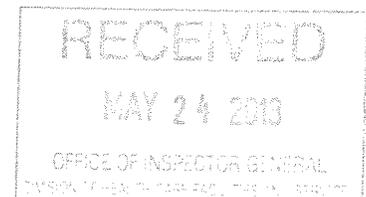
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K 050	Continued From page 10 shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on interview and fire alarm inspection review, the facility failed to test the fire alarm system quarterly per NFPA standards. The deficiency had the potential to affect ten (10) of ten (10) smoke compartments, residents, staff,	K 052	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The Simplex representative made adjustments to the language of the current contract. Changes to the contract will include testing and maintenance of the fire alarm system will be conducted on a quarterly basis. These changes to the current contract will enable the fire alarm system to be in compliance with NFPA 70 National Electrical Code and NFPA 72. (Attachment 1) This contract will be effective 5/9/13.	



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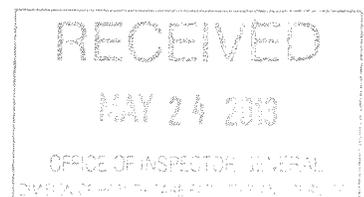
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K 052	Continued From page 11 and visitors. The facility has one hundred forty four (144) certified beds with a census of ninety eight (98) on the day of the survey. The facility failed to conduct quarterly fire alarm testing. The findings include: Fire alarm inspection review, on 03/20/13 at 2:59 PM, with the Maintenance Superintendent revealed the facility failed to conduct a fire alarm inspection in the first (1st), second (2nd), and forth (4th) quarter of 2012. The facilities main fire alarm panel was located in the Main Hospital on the campus. The main fire alarm panel served four (4) separate buildings on the campus. Each quarter a fire alarm inspection was performed on one of the four buildings, three (3) of the buildings are not certified under the facilities provider number. During only one of the four quarters, on 08/22/12, was the Nursing Facility building inspected. The main panel was monitored twenty four (24) hours a day by the hospital. Interview, on 03/20/13 at 2:59 PM, with the Maintenance Supervisor revealed he was not aware the fire alarm testing was not being performed as required. Reference: NFPA 101 Life Safety Code (2000 edition) Actual NFPA Standard: NFPA 101, 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.	K 052	How the facility will identify other residents having the potential to be affected by the same deficient practice? All facility residents, staff, and visitors have the potential to be affected by the same deficient practice. On 5/9/13, the fire alarm system contract was adjusted to ensure that quarterly testing on the fire alarm system is completed. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Effective May 15, 2013, the Safety Specialist/Maintenance Superintendent will conduct routine monitoring on the first week of every thlrd month to ensure that quarterly testing has been conducted on the fire alarm system. In an event quarterly testing has not been completed at that time, the Safety Specialist /Maintenance Superintendent will notify the Simplex representative through e-mail or telephone regarding the completion of the quarterly fire alarm testing and maintenance. The first quarterly inspection of the upgraded fire alarm system will be conducted prior to 6/30/13. The Simplex representative will in-service the Safety Specialist, Maintenance Superintendent, and the Safety Officer regarding the service contract and the quarterly fire alarm testing and maintenance at this time. (Attachment J) Continued on Page 18		
K 064	NFPA 101 LIFE SAFETY CODE STANDARD	K 064			



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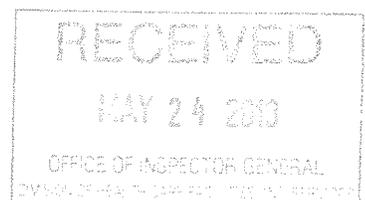
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185228	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/21/2013
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K 064 SS=D	<p>Continued From page 12</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that fire extinguishers were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of ten (10) smoke compartments, smokers, staff, and visitors. The facility is certified for one hundred forty four (144) beds with a census of ninety eight (98) on the day of the survey. The facility failed to ensure the designated smoking areas had a fire extinguisher.</p> <p>The findings include:</p> <p>Observation, on 03/21/13 at 1:01 PM, with the Maintenance Superintendent revealed there was no fire extinguisher located in the 332 Hall designated smoking area for residents.</p> <p>Interview, on 03/21/13 at 1:01 PM, with the Maintenance Superintendent revealed he was not aware a fire extinguisher was required to be located in the smoking areas.</p>	K 064	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>On 3/25/13, a portable fire extinguisher was installed in the kitchenette (located within the designated smoking area) on unit 332. On 3/28/13, two additional portable fire extinguishers and five fire blankets were ordered. On 5/16/13, a fire blanket was installed on unit 332.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>As all facility residents, staff and visitors have the potential to be affected by the same deficient practice, the corrective action taken was that on 3/25/13, the Safety Specialist/Maintenance Superintendent reviewed all designated smoking areas for the potential need for fire extinguishers.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>A portable fire extinguisher was installed in the kitchenette (located within the designated smoking area) on unit 332. On 3/28/13, two (2) additional portable fire extinguishers and five fire blankets were ordered. On 5/16/13, a fire blanket will be installed on unit 332. On 3/25/13, portable fire extinguishers were installed in kitchenettes (located within the designated smoking areas) on units 311 and 331.</p> <p>Continued on page 19</p>		



