

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

PRINTED: 05/17/2012  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/13/2012
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NAME OF PROVIDER OR SUPPLIER  HERITAGE MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066
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F 000	INITIAL COMMENTS  AMENDED 05/17/12 F282 at a scope/severity of a "J" lowered to a scope/severity of a "D" F323 at a scope/severity of a "J" lowered to a scope/severity of a "D" F490 (J) deleted  An annual survey was conducted on 04/10/12 through 04/13/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of a "D."	F 000		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the "Light Housekeeper" job description, it was determined the facility failed to provide housekeeping services necessary to maintain a sanitary, orderly and comfortable environment related to a yellow-colored liquid on the bathroom floor between Room #310 and Room #312.  Findings include:  A review of the "Light Housekeeper" job description, revealed the housekeeper is	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE 5/18/12

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

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F 253	<p>Continued From page 1</p> <p>responsible for the daily cleaning and sanitizing of bathrooms including sinks, tubs and commodes.</p> <p>Observation of the bathroom between Room #310 and Room #312 during the initial tour, on 04/10/12 at 10:50 AM, revealed an area of yellow-colored liquid on the floor, approximately 12 inches by eight (8) inches, in front of the toilet, and a brown, rust-colored substance in the crevice around the base of the toilet. Further observation, on 04/10/12 at 2:40 PM, in the aforesaid bathroom, revealed the yellow-colored liquid was still on the floor, partially dried. A strong urine odor was present in the bathroom.</p> <p>An interview with Certified Nurse Aide (CNA) #4, on 04/13/12 at 6:20 PM, revealed the residents who reside in Room #310 and Room #312 utilize the bathroom adjoining these rooms.</p> <p>An interview with Housekeeper #1, on 04/11/12 at 8:30 AM, revealed he was the housekeeper for the 300 Hall on 04/10/12. He stated, that on 04/10/12 at 6:30 AM, he observed urine in the floor of the bathroom between Room #310 and Room #312, and cleaned it up. He revealed he was in training as the Housekeeper Manager and was required to complete rounds on all four halls. He further revealed he could have missed the yellow liquid on the floor while making rounds, and stated, "If it was not cleaned up, it would be my fault."</p> <p>An interview with the Housekeeping Supervisor, on 04/11/12 at 1:25 PM, revealed the bathrooms were checked when housekeepers began their shift between 6:30 AM and 7:00 AM. He stated the housekeeper first checked all of the rooms to</p>	F 253	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F 253 The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and homelike environment to include:</p> <ol style="list-style-type: none"> <li>1. The yellow colored liquid on the bathroom floor between Room #310 and Room #312 has been removed.</li> <li>2. The executive Director and housekeeping supervisor made rounds of all resident bathrooms to ensure there was no liquid in the floor.</li> <li>3. All staff will be in-serviced by 5/21/2012 by the staff development coordinator to monitor rooms and floors for items that would detract from a sanitary, orderly and comfortable interior to ensure this deficiency does not reoccur. Housekeepers will be in-serviced by 5/21/2012 by the housekeeping supervisor to give additional visits to any rooms which may require more frequent monitoring on a daily basis.</li> <li>4. The housekeeping supervisor will monitor bathrooms on a daily basis and report to the PI Committee at least monthly for three months and until this deficiency is determined to have been corrected and compliance is sustained.</li> </ol>	5/21/2012

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F 253	Continued From page 2 remove trash from the floor and to clean the tables. The housekeepers go back to sweep and mop the floors. He revealed after every third room, the housekeeper should go back and check the previous three rooms. He stated, "If he was following the process, it should have been cleaned up."	F 253	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to develop a	F 279	F 279 1. The care plan for resident #2 has been updated to reflect her foley catheter and it is being followed and properly documented.  2. All care plans for all residents have been reviewed by the nursing administrative staff to ensure they accurately reflect the current needs and care of each resident with changes made as necessary.  3. The Staff Development Coordinator will in-service licensed nurses by 5/21/2012 with emphasis on the development of a care plan which addresses the current services needed for the resident to attain or maintain their highest practicable physical, mental and psychosocial well-being and making additional changes as the resident's condition changes to ensure this deficiency does not recur. All residents with foley catheters will be reviewed weekly times 4 weeks and monthly thereafter if no concerns exist. New orders will be reviewed daily by the Director of Nursing and on the weekends by the weekend supervisor to determine if a care plan update is needed and to ensure this deficiency does not recur.	5/21/2012

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F 279	<p>Continued From page 3</p> <p>comprehensive care plan for one resident (#2), in the selected sample of twenty residents. The facility received a physician's order, on 02/21/12, for Resident #2 to have a urinary catheter inserted; however, the facility failed to develop a care plan for the resident's use of the catheter and did not update the Nurse Aide Assignment Sheet.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure for Comprehensive Care Plan of Care, revised on 05/28/08, revealed, "The care plan is to reflect changes in care, service and treatment. The Care plan identifies resident centered problems/needs/strengths. The care plan identifies measurable goals with established completion dates. The care plan identifies disciplines to assist with implementation of interventions."</p> <p>A record review revealed the facility admitted Resident #2 on 09/20/04 with diagnoses to include Diabetes Type II, Chronic Obstructive Pulmonary Disease, and Hypertension. A review of the change of condition form, dated 02/21/12, revealed placement of a catheter. Further review of Resident #2's record revealed an Evaluation of Medical Justification for Indwelling Catheter use, dated 02/22/12. A review of the Treatment Record, dated April 2012, revealed no evidence of an indwelling catheter for Resident #2.</p> <p>Review of the comprehensive care plan, revised 02/15/12, revealed there was no evidence the facility had developed a care plan for the resident's use of an indwelling catheter.</p>	F 279	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>4. The DNS and Unit Managers will monitor through record review that comprehensive care plans are developed as indicated and will report to the Performance Improvement committee at least monthly for three months and until the committee determines this plan of correction has been sustained.</p>		

