

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

PRINTED: 07/10/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/25/2015
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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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 000}

INITIAL COMMENTS

{F 000}

A second Onsite Revisit Survey (for the 05/14/15 survey) was initiated on 06/24/15 and concluded on 06/25/15. Based on the facility's acceptable Plan of Correction (POC) and the onsite revisit the facility was determined to be in compliance on 05/22/15, as alleged.

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

TITLE

(X6) DATE

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.

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

PRINTED: 06/08/2015
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MOREHEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351		
(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)	(X6) COMPLETION DATE	
{F 000}	INITIAL COMMENTS AMENDED An onsite revisit was initiated on 05/12/15 and concluded on 05/14/15 for the 02/12/15 Re-certification Survey. Based on the facility's acceptable Plan of Correction and the on-site revisit it was determined the deficiencies were corrected on 05/09/15, as alleged. However, non-compliance continued, as additional deficient practice was identified at F281 at a Scope and Severity of a "D".	{F 000}			
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: Based on observation, interview, review of the facility's policy and review of the Centers for Medicare/Medicaid Services (CMS) Standards of Practice for Long Term Care Pharmacy Services, it was determined the facility failed to meet professional standards of quality during a medication pass. Observation revealed Licensed Practical Nurse (LPN) #1 left medications on top of the medication cart in the hall, unattended and unsecured, while she entered a resident's room. The findings include: Review of the Centers for Medicare/Medicaid Services (CMS) Standards of Practice for Long	F 281	Medications were immediately discarded by the licensed nurse on May 12, 2015 and Resident A had no change in condition. Medical Director was informed that Resident A did not receive medications that were left on the cart and was re-educated that only licensed nursing, pharmacists and residents that self-administers medications can supervise and store medication by the Director of Nursing on May 14, 2015, and No new orders noted. All residents have potential to be affected. #2 A one-time audit of all medication storage areas was completed by treatment nurse, Assistant Director of	5/22/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Brian Adams* TITLE: *ED* (X6) DATE: *6/11/15* 05/29/2015

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 LIFE CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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F 281 Continued From page 1

Term Care Pharmacy Services, Section C, Sub-section titled "Medication Carts", revealed the following: "Medication carts must be supervised at all times by the nurse administering medications".

Review of the facility's "Med Pass Procedure", undated, revealed no medications were to be left unattended on top of the medication cart.

Interview with the Director of Nursing (DON), on 05/14/15 at 6:51 PM, revealed the facility utilized the Lippincott Manual of Nursing Practice as their standard of practice for policy development and expectations for best nursing practice. The facility did not provide an actual reference to a standard of practice related to securing medications on the medication cart. Furthermore, a review of the Lippincott Manual of Nursing Practice, Ninth Edition, revealed no standard of practice related to the topic.

Observation, on 05/12/15 at 4:45 PM, revealed LPN #1 left three (3) pills in a medicine cup on top of an unattended medication cart in the hall when she entered a room to check on a resident that was crying. Continued observation revealed the Health Information Management (HIM) Director approached the medication cart and proceeded to take a Medication Administration Record (MAR) from the book on top of the cart. During the process, she knocked the medicine cup over and spilled the pills. The HIM Director picked up the pills with her fingers, replaced them in the cup, obtained the MAR and left the area. Further observation revealed upon her return to the medication cart, and after intervention by the State Agency Surveyor, LPN #1 disposed of the pills.

F 281 Nursing, and MDS Coordinator on May 14, 2015, to identify any issues with proper storage/monitoring of medications. No issues were identified.

Regional Director of Clinical Service and Director of Nursing audited all medication carts and all medication rooms to identify any issues with medication storage and supervision on May 14, 2015. No issues were identified.

A one-time audit of nursing giving medications to 10 residents was completed by the Director of Nursing, Assistant Director of Nursing, and Unit Manager on May 15, 2015, to identify if medications were stored and supervised per policy. No issues were identified.