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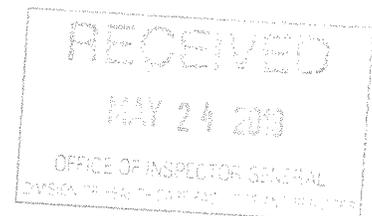
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K 064	Continued From page 13 Reference: NFPA 10 1999 4-3.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d)* Safety seals and tamper indicators not broken or missing (e) Fullness determined by weighing or "hefting" (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place 4-3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 4-3.2 (a), (b), (h), and (i), immediate corrective action shall be taken.	K 064	On 4/4/13, a portable fire extinguisher was installed in unit 312 kitchenette (located within the designated smoking area). On 5/16/13, fire blankets were installed on units 311, 312 and 331. How the facility plans to monitor its performance to ensure that solutions are sustained? Effective 5/15/13, the Safety Specialist/Maintenance Superintendent will monitor the fire extinguishers and blankets for placement weekly (for one month) during unit rounds. The Safety Specialist (Maintenance Supervisor) will make monthly (for one quarter) and quarterly (for one year) inspections to ensure placement of portable fire extinguishers and blankets in resident smoking areas and report findings to MHMR Facility Services Supervisor/ Superintendent. (Attachment H, I and J) The results of these monitors will be reported to the Quality Assurance Committee and the Safety Risk Management Committee on a quarterly basis for one (1) year with action plans developed for any issues of noncompliance.	6/30/13
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? On 3/25/13, an emergency battery operated light was installed in the load side of the generator transfer switch room for emergency lighting.	



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K 144	Continued From page 14 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect ten (10) of ten (10) smoke compartments, residents, staff, and visitors. The facility is certified for one hundred forty four (144) beds with a census of ninety eight (98) on the day of the survey. The facility failed to provide emergency battery lighting for the generator transfer switch room. The findings include: Observation, on 03/21/13 at 2:00 PM, with the Maintenance Superintendent revealed the facility did not provide an emergency battery operated light for the transfer switch room. Interview, on 03/21/13 at 2:00 PM, with the Maintenance Superintendent revealed he was not aware the transfer switch room did not have an emergency battery operated light. Reference: NFPA 110 (1999 Edition). 5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency	K 144	How the facility will identify other residents having the potential to be affected by the same deficient practice? As all facility residents, staff and visitors have the potential to be affected by the same deficient practice, on 3/25/13, an emergency battery operated light was installed on the load side of the generator transfer switch room for emergency lighting. On 5/9/13, all campus Maintenance staff were in-serviced on the installation of the emergency battery operated light with all in-servicing to be completed by 5/16/13. (All employees on extended leave at the time of in-servicing will be in-serviced upon return to work.) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Beginning May 15, 2013, the Safety Specialist /Maintenance Superintendent will check the emergency battery operated light weekly for three (3) months then monthly for three (3) months and then quarterly for one (1) year for operative performance. How the facility plans to monitor its performance to ensure that solutions are sustained? Findings will be reported to MHMR Facility Superintendent/ Supervisor who will report the results to Quality Assurance committee and Safety Risk Management Committee quarterly. (Attachments O, P, and Q).	6/30/13



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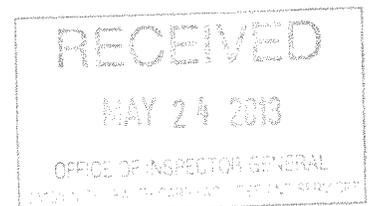
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K 144	<p>Continued From page 15</p> <p>lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.</p> <p>Reference: NFPA 99 (1999 Edition)</p> <p>Actual NFPA Standard: NFPA 99, 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1.</p> <p>(b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b).</p> <p>Actual Standard: NFPA 110, 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p> <p>Actual Standard: NFPA 99, 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the</p>	K 144		



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K 144	<p>Continued From page 16</p> <p>shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>(b) Inspection and Testing.</p> <p>1. Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.</p> <p>3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.</p> <p>Actual Standard: NFPA 99, 3- 3-4.4.2. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.</p>	K 144		



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K052 1	Continued from Page 12	K052 1	<p>How the facility plans to monitor its performance to ensure that solutions are sustained?</p> <p>Effective 5/15/13, the MHMR Facility Supervisor/Superintendent will review the fire alarm monitor to ensure that the quarterly testing is being conducted on the fire alarm system per NFPA standards. Any identified problems with the corrective action plan will be reported to the QA Committee.</p>	6/30/13	



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K064	Continued from Page 13	K064	Additionally, on 5/16/13, portable fire extinguishers and blankets were secured in the outside pavilion area. On 5/14/13, all facility staff will be in-serviced in regards to installation of and the use of the portable fire extinguishers and fire blankets and the storage location of each in resident smoking areas on units 311, 312, 331 and 332. Additionally, Nursing SOP Section IV #2G will be revised and reviewed to include the addition of portable fire extinguishers and fire blankets to designated smoking areas. (Attachments K, L, M, and N)		

