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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES
PRINTED: 12/06/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2010
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NAME OF PROVIDER OR SUPPLIER HIGHLANDS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1706 STEVENS AVENUE LOUISVILLE, KY 40205
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		
K 038 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were readily accessible, according to NFPA standards. Exit doors must be maintained to ensure residents, staff and visitors have a means to exit the building during an emergency. The deficiency affected six (6) smoke compartments, ninety three (93) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation on 11/17/10 at 11:30am revealed an exit leading from Unit 1 B across from Unit Manager's Office was locked using a keypad. The exit had delayed egress hardware but did not function when tested. Further observation revealed exits with non functioning delayed egress hardware at Unit 1 C across from room</p>	K 038	<p>K 038</p> <ol style="list-style-type: none"> The facility has contacted outside agencies to obtains bids for re-setting the egress function of the doors identified on 1B, 1C and 2C. A facility tour was completed by the Director of Maintenance on 11/21/10 to validate that no other doors were identified. The preventative maintenance protocol was revised by the Administrator. The revision included a adding a weekly audit to validate that exits are readily accessible with egress functions at all times. The results of these audits will be reviewed by the Administrator and will be presented to the Quality Assurance & Assessment committee for no less than 2 months. The Quality Assurance and Assessment committee will determine if additional auditing or education is required. Director of Maintenance and the Administrator are responsible for the completion of this Tag - Facility alleges compliance as of January 2, 2011. 	

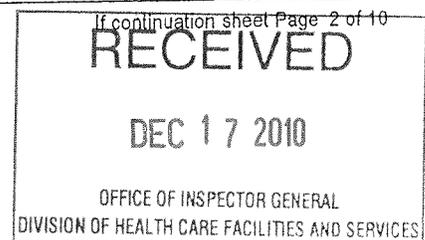
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Karel Hamilton* TITLE *Administrator* (X6) DATE *12-15-10*

A 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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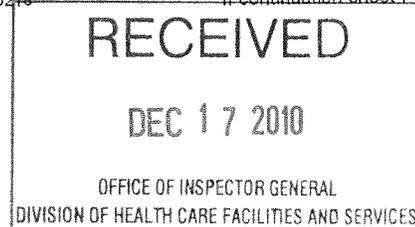
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K 038	<p>Continued From page 1</p> <p>102, Unit 2 C across from room 222. The observation was confirmed with Maintenance Director.</p> <p>Interview on 11/17/10 at 11:30am, with the Maintenance Director, revealed the delayed egress hardware was disabled by the fire alarm monitoring company after an order from the Fire Marshal's Office.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayedegress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p>	K 038		



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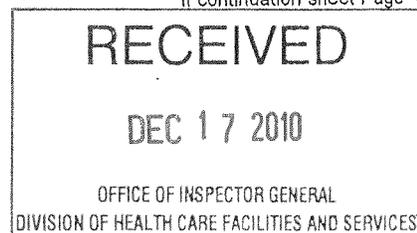
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K 038	Continued From page 2 (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS NFPA 101 LIFE SAFETY CODE STANDARD	K 038		
K 056 SS=D	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 056	K 056 1. The canopy automatic sprinkler was installed on 12/09/10 and is fully operational. 2. Maintenance has checked all other areas of facility and has found no other areas that require sprinkler to be installed.	



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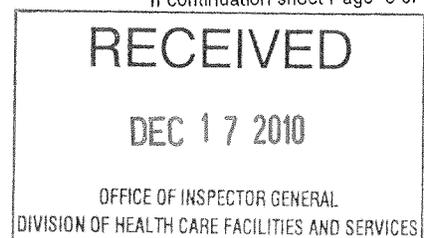
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K 056	Continued From page 3 Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview on 11/17/10, it was determined the facility failed to ensure the building had a complete sprinkler system, according to NFPA standards. The findings include: Observation on 11/17/10 at 10:30am, with the Maintenance Director, revealed a large canopy over the main front entrance to the facility. The canopy was not sprinkled and was constructed with combustible material. Interview with the Maintenance Director on 11/17/10 at 10:30am, indicated that he was not aware that the canopy needed sprinklers. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056	3. No policy or procedure revisions are required. 4. Sprinkler will be monitored through quarterly sprinkler inspections. 5. Director of Maintenance and the Administrator are responsible for the completion of this Tag - Facility alleges compliance as of January 2, 2011.	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 066		