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F 279	<p>Continued From page 3</p> <p>comprehensive care plan for one resident (#2), in the selected sample of twenty residents. The facility received a physician's order, on 02/21/12, for Resident #2 to have a urinary catheter inserted; however, the facility failed to develop a care plan for the resident's use of the catheter and did not update the Nurse Aide Assignment Sheet.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure for Comprehensive Care Plan of Care, revised on 05/28/08, revealed, "The care plan is to reflect changes in care, service and treatment. The Care plan identifies resident centered problems/needs/strengths. The care plan identifies measurable goals with established completion dates. The care plan identifies disciplines to assist with implementation of interventions."</p> <p>A record review revealed the facility admitted Resident #2 on 09/20/04 with diagnoses to include Diabetes Type II, Chronic Obstructive Pulmonary Disease, and Hypertension. A review of the change of condition form, dated 02/21/12, revealed placement of a catheter. Further review of Resident #2's record revealed an Evaluation of Medical Justification for Indwelling Catheter use, dated 02/22/12. A review of the Treatment Record, dated April 2012, revealed no evidence of an indwelling catheter for Resident #2.</p> <p>Review of the comprehensive care plan, revised 02/15/12, revealed there was no evidence the facility had developed a care plan for the resident's use of an indwelling catheter.</p>	F 279		
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F 279	<p>Continued From page 4</p> <p>Furthermore, review of Nurse Aide Assignment Sheets, dated 04/10/12, revealed no evidence of Resident #2 having a indwelling catheter under the Bowel &amp; Bladder section. However, on 04/10/12 at 2:55 PM, Resident #2 was observed with an indwelling catheter.</p> <p>An interview with RN #2, on 04/12/12 at 4:55 PM, revealed "I hadn't intended to leave the catheter in, it was only to drain fluid, that's why I didn't start a care plan. I was waiting for the physician to call back with further orders."</p> <p>An interview with Licensed Practical Nurse (LPN) #3, on 04/13/12 at 3:20 PM, revealed CNA care plans were updated daily at the morning interdepartmental meetings. She stated, "we go over all new physician's orders and read over the 24-hour book and make changes that need to be added or deleted to the CNA care plan sheets. Then we send them to data entry who prints them out, and puts the new sheets in the CNA books."</p> <p>An interview with the Social Worker, on 04/13/12 at 3:55 PM, revealed "we use the care plan update slips, until the care plan is put into place. The new updated care plan is not triggered until the next Resident Assessment or the next Care plan meeting."</p> <p>An interview with the Director of Nursing (DON), on 04/13/12 at 5:20 PM, revealed the updated care plan slip should have been more specific when providing resident care, until the comprehensive care plan was developed, and it should not have taken so long to develop a care plan. She revealed RN #2 should have implemented a care plan for the indwelling</p>	F 279			

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F 279  F 282 SS=D	Continued From page 5 catheter on 02/21/12. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure it was determined the facility failed to ensure one resident (#9), in the selected sample of twenty, was provided the care and services in accordance with the written plan of care. The facility assessed Resident #9 upon admission as having wandering and exit seeking behaviors and successfully exiting the building without staff knowledge on 07/08/11 and 04/10/12. The facility developed care plan interventions to include the utilization of a noise-making device on his/her wheelchair to alert the staff of movement. On 04/11/12, the facility failed to ensure the noise-makers were applied to both wheels of the resident's wheelchair and the one that was in place did not function. The staff was unaware one noise-maker was not in place or that the one on the wheelchair did not function. Thus, the facility failed to ensure adequate implementation of the care plan intervention to alert staff of the resident's movement in his/her wheelchair to prevent elopement.  Findings include:	F 279  F 282	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  F 282 The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. <ol style="list-style-type: none"><li>1. Resident #9 is no longer residing at this facility.</li><li>2. All care plans of all residents have been audited to ensure all residents are receiving care and services in accordance with their written plan of care.</li><li>3. All staff have been in-serviced on the resident elopement policy, missing resident search steps, missing resident search checklist, missing resident profile, resident supervision and monitoring and resident monitoring tool and immediate reporting and implementation of the resident's care plan. All residents are being assessed upon admission and upon significant change of condition for wander/elopement risk. All residents with newly identified exit</li></ol>	5/21/2012

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F 282	<p>Continued From page 6</p> <p>A review of the facility's policy/procedure, "Comprehensive Plan of Care" included "Develop goals and approaches that are resident centered (rather than staff-centered) for each problem and/or condition that: are realistic, are specific, are measurable" and "The frequency of service to be provided, and the interdisciplinary team members responsible for providing care of service."</p> <p>A record review revealed the facility admitted Resident #9 on 01/13/11 with diagnoses to include Alzheimer's Disease and Dementia with Behavior Disturbance and Delusions. A care plan with interventions, dated 01/13/11, included: 8) Noise sticks on his/her wheelchair wheels. A review of Resident #9's care plan, entitled "I am at risk for wandering/elopement," dated 01/13/11, revealed an intervention, dated 03/31/11, "It's ok to have noise sticks on my wheelchair wheels." A review of the quarterly Minimum Data Set (MDS) assessment, dated 03/20/12, revealed the resident was severely cognitively impaired and demonstrated wandering behaviors.</p> <p>Review of the Nurses' Notes, on 07/08/11 at 7:30 AM, revealed Resident #9 was successful in exiting the building without the supervision of the staff. Review of the facility's summary completed on 04/12/12 for the event of 07/08/11, revealed the resident was discussed in an IDT meeting and possible interventions to include noise-makers on the wheelchair to alert the staff when traveling to encourage the resident to remain on his/her own hall. There was nothing in the summary to address if the noise sticks were heard or if they were in place or if staff was knowledgeable of the resident's whereabouts.</p>	F 282	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>seeking behaviors are being placed on 1:1 supervision for at least seventy-two hours and until the IDTeam assesses and determines proper supervision, and updates the resident's care plan. All wander/elopement risks will be reviewed weekly by the IDTeam to ensure the care plan is current and appropriate supervision is being provided. Meal and break times are being assigned daily to ensure supervision is maintained on the hall at all times. The social services director will monitor behavior logs on a monthly basis and report any concerns to the performance improvement committee.</p> <p>4. The executive director is responsible for implementing and maintaining this plan of correction and will monitor monthly through performance improvement meetings for three months and/or until it is determined this deficiency is corrected.</p>		

