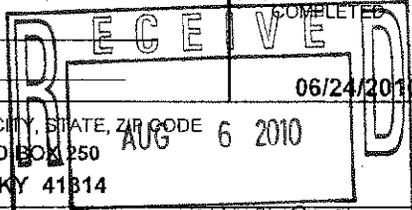


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Amended 303

PRINTED: 08/04/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2010
NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11, P O BOX 250 BOONEVILLE, KY 41314	
(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 MUST BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 156 SS=B	<p>A standard health survey was conducted on June 22-24, 2010. Deficient practice was identified with the highest scope and severity at an "E" level.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services,</p>	F 156	<p>Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.</p> <p><u>F 156 B Notice of Rights, Rules, Services, Charges</u></p> <p><i>Residents Found To Have Been Affected</i> The facility has validated that residents #3, #6, #7, #8, and #16 have completed verification of their receipt of the Notice of Medicare Provider Non-Coverage Denial.</p> <p><i>Identification of Other Residents with the Potential to Be Affected</i> All residents with Medicare coverage have been audited for Non-Coverage Denial notices. The facility has completed verification of their receipt of the Notice of Medicare Provider Non-Coverage Denial.</p>	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Judy Perry* TITLE: *Administrator* (X6) DATE: *08/05/10*

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 156	Continued From page 1 including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and	F 156	Systemic Changes The Medical Records Coordinator will provide resident Non-Coverage Denial notices to the Business Office Manager. The Business Office Manager will mail Medicare Non-Coverage Denial notices to the resident and/or responsible party by certified mail and verify return receipts. Monitoring The Medical Records Coordinator will provide the Medicare Utilization Committee with names of residents who have been sent a Medicare Non-Coverage Denial notice their verification of receipts. The Medicare Utilization Committee will validate that verifications have been received.	08/04/2010

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F 156	<p>Continued From page 2</p> <p>provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to include the verification of receipt of a Notice of Medicare Provider Non-Coverage denial notice for five (5) of five (5) residents' (residents #3, #6, #7, #8, and #16) records reviewed that had received a denial notice.</p> <p>The findings include:</p> <p>A review of the denial notices for non-Medicare coverage for residents #3, #6, #7, #8, and #16 revealed that the notices sent to the resident/responsible party failed to include verification of receipt of the notice.</p>	F 156	

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<p>F 156</p> <p>F 225 SS=D</p>	<p>Continued From page 3</p> <p>An interview with the Medical Records Manager (MRM) conducted on June 24, 2010, at 1:00 p.m., revealed the MRM was responsible for issuing the denial notices to the residents/responsible parties. The MRM stated she was unaware of the requirement to verify that the resident/responsible party received the denial notice. The MRM further stated the denial notice form letter utilized by the facility had a second page with an area for a verification of receipt signature and a checkbox to indicate if the resident/responsible party would like to have the bill sent to the Medicare Intermediary; however, the MRM did not include the second page when the denial letter was mailed to the resident/responsible party.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p>	<p>F 156</p> <p>F 225</p>	<p><u>F 225 D Investigate/Report Allegations/Individuals</u></p> <p><i>Residents Found To Have Been Affected</i> All residents have the potential to be affected and no targeted residents were listed in this citation.</p> <p><i>Identification of Other Residents with the Potential to Be Affected</i> All residents have the potential to be affected. The facility provided education to residents and/or responsible parties regarding misappropriation of property, the reporting policies of such to facility and the facility's reporting responsibilities to government agencies.</p>	

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F 225	<p>Continued From page 4</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure all allegations of misappropriation of residents' property were reported to the appropriate state agencies. During the group interview conducted with nine (9) alert/oriented residents, two (2) residents reported personal items were missing. The residents stated there was a "rogue" in the facility and they did not feel safe/protected from theft. The residents stated the missing items had been reported to Facility Administration; however, there was no evidence the facility reported the allegations of misappropriation of resident property to the appropriate state agencies.</p> <p>The findings include: A group interview conducted with nine alert and oriented residents on June 23, 2010, at 9:00 a.m., revealed two of the nine residents had missing clothing items that had been reported to the</p>	F 225	<p>Systemic Changes Missing personal items will be reported to the Social Worker/Designee and a concern/grievance report will be completed. The Social Worker/Designee will complete the investigation and findings will be submitted to the Administrator. The Administrator will report misappropriation of property to the appropriate government agencies. Logs and resolutions to grievances will be maintained by the Social Worker.</p> <p>Monitoring The Administrator will submit grievances, resolutions and reporting misappropriation of resident property to state agencies to the Quality Assurance Committee for their recommendations and follow-up.</p>	8/04/2010

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F 225	<p>Continued From page 5</p> <p>facility. The residents stated the facility looked for the missing clothing; however, the facility could not find the items, and the facility replaced the items. The residents stated they believed there was a "rogue" in the facility and had been told not to leave any monies "lying around." The residents stated they did not feel safe/protected from theft by the facility.</p> <p>An interview with the Social Worker on June 23, 2010, at 4:50 p.m., revealed when a resident reported a missing item a resident concern report was generated and the facility began to search for the missing item. The Social Worker investigated the missing item, and all department heads were notified in the morning meeting of the missing item, and the department heads then search their areas. According to the Social Worker, if the item was not found the Administrator was notified, and the Administrator would decide to replace the item or not. The Social Worker stated that state agencies were not notified when a resident reported incidents of missing personal property.</p> <p>An interview with the Administrator on June 23, 2010, at 3:50 p.m., revealed the Social Worker filled out a resident concern report, and notified Laundry and Housekeeping to look for the missing items. The Social Worker would interview the resident to determine when the item was missing and any details regarding the item. The Administrator stated the Social Worker would contact the responsible party to determine if the family had taken the item home, as well as to notify them of the item being missing. The missing item would then be reported in the morning meeting and all areas would assist to look for the missing item. The Administrator stated if the item could not be found, the facility</p>	F 225		

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F 225	Continued From page 6 either replaced the item or gave the responsible party the money to replace the item for the resident. The Administrator stated the state agencies were not contacted regarding reported incidents of missing personal property. A review of the facility policy related to misappropriation of resident property (no date) revealed that all incidents of misappropriation of resident property were required to be reported to the Administrator or designee immediately. The policy further noted an in-house investigation would be initiated and the Administrator or designee would notify the appropriate state agencies.	F 225		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to resolve grievances made by residents during the resident council meetings. During the group interview conducted with nine (9) alert/oriented residents, the residents verbalized that the facility administrative staff did not respond to grievances/concerns identified during the resident council meetings. In addition, a review of the resident council meeting minutes for the past three months revealed residents had verbalized	F 244	<u>F 244 E Listen/Act on Group Grievance/Recommendation</u> <i>Residents Found To Have Been Affected</i> All residents have the potential to be affected and no targeted residents were listed in this citation. <i>Identification of Other Residents with the Potential to Be Affected</i> All residents have the potential to be affected. Interviews have been completed with each resident or responsible party to note any concerns. These concerns have written resolutions and follow-up.	