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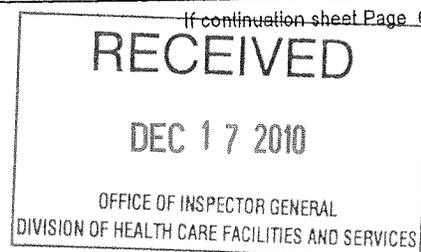
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K 066	<p>Continued From page 4</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation, policy review and interview, it was determined the facility failed to ensure the smoking policy was followed.</p> <p>The findings include:</p> <p>Observation on 11/17/10 at 10:45am, revealed cigarette butts were found next to the fuel supply for the emergency generator. The emergency generator fuel tank had a no smoking sign posted on it. The observation was confirmed with the</p>	K 066	<p>K 066</p> <ol style="list-style-type: none"> Maintenance immediately removed all cigarette butts and the ashtray from the emergency generator area on 11/18/10. Maintenance toured the facility and found no other areas of concern. Maintenance Supervisor inserviced maintenance assistant on 11/18/10 regarding the hazards of smoking in this area; and all generator vendors on 12/13/10 regarding smoking hazards in this area. The policy and procedure for smoking was reviewed by Administrator on 11/18/10 and found to be acceptable. Maintenance staff will audit this area weekly for three months to validate that no cigarettes, butts or ashes are found in this area. Any concerns will be immediately reported to Administrator for further action. The results of these audits will be reviewed by the Administrator and will be presented to the Quality Assurance & Assessment committee for no less than 3 months. The Quality Assurance and Assessment committee will determine if additional auditing or education is required. Director of Maintenance and the Administrator are responsible for the completion of this Tag - Facility alleges compliance as of January 2, 2011. 	



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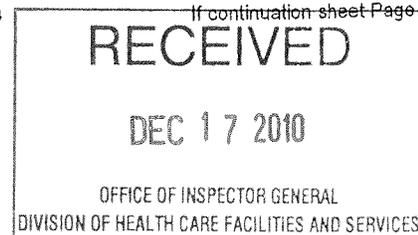
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K 066	<p>Continued From page 5 Maintenance Director.</p> <p>Interview on 11/17/10 at 10:45am, with the Maintenance Director, revealed the area was not to be used as a smoking area.</p> <p>Review of the Smoking Policy on 11/17/10 at 3:00pm, revealed smoking was to only take place in designated smoking areas.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is</p>	K 066		



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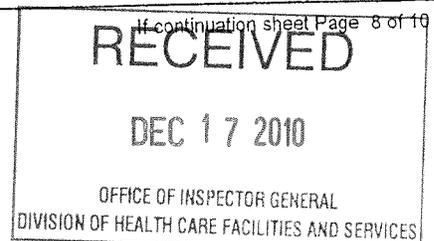
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K 066	Continued From page 6 permitted.	K 066		
K 070 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were according to NFPA standards. Portable space heaters used in health care facilities must be of an approved type to limit the risk of fire. The deficiency affected one (1) smoke compartment.</p> <p>The findings include:</p> <p>Observation on 11/17/10 at 12:20pm, revealed a portable space heater in the Restorative Office. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 11/17/10 at 12:20pm, with the Maintenance Director, revealed he was told by a federal surveyor the portable space heater was approved for use in a health care facility. Further interview revealed the facility could not provide documentation the space heater was approved for use in health care facilities.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable</p>	K 070	<p>K 070</p> <ol style="list-style-type: none"> The portable heater was immediately removed from the Restorative Office by the Director of Maintenance on 11/17/10. Maintenance conducted an audit of the remainder of facility and found two other portable heating units which were removed immediately. A policy and procedure for the use of portable heaters was created by the Administrator. This policy includes the use of heaters that are NFPA approved and are used in areas where staff work but do not sleep. The policy also notes that any heating elements cannot exceed 212 degrees Fahrenheit. Maintenance will conduct an audit weekly for 3 months to assure no additional portable heating units are used unless they meet the NFPA standards. The results of these audits will be reviewed by the Administrator and will be presented to the Quality Assurance & Assessment committee for no less than 3 months. The Quality Assurance and Assessment committee will determine if additional auditing or education is required. Director of Maintenance and the Administrator are responsible for the completion of this Tag - Facility alleges compliance as of January 2, 2011. 	