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F 282	<p>Continued From page 7</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 04/12/12 at 10:45 AM, revealed, on 04/10/12, she was working on the 200 Hall and had just returned from a lunch break about 7:30 PM and was in a resident's room when she heard a door alarm. When stepping into the hall, LPN #1 determined the PT department exit door alarm was sounding. The double doors leading into the PT department were closed and the pull tab alarm on those doors was not sounding. LPN #1 went to the PT department, through the double doors and looked outside and saw Resident #9 in his/her wheelchair at the end of the sidewalk with his/her arms folded. Resident #9 was returned to the building, assessed with no injury and one to one supervision was initiated. LPN #1 had not seen Resident #9 on the 200 Hall prior to being found outside the PT department's exit door and had not heard the noise-maker devices on the wheelchair.</p> <p>CNA #1 interview, on 04/12/12 at 9:35 AM, revealed she was working the 100 Hall, on 04/10/12, and CNA #2, was on lunch break. CNA #1 stated she was gathering linens and answering call lights and did not notice Resident #9 was not on the hall and did not hear a door alarm. CNA #1 was not aware Resident #9 exited the facility through the Physical Therapy department exit door until LPN #1 told her. The CNA revealed Resident #9 was known to wander into other residents' rooms and often went to the exit doors and required redirection.</p> <p>An interview with Registered Nurse (RN) #2, on 04/13/12 at 6:00 PM, revealed she was working on the 100 Hall and had been busy on 04/10/12.</p>	F 282			

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F 282	<p>Continued From page 8</p> <p>She had been on the 400 Hall speaking with a family member around 7:30 PM, when the 200 Hall nurse (LPN #1) informed her Resident #9 had exited the building. RN #2 stated Resident #9 was "active," but was on the 100 Hall when last seen. The two CNAs were on the 100 Hall when she left to speak with a family member on the 400 Hall.</p> <p>An interview with the Director of Nursing (DON), on 04/12/12 at 12:05 PM, revealed she was notified by LPN #1, on 04/10/12 around 7:30 PM, that Resident #9 had gotten out of the facility through the exit door. CNA #1 had been in a resident's room and did not notice Resident #9 leave the 100 Hall and was unaware the resident had exited the building, until someone told her and CNA #2 had been on lunch break.</p> <p>On 04/11/12 at 9:30 AM, observation revealed Resident #9 was in his/her room in a wheelchair with a personal alarm in place and Certified Nurse Aide (CNA) #1 was with the resident. One of the wheel's on the wheelchair had a plastic noise-maker attached with plastic ties. The other wheel had plastic ties, but no noise-maker was in place. A demonstration at the time revealed the noise-maker that was attached to the wheelchair's wheel did not make any noise when the wheelchair was rolled. A basket containing four noise-makers that was located on the bedside table revealed four noise-makers of which only two made a sound. An interview, conducted with CNA #1, revealed she was providing one to one supervision to Resident #9 due to exiting the facility the previous night. The CNA was unaware the noise-maker was not functioning or that one was missing. She stated</p>	F 282			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  04/13/2012
NAME OF PROVIDER OR SUPPLIER  HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
(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 282	Continued From page 9 the noise-makers had to be replaced from time to time and was unaware if anyone was to check them to see if they were in place or to ensure they were working. The CNA thought if someone noticed the noise-makers were not working, that maintenance would replace them. A review of the CNA assignment sheet for Resident #9, listed under the ALERT section, revealed "redirect to his/her hall and stay with him/her until back to his/her hall, wanderguard to (L) ankle." There was no documented evidence that the assignment sheet addressed noise-makers on the resident's wheelchair wheels.  Further interview with the DON revealed the facility had no system to monitor the noise-maker devices for the resident's wheelchair wheels to ensure placement and function, and she thought the nurses would notice if the noise-makers were not in place or not functioning. The facility was unable to provide documented evidence that they verified the noise-makers were in place or checked for function after both incidents of elopement as this was an intervention used to alert staff when the resident was "on the move". Therefore the facility could provide no evidence that they ensured the care plan intervention was followed related to the application of two noise makers to the wheelchair wheels and failed to ensure the devices functioned appropriately.	F 282			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323			

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NAME OF PROVIDER OR SUPPLIER  HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42068		
(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 323	Continued From page 10  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure it was determined the facility failed to ensure one resident (#9), in the selected sample of twenty residents, received adequate supervision to prevent accidents. The facility failed to ensure their "Patient Supervision and Monitoring" was effective and implemented to ensure adequate supervision of residents with wandering and elopement risk. The facility failed to ensure interventions implemented for elopement prevention were effective and were being monitored to ensure the devices were functioning. The facility assessed Resident #9, as having wandering and exit-seeking behaviors and implemented multiple interventions to include a wanderguard bracelet and a noise-making device to his/her wheel chair to alert the staff of the resident's movement. On 04/10/12 at 7:30 PM, Resident #9 exited the building through the (PT) department exit door. Staff was unaware of Resident #9's whereabouts until they heard the door alarm at which time they responded bringing the Resident back in the facility. The facility identified that staff failed to ensure the tab alarm was applied to the PT Department doors which failed to alert the staff that a resident was entering the Therapy Department. Staff interviews revealed they did not observe the resident or hear the resident's noise-maker wheelchair devices when the resident propelled	F 323			