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F 244	<p>Continued From page 7</p> <p>concerns related to noise levels in the facility and menus/food items being served too frequently. However, there was no evidence the facility had listened/acted upon the grievances voiced by the residents.</p> <p>The findings include:</p> <p>An interview with nine alert and oriented residents on June 23, 2010, at 9:00 a.m., revealed that the facility did not notify the residents of the findings of grievances voiced during the monthly resident council meetings. The group stated that for three months in a row the resident council had complained about noise levels in the main dining room being too loud, and about menu items (chicken/turkey) being served too frequently. The residents stated they had not received any resolutions from the facility in regard to the group's complaints.</p> <p>A review of the resident council meeting minutes for April 2010, May 2010, and June 2010 revealed the residents complained about noise levels in the main dining room, and about menus/food items (chicken, pork and beans, and turkey) being served too frequently.</p> <p>An interview with the Social Worker/Activity Director on June 23, 2010, at 4:50 p.m., revealed the SW/AD held the monthly resident council meetings with the residents. The SW/AD stated that when the residents verbalized complaints/concerns, a "Resident Concern Report" was required to be completed and the form contained a space to document the resolution to the resident's complaints. However, the SW/AD stated the "Resident Concern Reports" were not always completed and the</p>	F 244	<p>Systemic Changes</p> <p>A revised report will be completed by the Social Worker for any concern/grievance voiced by residents, families, responsible parties and groups of individuals such as the Resident Council. The Social Worker will investigate all concerns/grievances and provide written documentation of resolutions and these resolutions will be reported back to the originating party. The Administrator will have monthly reviews with the Social Worker of all grievances, resolutions and feedback to originating parties.</p> <p>Monitoring</p> <p>The Administrator will submit all concerns/grievances, resolutions and reporting back to the originating party to the Quality Assurance Committee for their recommendations and follow-up.</p>	08/04/2010

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F 244	Continued From page 8 residents were told verbally of the resolution. An interview with the Administrator on June 23, 2010, at 3:50 p.m., revealed the SW/AD was to follow up with the residents regarding concerns/grievances voiced by the residents in resident council. The Administrator further stated that any concerns were brought to the Administrator's attention and the concerns were voiced in the morning meetings.	F 244		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: *Amended-- Based on observation, interview, and record review, it was determined the facility failed to provide services to meet professional standards of quality for two (2) of twenty-two (22) sampled residents. The facility failed to provide dressing changes every three (3) days as ordered by the physician for resident #8. Facility staff was observed to administer crushed medications to resident #10 without rinsing the container used to crush the medication and without verifying the placement of the resident's gastrostomy tube. The findings include: 1. A review of the medical record for resident #8 revealed a physician's order dated June 11, 2010, for wound care to be provided to a staged ulcer to the left inner buttock. According to the	F 281	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.	

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F 281	<p>Continued From page 9</p> <p>physician's order the wound was to be cleaned with soap and water and a Versiva dressing was to be applied every three days. A review of the treatment record for the resident revealed the dressing for resident #8 was to be changed on June 22, 2010.</p> <p>Observation on June 22, 2010, of resident care with CNAs #1 and #2 revealed resident #8 had a pressure ulcer noted to the resident's left inner buttock/thigh. The wound was reddened in appearance, open, and with no drainage. The wound did not have a dressing covering the wound.</p> <p>Observation of wound care with the facility's wound care nurse at 3:35 p.m. on June 23, 2010, revealed resident #8 did not have a dressing covering the wound on the left inner buttock/thigh. The wound was cleansed by the wound care nurse with sterile water, and a Versiva dressing was applied.</p> <p>An interview with the facility's wound care nurse at 3:35 p.m. on June 23, 2010, revealed she/he had been employed by the facility for one year. The wound care nurse stated she/he works each wing two times weekly, however, when he/she is not working the floor nurse is responsible for providing wound care to the residents. The nurse further stated he/she was not working on the date the dressing was scheduled to be changed.</p> <p>An interview was conducted on June 23, 2010, with the Registered Nurse (RN) who was responsible for providing wound care for resident #8 on June 22, 2010. The RN stated he/she did not have time to change the dressing for resident #8. The RN stated he/she was aware the</p>	F 281	<p><u>F 281 D Services Provided Meet Professional Standards</u></p> <p><i>Residents Found To Have Been Affected</i> Resident #8 is receiving dressing changes every 3 days as ordered by the physician by the facility treatment nurse. The placement of the gastrostomy tube for Resident #10 is being verified before medication administration.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected. All residents are receiving services that meet professional standards including wound care as verified by auditing of the treatment records daily by the RN clinical manager. Medications are being administered appropriately through gastrostomy tubes after verification of placement of the tube as evidenced by the med pass competency observations performed by the Director of Nursing and the RN Clinical Manager.</p> <p><i>Systemic Changes</i> Pharmacy has reviewed the Medication Administration Records for all residents with a gastrostomy tube to validate that the medications can be administered per G-tube. An in-service has been conducted on 7-29-10 with the licensed nurses and CMT's on medication administration including medications that are not to be crushed along with g-tube</p>	

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F 281	<p>Continued From page 10</p> <p>resident's dressing was due to be changed on June 22, 2010. The RN stated the shift had been very busy and he/she had not had time to do wound care for resident #8. The RN stated the RN had passed on in shift report at 7:00 p.m., that the resident's dressing had not been changed. However, the RN further stated the night shift had also been very busy and had not gotten time to provide the dressing change.</p> <p>2. During the medication administration pass conducted on June 22, 2010, at 4:00 p.m., observations revealed the RN removed Lortab 10/500 mg from the narcotics drawer of the medication cart. The RN was observed to place the tablet into a plastic container and to crush the medication. The RN was then noted to discard the plastic container into the trash bag; however, a small amount of the white powder remained in the plastic container. The RN was then observed to administer the medication to resident #10 via a gastrostomy tube (G/T). Prior to administering the medication, the Registered Nurse (RN) disconnected the G/T and poured approximately 30 cc of water into an Asepto syringe and then added the crushed medication to the Asepto syringe. The RN was observed to administer the medication to resident #10 and flush the G/T with water. However, the RN failed to verify the appropriate placement of the G/T prior to administering the medication/water to resident #10.</p> <p>A review of the facility's policy/procedure (no date) related to G/T medication administration revealed G/T placement was required to be verified prior to administering medications by using two methods: aspiration, and to check for residual.</p>	F 281	<p>administration by the Director of Nursing on 7-29-10. Additionally the licensed nurses and CMT's have been checked off with a med pass observation by a registered nurse and competency validated. The Director of Nursing also in-serviced the nurses on 7-29-10 on wound care and following the physician's orders. The facility has added a RN clinical manager to assist in monitoring clinical services provided to the residents including daily auditing of treatment books and quarterly med pass observations with the nurses and CMT's.</p> <p>Monitoring The audits being performed by the RN clinical manager on treatments and medication pass observation is given to the Director of Nursing daily. The Director of Nursing will review and report findings to the quarterly Quality Assurance Committee Meetings for recommendation and follow-up.</p>	08/04/2010