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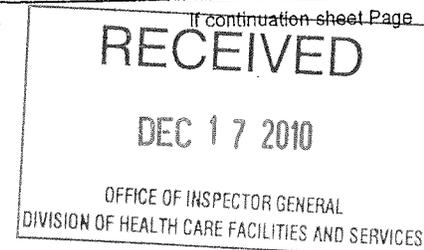
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K 070	Continued From page 7 space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). NFPA 101 LIFE SAFETY CODE STANDARD	K 070		
K 073 SS=E	No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview on 11/17/10, it was determined the facility failed to ensure that no combustibile decorations were used in the facility, according to NFPA standards. The findings include: Observation on 11/17/10 at 11:30am with the Maintenance Director, revealed four (4) resident rooms with hanging decorations on the doors that were not flame retardant. The resident rooms were numbered 136, 207, 221, and 249. Interview with the Maintenance Director on 11/17/10 at 11:30am, revealed they were unaware that these decorations were on the doors. Reference: NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are	K 073	K 073 1. Maintenance immediately sprayed the items in resident rooms 136, 207, 221, and 249 with flame-retardant spray and then tagged items of having been sprayed. 2. A facility tour was completed by Maintenance on 12/1/10 and all other decorations identified were sprayed with flame-retardant spray and tagged. 3. The preventative maintenance protocol schedule was reviewed by administrator and revised to include monitoring furnishings and decorations to ensure that these items are non-flammable. If items are flammable, they must be sprayed with flame-retardant spray and tagged. 4. Maintenance will conduct an audit weekly of all areas to assure that any additional non-flame retardant items are sprayed and marked. The results of these audits will be reviewed by the Administrator and will be presented to the Quality Assurance & Assessment committee for no less than 3 months. The Quality Assurance and Assessment committee will determine if additional auditing or education is required. 5. Director of Maintenance and the Administrator are responsible for the completion of this Tag - Facility alleges compliance as of January 2, 2011.	



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K 073	Continued From page 8	K 073		
K 076 SS=D	<p>flame-retardant.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview on 11/17/10, it was determined the facility failed to ensure combustible materials were not stored within five (5) feet of oxygen cylinders, according to NFPA standards.</p> <p>The findings include:</p> <p>Observation on 11/17/10 at 12:00pm with the Maintenance Director, revealed combustible materials which included tubing boxes, stored within five (5) feet of oxygen cylinders.</p> <p>Interview on 11/17/10 at 12:00pm with the Maintenance Director, indicated that he was unaware that combustibles should not be stored within five (5) feet of the oxygen cylinders.</p>	K 076	<p>K 076</p> <ol style="list-style-type: none"> Maintenance and nursing immediately removed the tubing boxes from the oxygen cylinder area, and notified the vendor of the storage concern. All oxygen storage areas were identified. Any cardboard items or combustible materials were immediately removed. The policy and procedure for storage of oxygen was created by the Director of Nursing. The policy included appropriate storage of items surrounding the oxygen cylinders. Maintenance will conduct an inspection weekly for 4 months and to assure that no combustible materials are stored in the cylinder area. The results of these audits will be reviewed by the Administrator and will be presented to the Quality Assurance & Assessment committee for no less than 4 months. The Quality Assurance and Assessment committee will determine if additional auditing or education is required. Director of Maintenance and the Administrator are responsible for the completion of this Tag - Facility alleges compliance as of January 2, 2011. 	



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K 076	Continued From page 9 Reference: NFPA 99 (1999 Edition) 8-3.1.11.2 Oxidizing gases such as oxygen and nitous oxide, shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the installation of Sprinkler Systems. (3) An enclosed cabinet or noncombustible construction having a minimum fire protection rating of 1/2 hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.	K 076		