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NAME OF PROVIDER OR SUPPLIER  HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
(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 323	<p>Continued From page 11</p> <p>through the 100 hall and traveled through the 200 hall. Thus, the facility failed to provide necessary supervision to a wandering resident who the facility had assessed as an elopement risk and failed to ensure interventions developed to ensure adequate supervision were effective and functional in alerting staff to address the resident's wandering behavior in order to prevent elopement.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Patient Supervision and Monitoring," dated 04/28/11, revealed patients are provided supervision when they present with conditions that may place other patients and/or themselves at risk for harm. The patients are supervised under normal circumstances to ensure optimal safety and clinical outcome. The patient is able to move about the center at will except in areas designated as "non-patient Areas" for safety reasons.</p> <p>A record review revealed the facility admitted Resident #9 on 01/13/11 with diagnoses to include Alzheimer's Disease and Dementia with Behavior Disturbance and Delusions. On 01/13/11, the facility assessed Resident #9 as at risk for elopement. The facility developed and implemented a care plan for elopement, dated 01/13/11, which included the following interventions: 1) Keep my picture available on the Medication Administration Record (MAR). 2) Make sure alarmed exits are functioning at all times. 3) Wanderguard to the left ankle, check every shift and as needed. 4) Assistance to find</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F 323</p> <p>The facility will ensure that the resident environment remains as free of accident hazards as is possible; and each resident will receive adequate supervision and assistance devices to prevent accidents.</p> <ol style="list-style-type: none"> <li>1. Resident #9 no longer resides at this facility.</li> <li>2. All residents have been reviewed for wander/elopement risks and to ensure adequate supervision is being provided.</li> <li>3. All staff have been in-serviced on the resident elopement policy, missing resident search steps, missing resident search checklist, missing resident profile, resident supervision and monitoring and resident monitoring tool and immediate reporting and implementation of the resident's care plan. All residents are being assessed upon admission and upon significant change of condition for wander/elopement risk. All residents with newly identified exit</li> </ol>	5/21/2012	

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NAME OF PROVIDER OR SUPPLIER  HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
(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 323	<p>Continued From page 12</p> <p>his/her room or appropriate area during wandering. 5) Staff to ensure needs were met and environment was comfortable. 6) Fold towels or watch baby doll or listen to the Bible being read. 7) Talk to his/her daughter on the phone. A review of the quarterly Minimum Data Set (MDS) assessment, dated 03/20/12, revealed the resident was severely cognitively impaired and demonstrated wandering behaviors.</p> <p>Documentation in the nurse's notes revealed, from 01/16/11 through 07/08/11, the resident exhibited thirteen (13) episodes of wandering behaviors, which included repetitive attempts to exit the facility and triggering the door alarms. Nurse's notes dated, 01/16/11 at 6:00 AM revealed "attempted to open side door and out through 100 Hall, was redirected". On 01/18/11 at 2:30 AM nurse's note stated "multiple times pushing at exit doors receiving intervention by staff". 01/18/11 at 3:00 PM the Nurse's note revealed "propelled to each facility door and set off the alarms, now on one to one for safety". On 01/28/11 at 3:00 PM Nurse's note revealed "pushing at door four (4)times, one to one initiated". On 02/06/11 at 3:00 PM Nurse's notes revealed the resident was wandering into other's rooms. 02/11/11 Nurse's note, timed 12:45 AM revealed "resident sitting around Nurse's station asking how to get out, tried to go out of front lobby doors and wandering around facility going in and out of other's rooms, will monitor" Nurse's note, dated 02/12/11 at 3:30 am revealed the resident was behind the Nurse's desk in charts, digging in trash cans, picking water pitchers off medication carts drinking it, while in other's room tried to climb in bed with other resident. On</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>seeking behaviors are being placed on 1:1 supervision for at least seventy-two hours and until the IDTeam assesses and determines proper supervision and updates the resident's care plan.. All wander/elopement risks will be reviewed weekly by the IDTeam to ensure the care plan is current and appropriate supervision is being provided. Meal and break times are being assigned daily to ensure supervision is maintained on the hall at all times. The social services director will monitor behavior logs on a monthly basis and report any concerns to the performance improvement committee.</p> <p>4. The executive director is responsible for implementing and maintaining this plan of correction and will monitor through monthly performance improvement meetings for three months and until it is determined this deficiency is corrected to ensure this deficiency does not reoccur.</p>		