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F 281	Continued From page 11 An interview conducted with the RN on June 22, 2010, at 4:30 p.m., revealed the RN stated G/T placement was to be verified by auscultation prior to administering medications. The RN further stated she had not been instructed to rinse the plastic container after crushing a medication to ensure all medications were removed. An interview conducted with the DON on June 24, 2010, at 1:25 p.m., revealed G/T placement was required to be verified per the facility's policy/procedure prior to administering medications. In addition, the DON stated medication cups and containers utilized to crush medications should be rinsed to ensure the correct dosage is administered to the residents.	F 281			
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: *Amended-- Based on observation, interview, and record review, it was determined the facility failed to maintain a medication error rate of less than five (5) percent. Three different staff nurses were observed during the medication administration observation conducted on June 22 and 23, 2010. Six (6) medication administration errors were observed in forty-five (45) opportunities, resulting in a 13 percent medication error rate.	F 332	<u>F 332 E Free of Medication Error Rates of 5% or more</u> <i>Residents Found To Have Been Affected</i> The physician for Resident # 11 was notified that the medication wasn't administered before the meal, no new orders received. The resident is currently receiving the medication before meals. The physician for Resident #12 was notified that the Ativan was being held due to decrease in resident's behaviors, a new order was received to change the medication to "hold for sedation". In addition, the physician was made aware of the Dilantin dose being administered 45 minutes past the allotted time frame and that the Metformin 500mg not been administered, no new orders received.		

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F 332	<p>Continued From page 12</p> <p>The findings include:</p> <p>1. Observations of medication administration for resident #11 on June 23, 2010, at 9:00 a.m., revealed the resident was administered 600 milligrams of Gemfibrozil. Instructions written on the Medication Administration Record (MAR) were to "take 1/2 hour before meals."</p> <p>An interview with RN #1, who administered the medication, was conducted at 2:50 p.m. on June 23, 2010. RN #1 stated he did not see the instructions to "take 1/2 hour before meals."</p> <p>An interview with RN #2 was conducted on June 23, 2010, at 3:40 p.m. RN # 2 stated she was responsible for reviewing the MARs for the month of June 2010 and "missed" the additional instructions when she was completing the review.</p> <p>2. Observation of medication administration for resident #12 on June 23, 2010, at 9:45 a.m., revealed the resident was administered Dilantin Liquid 200 milligrams/8 milliliters per gastrostomy tube (G/T). The resident had a physician's order for Dilantin 200 milligrams. A review of the Medication Administration Record (MAR) revealed resident #12 was scheduled to receive Dilantin at 8:00 a.m. and 8:00 p.m.</p> <p>An interview conducted on June 23, 2010, at 11:15 a.m., with the Licensed Practical Nurse (LPN) responsible for administering medications for resident #12 revealed the LPN had experienced a hectic/busy morning and as a result the medications were not administered per the scheduled times on the MAR. The LPN stated that he/she was aware medications were to be administered no sooner than one hour prior</p>	F 332	<p>The Resident is currently receiving medications as ordered by the physician and according to professional standards and in a timely manner which is, no earlier than one hour before the scheduled times and no later than one hour after the scheduled time. Also Resident #12 is also receiving the Ascorbic Acid and Multivitamin per G-tube as recommended by the facility's Pharmacist. The physician for Resident #21 has been notified of receiving her am doses of medications one hour past the allotted time frame, no new orders received. The resident is currently receiving her medications as ordered by the physician in a timely manner which is, no earlier than one hour before the scheduled times and no later than one hour after the scheduled times.</p> <p>Identification of Other Residents with the Potential to be Affected</p> <p>The Director of Nursing and the RN Clinical Manager are monitoring medication pass completion times to make sure time frames are in compliance. The Medication Administration Records (MAR) have been compared with the physician's orders to verify that all medications are on the MAR's including special instructions for administration of all residents by the facility RN Quality Assurance Nurse. Medication pass observation checks have been completed on all licensed nurses and Certified Medication Technician's (CMT) by the</p>	

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F 332	<p>Continued From page 13</p> <p>to administration time and no later than one hour after administration time.</p> <p>3. Observation of medication administration for resident #12 on June 23, 2010, at 9:45 a.m., revealed resident #12 had a physician's order for Ativan 0.5 milligrams twice daily. The Ativan was not administered during medication administration.</p> <p>A review of the medical record revealed resident #12 was readmitted to the facility on June 14, 2010, with a new order for Ativan 0.5 mg to be administered twice a day for behaviors. A review of the MAR revealed Ativan was scheduled to be administered at 8:00 a.m. and at 8:00 p.m.; however, the medication was not observed to be administered during the medication pass on June 23, 2010. The MAR further revealed Ativan had been withheld 11 times since the resident had been readmitted from the hospital on June 14, 2010. The Ativan had been charted as being withheld on June 15, 2010, at 8:00 a.m., June 16, 2010, at 8:00 a.m. and 8:00 p.m., June 17, 2010, at 8:00 a.m. and 8:00 p.m., June 18, 2010, at 8:00 p.m., June 19, 2010, at 8:00 a.m., June 20, 2010, at 8:00 a.m. and 8:00 p.m., June 22, 2010, at 8:00 a.m., and June 23, 2010, at 8:00 a.m.</p> <p>An interview conducted with the LPN responsible for administering medications for resident #12 was conducted on June 23, 2010, at 11:15 a.m. The interview revealed the LPN usually worked the night shift. The LPN stated the Ativan was not administered to resident #12 due to "the behavior the resident is having is normal for him."</p> <p>4. A review of the medical record for resident #12 further revealed the resident was readmitted to</p>	F 332	<p>RN Clinical Manager and the Director of Nursing.</p> <p>Systemic Changes</p> <p>The Licensed nurses and CMT's have been in-serviced on the proper procedures for Medication Administration including appropriate administration times, giving medications with special administration instructions, notifying the physician if for any reason a medication is not given and the importance of transcribing physician orders to the MAR's. The in-service was conducted on 7-29-10 by the Director of Nursing and RN Clinical Manager. This in-service will be completed on a quarterly basis. The following are new systems that the facility has implemented: Special instructions for the administration of medications will be highlighted in yellow to alert appropriate medication administration staff. New resident admission and readmission physician orders will require two nurses signature validating that the orders have been transcribed accurately to the MAR's. The monthly change over process will include checking all Physician's orders for the last month to the current month's MAR's and then checking the new (next month's) MAR's with the current month's MAR's, this will be completed each month by the RN Quality Assurance Nurse. The RN Clinical Manager will complete a second check comparing the old MAR with the new MAR before they are used. The licensed nurses and CMTs will have a med pass competency observation pass</p>		

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F 332	<p>Continued From page 14</p> <p>the facility on June 14, 2010, with a physician's orders for Metformin 500 mg to be administered to resident #12 twice a day per the resident's G/T; however, there was no evidence the medication had been transcribed to the MAR. The medication was not observed to be administered to resident #12 as ordered during the medication observation pass on June 23, 2010, at 8:00 a.m.</p> <p>An interview conducted with the LPN on June 23, 2010, at 11:15 a.m., revealed the LPN was not aware resident #12 had an order for Metformin.</p> <p>An interview with RN #2 was conducted on June 23, 2010, at 4:50 p.m. The interview revealed RN #2 was responsible for checking all MARs for the month of June 2010, however, was not responsible for checking residents' orders when a resident returned in the middle of the month from the hospital. The RN further stated the nurse who was responsible for checking the orders after resident #12 returned from the hospital on June 14, 2010, was on vacation at this time, and was not available for an interview.</p> <p>5. A review of the MAR for resident #21 revealed the resident had physician's orders to receive Diltiazem 30 mg for hypertension every six hours at 8:00 a.m., 2:00 p.m., 8:00 p.m., and 2:00 a.m. However, the medication was not observed to be administered to resident #21 until 10:00 a.m. on June 22, 2010.</p> <p>An interview conducted with the LPN on June 22, 2010, at 10:15 a.m., revealed the LPN stated, "Some days I can't get it all done." The LPN stated she had not reported these concerns with medication pass to anyone.</p>	F 332	<p>completed quarterly by the Clinical Manager, QA nurse, DON or with the pharmacy consultant.</p> <p>The Director of Nursing will have the responsibility for oversight of the monthly Medication Administration Record changeover process and will validate admission and readmission physician orders for compliance.</p> <p>The Director of Nursing will schedule the licensed nurses and CMTs for each quarterly med pass observation and medication pass in-service.</p> <p>Monitoring The Director of Nursing will review medication administration functions to include checking MARs, medication times, notifications and training with the Quality Assurance Nurse and the Clinical Manager. The DON will submit the findings and progress of medication administration to the quarterly Quality Assurance Committee Meetings for their recommendations and follow-up.</p>	08/04/2010	

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F 332	Continued From page 15 An interview conducted with the DON on June 24, 2010, at 1:25 p.m., revealed random audits were conducted at the facility by the consultant pharmacist during medication administration. The DON stated no problems related to the timeliness of drug administration had been identified. A review of the facility's policy/procedure related to medication administration (dated October 15, 2005) revealed medications are required to be administered at the time ordered, or within 60 minutes before or after the designated time except medications ordered before meals or after meals. 6. A review of the MAR for resident #21 revealed the resident had physician's orders to receive Lasix 20 mg (3 tablets) twice a day at 8:00 a.m. and 5:00 p.m. for hypertension. However, observation during the medication pass conducted on June 22, 2010, revealed the medication was not administered to resident #21 until 10:00 a.m.	F 332		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that – (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F 334	<u>F 334 E Influenza and Pneumococcal Immunizations</u> <i>Residents Found To Have Been Affected</i> The responsible party for Resident #15 has received the information/education regarding the risks/benefits of the Influenza and Pneumococcal Immunizations and signatures obtained, vaccines were still declined. The responsible party for Resident #14 has received the information/education	

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F 334	<p>Continued From page 16</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical</p>	F 334	<p>regarding the risks/benefits of the Influenza and Pneumococcal Immunizations and signatures obtained, vaccines were still declined. The responsible party for Resident #9 has received the information/education regarding the risks/benefits of the Influenza and Pneumococcal Immunizations and signatures obtained, vaccines were still declined. The responsible party for Resident #10 has received the information/education regarding the risks/benefits of the Influenza and Pneumococcal Immunizations and signatures obtained, vaccines were still declined. The responsible party for Resident #12 has received the information/education regarding the risks/benefits of the Influenza and Pneumococcal Immunizations and signatures obtained, vaccines were still declined. The responsible party for Resident #4 has received the information/education regarding the risks/benefits of the Influenza and Pneumococcal Immunizations and signatures obtained, vaccines were still declined. The responsible party for Resident #17 has received the information/education regarding the risks/benefits of the Influenza and Pneumococcal Immunizations and signatures obtained, vaccines were still declined.</p>	

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F 334	<p>Continued From page 17 contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide education regarding the benefits and potential side effects for the influenza and pneumococcal vaccines for seven (7) of twenty-two (22) sampled residents.</p> <p>The findings include:</p> <p>1. A review of the medical record for resident #15 revealed the resident was admitted to the facility on May 19, 2010. Further review of the medical record revealed documentation that the resident's responsible party (R/P) refused the influenza and pneumococcal vaccines when the resident was admitted to the facility. However, there was no evidence the facility provided the resident's R/P with information/education regarding the risks/benefits of these vaccines.</p> <p>A review of the admission assessment conducted on May 24, 2010, revealed resident #15 was assessed to have short/long-term memory deficits and to be severely impaired with decision-making skills. Resident #15 was not interviewable.</p>	F 334	<p>Identification of Other Residents with the Potential to be Affected All residents have the potential to be affected. All residents or resident's responsible parties will receive education on the risks/benefits of the Influenza and Pneumococcal Immunizations by certified mail with verification of return receipt. The responsible party will be contacted by phone with two witnesses on any undelivered receipts and documented in the resident's charts.</p> <p>Systemic Changes The facility is implementing a new process in which the Admissions Director will assure that all newly admitted or readmitted residents or their responsible party will be educated on the risks and benefits for the Influenza and Pneumococcal Immunizations. The documentation of the education for the risks and benefits of the immunizations will be filed in the resident's record. The Medical Records Coordinator will assume the responsibility of sending out the offer letters along with the education and risk and benefits for the Influenza and Pneumonia Immunization every year to each resident or responsible party including the residents who had declined the immunizations the past year. In addition, the Medical Records Coordinator will track the return offer letters and on the letters not returned, the families will be called by phone to get their wishes on the immunizations and documented in the resident's medical record. The Medical Records</p>	

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F 334	<p>Continued From page 18</p> <p>An interview conducted with the Admissions Clerk (AC) on June 24, 2010, at 10:50 a.m., revealed the AC informed the resident and the R/P about the availability of the vaccines and if the vaccine was refused the resident or R/P signed the vaccine form. The AC stated no education/information was provided to the resident or the resident's R/P regarding the vaccines.</p> <p>A review of the facility's policy/procedure related to the influenza vaccine (no date) revealed the resident would be offered an influenza vaccine annually. The policy/procedure noted the vaccine was considered an elective and required the signature of the resident, guardian, or responsible party. The policy/procedure further noted the resident and/or legal representative would receive education regarding the benefits and potential side effects of the vaccine and the facility was required to maintain documented evidence of the education.</p> <p>A review of the facility's policy/procedure related to the pneumococcal vaccine (no date) revealed the resident or responsible party would be asked regarding the resident's vaccine history and the resident's age at the time of immunization. The policy/procedure noted if there was no prior history of vaccination, the vaccine would be offered to the resident at that time. The policy/procedure further noted the resident and/or legal representative would receive education regarding the benefits and potential side effects of the vaccine and the facility was required to maintain documented evidence of the education.</p> <p>2. A review of the medical record for resident #14</p>	F 334	<p>Coordinator will give the list of resident's who are to receive the immunizations each year to the Director of Nursing for appropriate administration.</p> <p>Monitoring The Director of Nursing will submit Influenza and Pneumococcal Immunizations reports to include evidence of information/education and risks/benefits to the quarterly Quality Assurance Committee for their review, recommendations and follow-up.</p>	08/04/2010	