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NAME OF PROVIDER OR SUPPLIER  HERITAGE MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066
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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
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F 323	<p>Continued From page 13</p> <p>02/17/11 at 1:15 PM the resident was attempting to enter the facility kitchen. On 03/14/11 at 8:00 PM threatened to "cut off" the wanderguard.</p> <p>Review of quarterly review documentation, dated 03/15/11, revealed noise makers to wheels of wheel chair to alert staff and make staff aware of where the resident was located in the building, however, further review of the care plan revealed the facility added the following intervention, dated 03/31/11, 8) Noise sticks on wheelchair wheels.</p> <p>On 03/16/11 at 4:00 AM was "trying to get out doors". On 03/20/11 at 2:00 PM, Nurse's notes reveal "propelling self in wheel chair attempts to go out some doors and goes in other resident rooms is on fifteen (15) minute monitoring. 03/25/11 at 2:55 AM, Nurse's note reveals "repeatedly tried to get out the door and in and out of other resident's rooms. On 03/26/11 at 8:30 AM the notes indicate "was wandering in and out of others' rooms. On 04/02/11 at 4:15 AM "attempted to get out through back doors two (2) times" was documented in the Nurse's notes. On 05/06/11 at 2:00 AM "wandering into others's rooms requiring continuous monitoring". On 06/08/11 at at 2:50 AM, the Nurse's note revealed "has been trying to get out of doors. Has been in and out of others's rooms, been on medication carts"</p> <p>On 07/08/11 at 7:30 AM, the Nurse's note revealed "Resident very agitated this AM. Combative with staff and other patients. Not easily redirected. Using wheel chair and pushing through exits. Noted to exit the building out of the therapy door this AM. Brought back into the</p>	F 323		
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NAME OF PROVIDER OR SUPPLIER  HERITAGE MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066
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F 323	<p>Continued From page 14</p> <p>building with staff and placed with a staff member for monitoring. ..." Review of the summary, undated, provided by the Administrator on 04/12/12, revealed the resident was discussed in an IDT meeting and possible interventions to include noise-makers to the wheelchair to alert the staff when traveling to encourage the resident to remain on his/her own hall. An interview with the Director of Nursing (DON), on 04/12/12 at 12:05 PM, revealed PT department staff was to notify nursing when leaving for the day (5:30 PM to 6:00 PM usually) and nursing would engage a pull tab alarm on the double doors leading to the PT department to alert staff when a resident was attempting to go into the PT department.</p> <p>On 07/24/11 at 5:30 PM attempted to exit the 100 Hall exit. On 07/25/11 at 1:30 AM the resident was going from hall to hall trying to find an exit per the Nurse's notes. On 08/30/11 at 5:15 AM, Nurse's note revealed "observed to stand from wheel chair and remove pull tab alarm and enter Physical Therapy department requiring intervention".</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 04/12/12 at 10:45 AM, revealed, on 04/10/12, she was working on the 200 Hall, had just returned from a lunch break about 7:30 PM, and was in a resident's room when she heard a door alarm. When stepping into the hall, LPN #1 determined the PT department exit door alarm was sounding. The double doors leading into the PT department were closed and the pull tab alarm on those doors was not sounding. LPN #1</p>	F 323		
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NAME OF PROVIDER OR SUPPLIER  HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
(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 323	<p>Continued From page 15</p> <p>went to the PT department through the double doors and looked outside and saw Resident #9 in his/her wheelchair at the end of the sidewalk with his/her arms folded. Resident #9 was returned to the building, assessed with no injury and one to one supervision was initiated. LPN #1 had not seen Resident #9 on the 200 Hall prior to being found outside the PT department exit door and had not heard the noise-maker devices on the wheelchair.</p> <p>An interview with CNA #1, on 04/12/12 at 9:35 AM, revealed she was working the 100 Hall, on 04/10/12, and CNA #2, who was working with her, had left for a lunch break. CNA #1 stated she was gathering linens and answering call lights and did not notice Resident #9 was not on the hall and did not hear a door alarm. CNA #1 was not aware Resident #9 had exited the facility through the PT department exit door, until LPN #1 told her. The CNA revealed Resident #9 was known to wander in to other residents' rooms and often went to the exit doors and required redirection.</p> <p>Observation, on 04/11/12 at 9:30 AM, revealed Resident #9 was in his/her room in a wheelchair with a personal alarm in place and Certified Nurse Aide (CNA) #1 was with the resident. One wheelchair wheel had a plastic noise-maker attached with plastic ties. The other wheelchair wheel had plastic ties, but no noise-maker was in place. A demonstration, at the time, revealed the noise-maker that was attached to the wheelchair wheel did not make any noise when the wheelchair was rolled. A basket containing four noise-makers that was located on the bedside table revealed only two noise-makers actually</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER  HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066	
(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 323	<p>Continued From page 16</p> <p>made a sound. An interview conducted with CNA #1 at the time revealed she was providing one to one supervision to Resident #9 due to exiting the facility the previous night. The CNA was unaware the noise-maker was not functioning or that one was missing. She stated the noise-makers had to be replaced from time to time and was unaware if there was a system to verify if they were working and thought maintenance would replace them when staff requested.</p> <p>An interview with the Director of Nursing (DON), on 04/12/12 at 12:05 PM, revealed she was notified by LPN #1, on 04/10/12 around 7:30 PM, that Resident #9 had gotten out of the exit door. LPN #1 reported to the DON that she heard a door alarm and when she looked outside, she saw Resident #9 on the sidewalk outside. The resident was returned to the building, assessed and placed on one to one supervision. CNA #1 was in a resident's room and did not see Resident #9 leave the 100 Hall and was unaware the resident had exited the building until someone told her, and CNA #2 had been away on a lunch break. The DON revealed nursing did not set the pull tab alarm on the PT department double doors leading into the PT department. There was no system to monitor the noise-maker devices for the resident's wheelchair wheels to ensure placement and function.</p>	F 323		

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NAME OF PROVIDER OR SUPPLIER  HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
(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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1971</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200)</p> <p>SMOKE COMPARTMENTS: Twelve (12) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 04/10/12. Heritage Manor Health Care Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred (100) beds and the census was eighty nine (89) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000			