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F 334	<p>Continued From page 19</p> <p>revealed the resident's responsible party refused the influenza and pneumococcal vaccines for the resident on May 8, 2007. There was no evidence the facility had provided resident #14 or the resident's responsible party with education regarding the risks and benefits of receiving the vaccines.</p> <p>3. A review of the medical record for resident #9 revealed the resident's responsible party refused the influenza and pneumococcal vaccines for the resident on July 24, 2007. There was no evidence the facility provided the responsible party with education regarding the risks and benefits of receiving the vaccines.</p> <p>4. A review of the medical record for resident #10 revealed the responsible party had refused the influenza and pneumococcal vaccines for resident #10 on May 29, 2008. There was no evidence the facility provided the responsible party with education regarding the risks or benefits of receiving the vaccines.</p> <p>An interview with the infection control nurse on June 24, 2010, at 4:00 p.m., revealed the facility received signed consent or refusal of consent for all vaccines, however, never addressed the risks and benefits for the vaccines with the responsible parties. The infection control nurse further stated the facility did not ask the responsible party if the vaccine could be given from year to year; the facility only asked about the vaccines upon admission, or upon the physician's request.</p> <p>5. A review of the medical record for resident #12 revealed the resident/responsible party refused the influenza and pneumococcal vaccines when the resident was admitted to the facility. There</p>	F 334		

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F 334	Continued From page 20 was no evidence the facility had provided resident #12 or the responsible party with education regarding the risks and benefits of receiving the vaccines. 6. A review of the medical record for resident #4 revealed the resident/responsible party refused the influenza and pneumococcal vaccines when the resident was admitted to the facility on October 6, 2009. There was no evidence the facility had provided resident #4 or the resident's responsible party with education regarding the risks and benefits of receiving the vaccines. 7. A review of the closed medical record for resident #17 revealed the resident was admitted to the facility on May 26, 2009, and discharged home on June 9, 2010. A review of the immunization record revealed the influenza and pneumococcal vaccines were refused. According to the documentation, the resident had signed a refusal form for these vaccines. However, there was no evidence the facility had provided information/education regarding the risks/benefits of these vaccines to resident #17.	F 334			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431	<u>F 431 D Drug Records, Label/Store Drugs & Biologicals</u> <i>Residents Found to Have Been Affected</i> The opened vial of injectable Vitamin B Complex and the opened vial of injectable Folic Acid that was stored in the medication refrigerator have been replaced with new vials and dated as opened.		

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F 431	<p>Continued From page 21</p> <p>professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to label all drugs and biologicals used in the facility in accordance with currently accepted professional principles including the expiration date when applicable. An opened vial of injectable Vitamin B Complex and a vial of injectable Folic Acid were stored in the medication refrigerator. However, the medication vials did not have a date to indicate when the vials had been initially opened.</p> <p>The findings include: Observation of the East Wing medication room</p>	F 431	<p>Identification of Other Residents with the Potential to be Affected The facility's policy is being followed and nurse's are dating and initialing vials of medication as opened and discarding the appropriate medications after 48 hours of being opened.</p> <p>Systemic Changes The Director of Nursing and the new RN Clinical Manager have in-serviced the Licensed Nurses and CMT's on 07/29/2010 on storage of Medication and Biologicals including dating and initialing vials when opened. The medication rooms and medication refrigerators are being checked weekly by the RN Clinical Manager for compliance and results are reviewed with the Director of Nursing.</p> <p>Monitoring The Director of Nursing submits Drug and Biological reports that includes opening and dating of vials, disposal of vials, and storage of vials to the quarterly Quality Assurance Committee Meetings for their review and recommendations.</p>	08/04/2010

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F 431	<p>Continued From page 22</p> <p>on June 24, 2010, at 3:45 p.m., revealed a multi-dose vial of Vitamin B Complex for intramuscular or intravenous use and a multi-dose vial of Folic Acid for intramuscular or subcutaneous use were stored in the medication refrigerator. The medication label did not contain a date to indicate when these medication vials had been first opened. The expiration date could not be determined for these medications.</p> <p>A review of the facility's policy (no date) related to drugs and biologicals revealed the nurse was responsible to date/initial the medication container when a vial of medication was opened.</p> <p>An interview was conducted with the East Wing Charge Nurse on June 24, 2010, at 4:00 p.m. The Charge Nurse stated multi-dose vials of Vitamin B Complex and Folic Acid were required to be dated when opened and discarded after 48 hours of being opened.</p>	F 431	
F 465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Multiple resident doors were observed to be soiled and splintered. The walls surrounding resident lavatories were observed to be covered</p>	F 465	<p>F 465 E <u>Safe/Functional/Sanitary/Comfortable Environment</u></p> <p><i>Residents Found To Have Been Affected</i></p> <p>1. Resident room doors 101, 102, 103, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 200, 201, 202, 204, 206, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 219, 220, 221, and 222 have been cleaned and new coatings applied.</p>