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

TITLE

(X5) DATE

*[Signature]* Executive Director 5/17/2012

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

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NAME OF PROVIDER OR SUPPLIER  HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066	
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K 000	Continued From page 1	K 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
K 017 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that rooms open to the corridor would not interfere with egress requirements in accordance with NFPA standards. The deficiency had the potential to affect six (6) of twelve (12) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds and the census was eighty nine (89) on the day of the survey.</p>	K 017	<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>K 017</b> It is the practice of this center to assure that all fire/smoke resistant walls are maintained within compliance at all times to include:</p> <ol style="list-style-type: none"> <li>The therapy room at the end of 200 hall corridor used for therapy treatment will be corrected by construction of hallway walls to separate treatment/therapy area from hallway egress, discussed with Jeremy Taylor, Life Safety Inspector, by phone on 5/1/2012. Construction drawings will be submitted for review and approval to the Frankfort, KY Office Code Enforcement office. Heritage is requesting a construction waiver of six months for submittals, review and approval by Code Enforcement, to begin construction of corridor separation walls. The training room at the end of 300 and painting area at the end of 400 hall corridors have been moved to other areas of the building not open to the corridor.</li> <li>All areas of the building will be examined to ensure no treatment rooms or hazardous areas are open to the corridor.</li> </ol>	5/8/2012

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NAME OF PROVIDER OR SUPPLIER  HERITAGE MANOR HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42088		
(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 017	<p>Continued From page 2</p> <p>The findings include:</p> <p>Observation, on 04/10/12 between 11:00 AM and 12:00 PM, with the Director of Maintenance revealed a therapy room at the end of 200 hall, a training room at the end of 300 hall, and a painting area at the end of 400 hall all open to the corridor. The contents of these rooms are not permitted to be in an area open to the corridor.</p> <p>Interview, on 04/10/12 between 11:00 AM and 12:00 PM, with the Director of Maintenance and the Administrator revealed these areas were originally designed as smoking lounges at the ends of the corridors. Further interview revealed that they were unaware that treatment rooms and hazardous areas could not be open to the corridor</p> <p>NFPA 101 (2000) edition 19.3.6.1 Corridors shall be separated from all other areas by partitions complying with 19.3.6.2 through 19.3.6.5. (See also 19.2.5.9.) Exception No. 1: Smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 shall be permitted to have spaces that are unlimited in size open to the corridor, provided that the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4. or</p>	K 017	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>3. The maintenance director will conduct a building survey to ensure no hazardous or treatment areas are open to the corridor and report to the Performance Improvement Committee on a monthly basis for three months and/or until compliance is maintained to ensure this deficiency does not recur.</p> <p>4. The Executive Director will oversee the performance improvement committee and be responsible for overall compliance.</p>	

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K 017	Continued From page 3 the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits.	K 017	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
K 029 SS=E	7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.  NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When 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  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	K 029	K 029 It is the practice of this center to assure that all hazardous locations are within compliance at all times to include:  1. Door closers will be installed on the clean linen door, office door and soiled linen door in the laundry area, the Utilization coordinator's office, medical records office, housekeeping closet on 400 hall, the MDS office at the end of 300 hall and the dry storage area of the kitchen. 2. All other areas of the building will be inspected by the maintenance director and closers installed where necessary. 3. The maintenance director will continue to monitor all doors for compliance to ensure this deficiency does not recur. 4. The maintenance director will report to the Performance Improvement Committee monthly for three months and/or until the committee determines compliance has been attained and sustained.	5/8/2012

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K 029	<p>Continued From page 4</p> <p>accordance with NFPA Standards. The deficiency had the potential to affect six (6) of twelve (12) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds and the census was eighty nine (89) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 04/10/12 between 10:30 AM and 2:15 PM, with the Director of Maintenance revealed the following hazardous areas did not have a door closer installed: clean linen in the laundry area, office in the laundry area, soiled linen in the laundry area, utilization coordinator office, medical records office, housekeeping closet on the 400 hall, the office door at the end of the 300 hall (MDS), and the dry storage area for the kitchen.</p> <p>Interview, on 04/10/12 between 10:30 AM and 2:15 PM, with the Director of Maintenance revealed he was not aware that areas with hazardous storage needed a door closer installed.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>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</p>	K 029			

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K 029	Continued From page 5 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 <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), 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.	K 029		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  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 Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water	K 056		

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K 056	<p>Continued From page 6</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect two (2) of twelve (12) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds and the census was eighty nine (89) on the day of the survey. The findings include:</p> <p>Observation, on 04/10/12 at 11:45 AM, with the Director of Maintenance revealed a canopy with no flame retardant rating located at the exterior of the exit for therapy that was 4' in width.</p> <p>Interview, on 04/10/12 at 11:45 AM, with the Director of Maintenance revealed he was unaware of the requirement for the area to be sprinkler protected.</p> <p>Observation, on 04/10/12 at 2:00 PM, with the Director of Maintenance revealed a standard response sprinkler head and a quick response sprinkler head in the same compartment located in the 400 hall lounge area.</p> <p>Interview, on 04/10/12 at 2:00 PM, with the Director of Maintenance revealed he was not</p>	K 056	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>K 056 It is the practice of this center to assure that automatic sprinklers are installed and maintained in accordance with NFPA 13 and NFPA 25 to remain in compliance at all times to include:</p> <ol style="list-style-type: none"> <li>1. The canopy to the rehab department has been removed and the sprinkler head in the 400 hall lounge has been replaced with the appropriate sprinkler head by a licensed contractor.</li> <li>2. A Licensed Contractor inspected all center areas to assure all areas of the building are in compliance.</li> <li>3. All future system alterations will be corrected by licensed contractors. The Maintenance Director will inspect Sprinkler Piping monthly and Document in the Centers Preventive Maintenance Logs for three months and then quarterly thereafter. Licensed Contractor will inspect center Sprinkler System Quarterly thereafter to ensure continued compliance. Quarterly inspections will be completed by the maintenance Director and a Licensed Contractor.</li> </ol>	5/8/2012

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K 056	Continued From page 7 aware that the sprinkler heads were mixed in this compartment. He revealed that had a lot of sprinkler heads changed and he must not have noticed just the one being changed.  Reference: NFPA 13 (1999 edition) 5-13.8.1. Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.  Reference: NFPA 13 (1999 Edition) 7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area.	K 056	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  These inspections will be documented in the Preventative Maintenance Program to ensure future compliance.  4. Life Safety Preventive Maintenance Logs will be reviewed monthly by the Safety Committee to ensure continued compliance. The Executive Director will be responsible to ensure this plan is implemented and sustained.	

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K 056	Continued From page 8 Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 056	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, 19.3.5.6, NFPA 10  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the kitchen had signage in place for the proper use of the Class-K portable fire extinguisher in accordance with NFPA standards. The deficiency had the potential to affect one (1) of twelve (12) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds and the census was eighty nine (89) on the day of the survey.  The findings include:  Observation, on 04/10/12 at 2:20 PM, with the Director of Maintenance revealed there was no signage stating that the hood suppression system must be used before the class K fire extinguisher. This type of extinguisher is used as a secondary measure to the range hood extinguishing system.	K 064	K 064 It is the practice of this center to assure that all miscellaneous life safety issues are within compliance at all times to include:  1. A placard has now been placed conspicuously near the class-K fire extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.  2. All fire extinguishers have been inspected by licensed contractor to ensure proper signage is in place.  3. The maintenance director will inspect fire extinguishers and signage monthly. Monthly inspections will be documented in preventive maintenance logs to ensure this deficiency does not recur.  4. Preventive maintenance logs will be reviewed by the safety committee monthly to ensure continued compliance. The Executive Director will be responsible for monitoring this overall plan of correction.	5/8/2012

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K 064	Continued From page 9  Interview, on 04/10/12 at 2:20 PM, with the Director of Maintenance revealed he was unaware of the signage requirement.  Reference: NFPA 10 (1998 Edition).  2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.	K 064	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure a class-k fire extinguisher for the kitchen was readily available, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of twelve (12) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds and the census was eighty nine (89) on the day of the survey.  The findings include:  Observation, on 04/10/12 at 2:20 PM, with the Director of Maintenance revealed there was no class k fire extinguisher located in the kitchen.  Interview, on 04/10/12 at 2:20 PM, with the Director of Maintenance revealed he was aware the extinguisher was required for the kitchen but he had moved it during some recent remodeling	K 069	K 069 It is the practice of this center to assure that all cooking facilities are protected in accordance to NFPA 96 to maintain compliance at all times to include:  1. A class k fire extinguisher has now been installed in the kitchen. 2. A licensed contractor has reviewed the cooking facilities to ensure they are properly protected. 3. The maintenance director will inspect kitchen equipment monthly for proper placement. Monthly inspections will be documented in the preventive maintenance logs. 4. Preventive maintenance logs will be reviewed by the Safety Committee monthly and report to the performance improvement committee monthly for three months and/or until compliance is sustained. The executive director will be responsible to ensure this plan of correction is implemented and maintained. The Executive Director will be responsible for monitoring this overall plan of correction.	5/8/2012	

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NAME OF PROVIDER OR SUPPLIER  HERITAGE MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42086
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K 069	<p>Continued From page 10 and had not remounted it.</p> <p>Reference: NFPA 10 1998 edition</p> <p>3-7 Fire Extinguisher Size and Placement for Class K Fires.</p> <p>3-7.1 Fire extinguishers shall be provided for hazards where there is a potential for fires involving combustible cooking media (vegetable or animal oils and fats).</p> <p>3-7.2 Maximum travel distance shall not exceed 30 ft (9.15 m) from the hazard to the extinguishers.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits.</p> <p>7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect five (6) of twelve (12) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds and the census was eighty nine (89) on the day of the survey.</p> <p>The findings include:</p>	K 069	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>K 072 It is the practice of this center to assure that all miscellaneous life safety issues are within compliance at all times to include:</p> <ol style="list-style-type: none"> <li>1. The tables at the end of 300 and 400 hall have been moved. The wheel chair and cardboard boxes are no longer stored at the end of 300 hall corridor. Cleaning carts and chairs are no longer stored in the laundry corridor.</li> <li>2. All areas of the building have been examined to ensure corridors are maintained as a reliable means of egress.</li> <li>3. All staff will be in-serviced by 5/8/2012 by the Staff Development Coordinator on the importance of maintaining a means of egress free of obstructions or impediments. Weekly rounds will be done by the maintenance director to ensure this practice does not re-occur.</li> <li>4. Results of rounds will be reviewed by the facility Performance Improvement Committee monthly. Preventive Maintenance Logs will be reviewed by the PI committee monthly for three months and/or until the committee determines this plan is implemented and sustained. The executive director is responsible for overall compliance..</li> </ol>	5/8/2012
K 072 SS=E		K 072		

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

PRINTED: 04/27/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  04/10/2012
NAME OF PROVIDER OR SUPPLIER  HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066	
(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 072	Continued From page 11 Observation, on 04/10/12 between 1:00 PM and 1:30 PM, with the Director of Maintenance revealed the corridor at the end of the 300 and 400 hall to be blocked by tables. Furthermore the corridor on 300 hall had cardboard boxes and a wheelchair stored in the corridor. Further observation showed cleaning carts and chairs to be stored in the laundry corridor.  Interview, on 04/10/12 between 1:00 PM and 1:30 PM, with the Director of Maintenance revealed the facility routinely stored the carts in the laundry hall, and that the tables were always placed in the 400 and 300 halls.  Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	5/8/2012
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  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, it was determined the facility failed to ensure that no combustible decorations were used in the facility in accordance with NFPA standards. The deficiency had the potential to affect twelve (12) of twelve (12) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds with a census of eighty nine (89) on the day of the survey.	K 073	<b>K 073</b> It is the practice of this center to assure that all life safety issues are in compliance at all times to include: 1. Stuffed animals and hanging decorations that are not flame retardant have been removed from the facility. 2. The executive director and maintenance director made rounds throughout the facility to ensure there were not any decorations that were not flame retardant with corrections made as necessary. 3. Staff will be in-serviced by 5/8/2012 by the staff development coordinator to recognize and report to the maintenance director or executive director any items being brought into the center by visitors or family members that might not be fire retardant. The admissions coordinator will inform residents and family members upon admission that only flame retardant decorations will be allowed in the center.	