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F 465	<p>Continued From page 23</p> <p>with a wood substance that was worn/faded. Several resident lavatory fixtures and/or drains were noted to be rusty and sink vanities were noted to have chipped areas with sharp edges. In addition, the former smoke room located on the East Wing continued to have a strong stale smoke odor.</p> <p>The findings include:</p> <p>Observations of the facility for June 22, 2010 thru June 24, 2010, revealed the following areas were in need of maintenance/housekeeping services:</p> <ol style="list-style-type: none"> 1. Observation of resident room doors revealed the doors were noted to have a heavy buildup of soil on resident rooms 101, 102, 103, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 200, 201, 202, 204, 206, 207, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, and 222. 2. Rough, splintered edges were observed on resident doors in rooms 109, 110, 111, 112, 114, 116, 117, 120, 121, 123, 128, 200, 201, 206, 207, 208, 209, 211, 212, 214, 215, 216, 217, 218, 219, and 221. 3. Rusty lavatory fixtures and/or drains were observed in resident rooms 103, 109, 110, 111, 112, 114, 118, 119, 120, 121, 122, 123, 124, 207, 208, 210, 213, 215, 216, and 217. 4. Walls surrounding the lavatories were observed to be covered with a wood surface that was worn/faded in resident rooms 103, 211, 212, 214, 215, 216, 217, and 221. 	F 465	<ol style="list-style-type: none"> 2. Resident room doors 109, 110, 111, 112, 114, 116, 117, 120, 121, 123, 128, 200, 201, 206, 207, 208, 209, 211, 212, 214, 215, 216, 217, 218, 219, and 221 have had rough, splintered edges repaired. 3. Resident rooms 103, 109, 110, 111, 112, 114, 118, 119, 120, 121, 122, 123, 124, 207, 208, 210, 213, 215, 216, and 217 have had rusty lavatory fixtures and/or drains replaced. 4. Resident rooms 103, 211, 212, 214, 215, 216, 217, and 221 have had wood surface on walls surrounding the lavatories refreshed with coatings. 5. Resident rooms 211, 214, and 219 have new vanity sink tops installed. 6. The former resident smoke room located in the East Unit has undergone renovation and no longer has a tobacco smoke odor. <p>Identification of Other Residents with the Potential to Be Affected The Housekeeping Supervisor will perform checks of all resident rooms to check for needed repairs that includes doors, lavatories, and vanity sink tops.</p> <p>Checks will be made of existing smoke areas for tobacco smoke odors.</p> <p>Systemic Changes A monthly audit form has been developed by the Housekeeping Supervisor for the maintenance of each resident room that includes doors, lavatories and vanities. The audit will be completed by the Housekeeping</p>	

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F 465	Continued From page 24 5. Vanity sink tops with sharp edges were observed in resident rooms 211, 214, and 219. 6. The former resident smoke room located in the East Wing day room was observed to have a strong odor of stale tobacco smoke; however, the smoke room had been moved to the West Wing several months ago. An interview with the Maintenance Director conducted during the environmental tour on June 24, 2010, at 1:30 p.m., revealed the Maintenance Director and Housekeeping Supervisor made weekly rounds to check for areas in need of housekeeping/maintenance services. The Maintenance Director further stated staff was to notify him of problems needing attention.	F 465	Supervisor. The Housekeeping Supervisor will review the maintenance audits with the maintenance department and the Administrator. Monitoring The Administrator will submit the monthly maintenance audit findings to the Quality Assurance Committee for their recommendations and follow-up.	08/04/2010
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide timely laboratory services to meet the needs for two (2) of twenty-two (22) sampled residents (residents #5 and #8). Resident #5 had physician's orders for a Dilantin level, Basic Metabolic Panel (BMP), Complete Blood Count (CBC), and a Prothrombin Time/International Normalized Ratio (PT/INR) to be conducted monthly. However, there was no evidence the lab tests had been obtained since May 13, 2010. Resident #8 had a physician's	F 502	<u>F 502 D Provide/Obtain Laboratory SVC-Quality/Timely</u> <i>Residents Found to Have Been Affected</i> Resident #5 had a Dilantin level, Basic Metabolic Panel (BMP), Complete Blood Count (CBC), and a Prothrombin Time/International Normalized Ratio (PT/INR) on June 23 rd , the physician was notified of results and no new orders were received. Resident #8 had a HbgA1C drawn on June 29 th , the physician was notified of results and no new orders were received.	

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F 502	<p>Continued From page 25</p> <p>order for an HgbA1C to be obtained every three (3) months; however, there was no evidence the lab test had been obtained since March 2, 2010.</p> <p>The findings include:</p> <p>1. A review of the medical record for resident #5 revealed the resident was admitted to the facility on January 6, 2006, with diagnoses that included Paranoia, Delusions, Alzheimer's Dementia, Chronic Anxiety, Gastroesophageal Reflux Disease, Hypertension, Coronary Artery Disease, and Seizure Disorder.</p> <p>Further review of the medical record revealed the resident's physician had ordered a Dilantin level, BMP, CBC, and PT/INR to be obtained monthly. There was no evidence in the resident's medical record that the laboratory testing had been completed since May 13, 2010.</p> <p>A review of the facility's laboratory calendar revealed the resident was scheduled for a lab draw on June 10, 2010, however, the tests had not been done.</p> <p>An interview with the Registered Nurse (RN) conducted at 4:45 p.m. on June 22, 2010, revealed the facility's procedure was for the Infection Control Nurse to write the routine lab tests on the large desk calendar at the nurses' station. The 11:00 p.m. to 7:00 a.m. staff was responsible to obtain the labs scheduled on the calendar. According to the RN, once the labs were obtained, the staff was to draw a line through the resident's name to indicate the lab had been obtained. If the lab could not be obtained for any reason, the information was to be passed on the next shift and no line was</p>	F 502	<p><i>Identification of Other Residents with the Potential to be Affected</i></p> <p>All residents have the potential to be affected. A lab audit has been completed by the facility's laboratory service to verify that all ordered lab work has been scheduled, drawn, results obtained and MD notified.</p> <p><i>Systemic Changes</i></p> <p>The facility has added a RN Clinical Manager to assist in monitoring clinical services provided to the residents including daily auditing of physician's orders. In addition, the lab tracking system has been revised to include the Clinical Manager receiving a copy of all physician orders daily and tracking all labs on a lab log sheet that includes tests ordered, the date the lab was drawn, the date results of lab was obtained and the date physician was notified. The desk lab calendar for the floor nurses which list the routine scheduled labs will be checked daily by the Clinical Manager to make sure the labs were drawn and will follow up on results of the labs. The facility has also in-serviced the licensed nurses on the procedures and tracking system of labs ordered and on the importance of obtaining labs timely and accurately, the in-service was conducted by the Director of Nursing and the Clinical Manager on 7-16-10.</p>	

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F 502	<p>Continued From page 26</p> <p>drawn through the resident's name. There was no line drawn through resident #5's name; however, the RN was unaware the labs had not been obtained on June 10, 2010, as scheduled until observed by the surveyor.</p> <p>An interview with the Infection Control Nurse (ICN) conducted at 5:00 p.m. on June 22, 2010, revealed the ICN was responsible to add routine laboratory tests to the calendars at the nurses' station and to check to ensure the labs had been obtained timely as ordered. The ICN further stated that he/she checked back near the end of the month to monitor that labs had been obtained. The ICN stated, "I don't have time to check any more often."</p> <p>2. A review of the medical record for resident #8 revealed the resident had been admitted to the facility on November 13, 2007, with diagnoses that included Diabetes Mellitus, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Hypertension, and Coronary Artery Disease.</p> <p>Further review of the medical record revealed the resident's physician had ordered an HgbA1C be obtained every three months. There was no evidence the HgbA1C had been obtained since March 2, 2010.</p> <p>A review of the facility's lab calendar revealed that the HgbA1C had not been added to the June calendar for the lab to be drawn.</p> <p>An interview conducted with the ICN on June 23, 2010, at 4:50 p.m., revealed that the HgbA1C had been omitted on the June lab calendar "by mistake."</p>	F 502	<p>The facility Quality Assurance Nurse will verify at the end of the month during monthly changeover of physician orders, that all ordered labs were obtained as a final check. The facility's laboratory service will conduct a quarterly lab audit of physician's orders to assure that all labs are scheduled and have been obtained in a timely manner. Findings will be reported to the Director of Nursing</p> <p>Monitoring The Director of Nursing will submit all lab findings to the quarterly Quality Assurance Committee Meetings for their recommendations and follow-up.</p>	08/04/2010	
F 514	483.75(l)(1) RES	F 514			