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K 073	Continued From page 12  The findings include:  Observation, 04/10/12 at 11:40 AM, with the Director of Maintenance revealed no policy for flame retardant spraying at the facility. Stuff animals and hanging decorations were found throughout the facility with no flame retardant.  Interview, 04/10/12 at 11:40 AM, with the Director of Maintenance revealed the facility did not allow decorations or stuff animals unless they had a flame retardant rating. He also confirmed the items we found did not have a flame retardant rating.  Reference: NFPA 101 (2000 Edition).  19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  A letter was sent by the executive Director on 5/7/2012 to all current family members informing them of this requirement.  4. Assigned angels will be instructed to monitor on their daily rounds for any new decorations which might not be fire retardant and report to the maintenance director or executive director. The maintenance director will make weekly rounds throughout the center to ensure no non-fire retardant decorations have been brought into the center and will report to the performance review committee monthly for three months and/or until the committee determines this deficiency to have been corrected and sustained. The executive director is responsible for monitoring compliance of this overall plan of correction.	
K 130 SS=D	NFPA 101 MISCELLANEOUS  OTHER LSC DEFICIENCY NOT ON 2786          This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure dead-end corridors were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of twelve (12) smoke compartments, residents, staff and visitors. The	K 130		

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K 130	Continued From page 13 facility is licensed for one hundred (100) beds and the census was eighty nine (89) on the day of the survey.  The findings include:  Observation, on 04/10/12 at 11:15 AM, with the Director of Maintenance revealed there was no second exit sign on the back of the laundry corridor. Making this exit not an exit made this over a 50' dead end corridor. Further observation showed the facility map that was provided showed a door marked exit on the facility map. Interview, on 04/10/12 at 11:15 AM, with the Director of Maintenance and the Administrator revealed they were unaware that you can only have a dead end corridor if it is impractical and unfeasible to provide a exit..  Reference: NFPA 101 (2000 Edition) 19.2.5.10 Existing dead-end corridors shall be permitted to be continued to be used if it is impractical and unfeasible to alter them so that exits are accessible in not less than two different directions from all points in aisles, passageways, and corridors.	K 130	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  K130 It is the practice of this center to assure that all miscellaneous life safety issues are within compliance at all times to include: 1. Exit signs have been installed in the laundry corridor. 2. All corridors throughout the facility have been examined to ensure exit signs are appropriately placed. 3. The maintenance director will conduct reviews of all exit signage during daily rounds and record findings in the preventive maintenance log on a weekly basis. Logs will be reviewed by the PI committee monthly for three months and/ or until this deficiency has determined to be corrected and sustained. 4. The executive director will be responsible for monitoring this overall plan of correction.	5/8/2012
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		

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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 the emergency generator was maintained in accordance with NFPA standards. The deficiency had the potential to affect twelve (12) of twelve (12) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds and the census was eighty nine (89) on the day of the survey.  The findings include:  Observation, on 04/10/12 at 2:15 PM, with the Director of Maintenance revealed the generator's battery charger was hooked directly to the generator battery. Battery chargers cannot be hooked directly to the generator battery due to increase risk of fire.  Interview, on 04/10/12 at 2:15 PM, with the Director of Maintenance revealed he was not aware of the battery charger being hooked directly to the generator battery.  Reference: NFPA 110 (1999 Edition).  5-12.6 The starting battery units shall be located as	K 144	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  K 144 It is the practice of this center to assure that all life safety issues are within compliance at all times to include: 1. The battery charger to the emergency generator is now permanently connected and is not directly connected to the battery. 2. All electrical wiring on the generator has been examined to ensure compliance. 3. Preventive Maintenance Logs will be maintained by the maintenance director weekly and reported to the PI committee monthly for three months and/or until it deems this deficiency corrected and sustained to ensure continued compliance. 4. The executive director will be responsible for the overall monitoring of this plan of correction.	5/8/2012

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K 144	Continued From page 15 close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers' recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.	K 144	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of twelve (12) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred (100) beds and the census was eighty nine (89) on the day of the survey.  The findings include:  Observations, on 04/10/12 between 10:30 AM and 2:10 PM, with the Director of Maintenance revealed electrical panels in the Unit Manager's Office, Med Room, and the Mechanical Room had storage within 3 feet of the electrical panels. The panels also had signs on them to maintain 3 feet of clearance around the panels.	K 147	K 147 It is the practice of this center to assure compliance with NFPA 70, National Electrical Code at all times to include:  1. The storage has been removed from the unit manager's office, med room and the mechanical room to maintain 3 feet of clearance from the electrical panels.  2. All electrical panels throughout the facility have been reviewed to ensure there is at least a 3 feet of clearance to the panels.  3. The maintenance director will make weekly rounds to ensure 3 feet of clearance. All staff will be inserviced by 5/8/2012 by the staff development coordinator to not place or store any item within 3 feet of an electrical panel.  4. The maintenance director will monitor through the use of preventive maintenance logs and report to the performance improvement committee monthly for three months and/or until the committee determines this deficiency is corrected and maintained.	5/8/11

  
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K 147	Continued From page 16  Interview, on 04/10/12 between 10:30 AM and 2:10 PM, with the Director of Maintenance revealed he was aware there could not be storage within 3 feet of electrical panels, but confirmed the storage was there.  Reference: NFPA 99 (1999 edition)  110-26. Spaces  About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K 147			