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F 514 SS=D	<p>Continued From page 27</p> <p>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain accurate clinical records for two (2) of twenty-two (22) sampled residents. Residents #6 and #10 had physician's orders for CPR to be given, however, both residents had signed Do Not Resuscitate documents in the resident's chart.</p> <p>The findings include:</p> <p>1. A review of resident #6's medical record revealed a signed Do Not Resuscitate consent form dated January 10, 2008, that expressed the responsible party's wishes for Do Not Resuscitate (DNR) for resident #6. Further review revealed a physician's order dated June 14, 2010, with the code status for resident #6 to be Cardiopulmonary Resuscitation (CPR).</p> <p>Observation of resident #6 on June 22, 2010,</p>	F 514	<p><u>F514D Resident Records-Complete/Accurate/Accessible Residents Found To Have Been Affected</u></p> <p>A physician's order for Do Not Resuscitate has been obtained for resident #6 and for resident # 10.</p> <p><i>Identification of Other Residents With The Potential To Be Affected</i></p> <p>All residents have the potential to be affected. An audit has been completed by the facility QA Nurse comparing the Physicians orders to the resident's Advance Directive to assure the Resident's Code Status is accurate.</p> <p><i>Systemic Changes</i></p> <p>The facility has implemented a new monthly change over process including a second nurse checking physician orders, and MAR's before they are used. Initially the facility's QA nurse will check all resident's physician's orders from current month to the new (month's) printed physician's orders to validate accuracy and then the RN Clinical Manager will complete a second check comparing the current month's physician's orders to the new month's printed physician's orders to assure accuracy of the medical records including code status. The RN Clinical Manager will report findings to the Director of Nursing.</p>	

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F 514	<p>Continued From page 28</p> <p>revealed resident #6 to be wearing a purple bracelet.</p> <p>A review of the facility policy titled Do Not Resuscitate (DNR) protocol (undated) revealed physician's orders should be obtained for the DNR status, as well as a signed consent form. The policy indicated that each resident whose code status was DNR was to wear a purple bracelet for immediate identification, and the resident's medical record was to have a white dot with a red stripe down the middle for easy identification of the DNR code status.</p> <p>Interview with two CNAs that worked with resident #6 revealed the code status for resident #6 was DNR. The CNAs stated that residents who had a DNR code status wore purple bracelets.</p> <p>An interview conducted with the infection control nurse (ICN) on June 24, 2010, at 4:00 p.m., revealed the ICN reviewed the charts on a monthly basis for new orders, and reviewed the physician's orders to assure the records were correct; however, the ICN stated the code status for resident #6 had been missed and the resident's code status was DNR</p> <p>2. A review of resident #10's medical record revealed a physician's order dated June 14, 2010, with the code status listed as CPR. Further review revealed a DNR consent dated September 8, 2008, signed by the responsible party for resident #10 indicating the resident's code status to be DNR. A photocopy of resident #10's orders from the primary caregiver was included in the admission orders for resident #10.</p> <p>An interview with resident #10's nurse on June</p>	F 514	<p>Monitoring</p> <p>The Director of Nursing will report findings to the quarterly Quality Assurance Committee Meeting for review and recommendations.</p>	08/04/2010

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/24/2010
NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11, P O BOX 250 BOONEVILLE, KY 41314		
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F 514	<p>Continued From page 29</p> <p>23, 2010, at 6:00 p.m., revealed that resident #10 had a code status of DNR. The nurse further stated that resident #10's chart was marked with a white dot and a red stripe to indicate DNR code status and resident #10 wore a purple bracelet to indicate DNR code status.</p> <p>An interview with the infection control nurse (ICN) on June 24, 2010, at 4:00 p.m., revealed the ICN reviewed the charts on a monthly basis for new orders, and reviewed the physician's orders to assure the records were correct; however, the ICN stated the code status for resident #10 must have been missed and the code status was DNR.</p> <p>A review of the facility policy titled Do Not Resuscitate (DNR) protocol (undated) revealed physician's orders should be obtained for the DNR status, as well as a signed consent form. The policy indicated that each resident whose code status was DNR was to wear a purple bracelet for immediate identification, and the resident's medical record was to have a white dot with a red stripe down the middle for easy identification of the DNR code status.</p>	F 514			

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 185273	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 6/24/2010
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F 164	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to protect the residents' privileged medical information for one (1) resident (resident #22) during the medication observation pass conducted on June 22, 2010. During the medication observation pass, the Medication Administration Record (MAR) was left open on top of the medication cart in the hallway exposing the resident's medical information to the public.</p> <p>The findings include:</p> <p>A medication observation pass conducted for resident #22 on June 22, 2010, at 4:05 p.m., revealed the facility staff nurse (RN #1) prepared the resident's medication and then went into the resident's room to administer the medications to resident #22. LPN #1 was observed to leave the MAR open and exposed to the resident's medical information, which included the resident's diagnoses and prescribed medications. Residents and other facility staff were observed to be in the hallway.</p> <p>An interview conducted with RN #1 on June 22, 2010, at 4:30 p.m., revealed the RN was required to keep the MAR covered when administering medication to the residents.</p> <p>An interview conducted with the Director of Nurses (DON) on June 24, 2010, at 1:25 p.m., revealed the medication nurses had been trained to cover the MAR when administering medications to the residents.</p> <p>A review of the facility policy/procedure (no date) to address confidentiality of the resident's medical record during medication administration revealed the MAR was required to be covered to protect the resident's personal information.</p>		

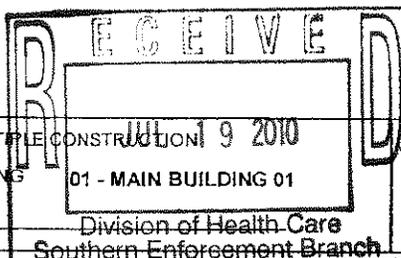
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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

The above isolated deficiencies pose no actual harm to the residents

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F 164	<p>Continued From Page 1</p> <p>F 164 A Personal <u>Privacy/Confidentiality of Records</u></p> <p><i>Residents Found To Have Been Affected</i> The MAR is presently covered for Resident #22 when administering medications. The nurse has been re-inserviced on the importance of covering the MAR for resident #22.</p> <p><i>Identification of Other Residents with the Potential to Be Affected</i> Confidentiality audits are completed with the medication pass observations to assure that confidentiality is being protected for all residents to include the MARs during medication administration.</p> <p><i>Systemic Changes</i> Nursing staff have been inserviced on the importance of confidentiality and how to achieve confidentiality. This inservice included the confidentiality of MARs and was conducted on 7-29-10.</p> <p><i>Monitoring</i> The newly hired Clinical Manager will monitor confidentiality of medication administration records quarterly at medication administration observations for licensed nurses.</p> <p>Completion Date: 8/04/2010</p>		

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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on June 24, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When 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, the facility failed to ensure that a hazardous area door was equipped with a self-closing device. This deficient practice affected one (1) of six (6) smoke compartments, staff, and approximately twenty-one (21) residents. The facility has the capacity for 99 beds with a census of 92 on the day of survey. The findings include:	K 029	<u>K 029 D Life Safety Code Standard</u> <u>NFPA 101</u> <i>Residents Found To Have Been Affected</i> A self-closing device has been installed on the door to the Medical Records room. <i>Identification of Other Residents with the Potential to Be Affected</i> All residents have the potential to be affected. All room doors have been checked and door closing devices are installed on all doors deemed to be a hazardous area. <i>Systemic Changes</i> The Maintenance Supervisor has developed an audit form to check each facility room to determine the need and presence for a door closing device. These checks will be performed monthly. Any rooms deemed to be a hazardous area and that needs a door closing device will have one installed within 24 hours. <i>Monitoring</i> The Administrator reviews the monthly safety check logs with the Maintenance Supervisor and submits the results to the quarterly meeting of the Quality Assurance Committee for their recommendations and follow-up.	8/04/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judy Perry TITLE: Administrator (X6) DATE: 07/16/10

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

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K 029	<p>Continued From page 1</p> <p>During the Life Safety Code tour on June 24, 2010, at 11:30 a.m., with the Director of Maintenance, a corridor door to the Medical Records room was observed to have an inoperable door closing device. Door closing devices are required on doors to rooms deemed to be a hazardous area. An interview revealed the Director of Maintenance was told to disable the door closing device by a consultant. The Director of Maintenance was unsure which rooms were considered hazardous that require door closing devices.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having 	K 029		

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K 029	Continued From page 2 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. 19.3.6.3.4 Door-closing devices shall not be required on doors in corridor wall openings other than those serving required exits, smoke barriers, or enclosures of vertical openings and hazardous areas.	K 029		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on an interview, the facility failed to ensure heat and air wall units (PTACs) were maintained by recommended manufacturer's standards. This deficient practice affected six (6) of six (6) smoke compartments, staff, and ninety-two (92) residents. The facility has the capacity for 99 beds with a census of 92 on the day of survey. The findings include: During the Life Safety Code tour on June 24,	K 067	<u>K 067 F Life Safety Code Standard NFPA 101</u> <i>Residents Found To Have Been Affected</i> All residents have the potential to be affected by K 067 Life Safety Code Standard. <i>Identification of Other Residents with the Potential to Be Affected</i> The Safety Committee Chairman contacted the manufacturer of the facility PTAC units to obtain the periodic maintenance recommendations for these units that include internal components. <i>Systemic Changes</i> The Safety Committee Chairman has developed a schedule for periodic maintenance of the facility PTAC units in accordance with the manufacturer's recommendations. The Maintenance Department will perform the maintenance on these units according to the manufacturer's recommendations and that includes the internal components. A maintenance record will be maintained by the Maintenance Director.	

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K 067	Continued From page 3 2010, at 11:15 a.m., with the Director of Maintenance, an interview revealed that resident, office, and other PTAC units located in the facility were maintained by changing the filter monthly. The Director of Maintenance stated no other maintenance was being performed on the PTAC units. Manufacturers of these units recommend having periodic maintenance performed on internal components of these units so the unit will operate as intended. Not complying with the manufacturer's recommendations may cause conditions to exist to create a potential fire hazard. An interview with the Director of Maintenance at 1:20 p.m. on June 24, 2010, revealed the Director of Maintenance did not think that not following manufacturer's recommendations could create a potential hazard with PTAC units.	K 067	Monitoring The Administrator reviews the maintenance performance record with the Maintenance Director monthly and submits the results to the quarterly meeting of the Quality Assurance Committee for their recommendations and follow-up.	8/04/2010
K 074 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3	K 074	<u>K 074 F Life Safety Code Standard NFPA 101</u> <i>Residents Found To Have Been Affected</i> New cubicle curtains have been installed in resident rooms #103, #104, #125, #126, #203, #210, #215, #216, #219 and #222 that meet the intent of the K 074 Life Safety Code Standard. These cubicle curtains meet NFPA requirements and have an 1/2" mesh design. <i>Identification of Other Residents with the Potential to Be Affected</i> All resident rooms have been checked for the presence of cubicle curtains that meet NFPA requirements and that have an 1/2" mesh design. All resident rooms are equipped with cubicle curtains that meet NFPA requirements.	

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K 074	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that resident room cubicle curtains met NFPA requirements. This deficient practice affected five (5) of six (6) smoke compartments, staff, and ninety-two (92) residents. The facility has the capacity for 99 beds with a census of 92 on the day of survey. The findings include: During the Life Safety Code tour on June 24, 2010, at 10:20 a.m., with the Director of Maintenance, a cubicle curtain located in resident room 219 was observed not to have the proper ½-inch mesh design (measured diagonally). This mesh design allows for proper water flow from the sprinkler head in case of fire. An interview with the Director of Maintenance revealed the facility had been changing these curtains out over a period of time to meet the requirement. Other cubicle curtains observed during the survey not to have the proper mesh design included, but were not limited to, resident rooms 103, 104, 125, 126, 203, 210, 215, and 216, and room 222. Reference: NFPA 13 (1999 Edition). 5-6.5.2.3* Suspended or Floor-Mounted Vertical Obstructions. The distance from sprinklers to privacy curtains, free standing partitions, room dividers, and similar obstructions in light hazard occupancies shall be in accordance with Table 5-6.5.2.3 and Figure 5-6.5.2.3.	K 074	Systemic Changes The Safety Committee Chairman has developed an audit form to check each resident room monthly for compliance of cubicle curtains to NFPA standards. The Housekeeping Supervisor will complete this monthly check of each resident room to assure that they are equipped with cubicle curtains that meet NFPA requirements that includes an 1/2" mesh design. Any non-compliant cubicle curtain will be replaced within 24 hours. Monitoring The Administrator reviews the monthly cubicle curtain audit with the Housekeeping Director and submits the results to the quarterly meeting of the Quality Assurance Committee for their recommendations and follow-up.	8/04/2010

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K 074	Continued From page 5 A-5-6.5.2.3 The distances given in Table 5-6.5.2.3 were determined through tests in which privacy curtains with either a solid fabric or close mesh [1/4 in. (6.4 mm)] top panel were installed. For broader-mesh top panels - for example, 1/2 in. (13 mm) or greater measured on the diagonal - the obstruction of the sprinkler spray is not likely to be severe and the authority having jurisdiction might not need to apply the requirements in 5-6.5.2.3.	K 074			