#3 Regional Director of Clinical Services re-educated Director of Nursing, MDS Coordinator, Assistant Director of Nursing, Business Office Manager, Executive Director, Payroll Clerk, Dietary Manager, Staff Development Coordinator, Maintenance Director, Activity Director, Unit Manager, MDS Assistant, Health Information Manager, Housekeeping Supervisor, Social Services, and Director of Rehab,

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F 281 Continued From page 2

Interview with LPN #1 upon her return to the medication cart, on 05/12/15 at approximately 4:50 PM, revealed she planned to administer the three (3) pills in the medicine cup to the resident for which they were intended. She stated the medication cart was in her view the entire time she was in the resident's room. However, she reported she did not see the HIM Director spill the pills and pick them up and replace them in the cup. LPN #1 further stated she should not have left the medication cart and the open container of pills unattended, but should have locked them inside the cart when she had to walk away. Continued interview revealed LPN #1 thought she could see the cart at all times, but acknowledged that was not the case in this instance.

Interview with the HIM Director, on 05/12/15 at 5:23 PM, revealed she should not have handled the pills that spilled from the cup, and she should have told LPN #1 what happened. She stated the only reason she picked the pills up was she didn't want to leave them "laying loosely" on top of the medication cart.

Interview with the DON, on 05/14/15 at 6:51 PM, revealed she was not aware LPN #1 was not present at the cart. She stated medications should always be in direct sight of the nurse, and, "We shouldn't have distractions while on med cart". Continued interview revealed the HIM Director should not have been in contact with the medications. She stated the pills should have been discarded and not placed back on top of the medication cart.

Interview with the Administrator, on 05/14/15 at 7:05 PM, revealed he had been made aware of

F 281 regarding storage, handling and monitoring of medications on May 14, 2015.

The Health Information Manager and licensed nurse who was at the medication cart during observation of Resident A were immediately re-educated on May 12, 2015 by the Director of Nursing related to storage, handling and monitoring of medications per policy.

Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator/Unit Manager/MDS Coordinator to re-educate all staff, which includes licensed nurses, nursing assistants, housekeeping, dietary, therapy, and maintenance, regarding storage and monitoring of medications. This will be completed by May 17, 2015. Any staff member not educated by May 17, 2015, will not be allowed to work beginning May 18, 2015, until they are educated.

All newly hired staff, which includes licensed nurses, nursing assistants, housekeeping, dietary, therapy, department heads, and maintenance, will be educated regarding medication storage, handling and monitoring per

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F 281 Continued From page 3
the incident at the medication cart on 05/12/15. He stated it was his expectation for all medications to be safely stored, handled and administered according to accepted professional standards.

F 281 policy by the SDC, ADON or UM beginning May 18, 2015.

#4 DON/ADON/SDC/UM/MDS Assistant to observe licensed nurses during times of administering medications to 10 residents a week for 4 weeks, then 5 residents a week for 4 weeks, beginning week of May 17, 2015, to ensure only licensed nurses, pharmacist and residents that self-administers medication are supervising or storing medications during medications pass, which will be documented on the medication pass audit form.

QA Team (consisting of Executive Director, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Unit Manager, Dietary Manager, Activity Director, and the Medical Director) to review all audits and make recommendations related to findings weekly x 2 weeks beginning May 15, 2015 then at least monthly until this issue is considered resolved. Continued QA monitoring of medication pass audits by DON, ADON, UM or SDC to ensure handling, monitoring and storage per policy will be on going in monthly QA at least quarterly.

#5 Date of Compliance: May 22, 2015

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(F 000)	INITIAL COMMENTS	(F 000)		
F 281 SS=D	<p>AMENDED</p> <p>An onsite revisit was initiated on 05/12/15 and concluded on 05/14/15 for the 03/27/15 Federal Monitoring Survey (FMS). Based on the facility's acceptable plan of correction it was determined the deficiency was corrected on 05/09/15 as alleged; however, an additional deficient practice was cited at a Scope and Severity of an "D".</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's policy and review of the Centers for Medicare/Medicaid Services (CMS) Standards of Practice for Long Term Care Pharmacy Services, it was determined the facility failed to meet professional standards of quality during a medication pass.</p> <p>Observation revealed Licensed Practical Nurse (LPN) #1 left medications on top of the medication cart in the hall, unattended and unsecured, while she entered a resident's room.</p> <p>The findings include: Review of the Centers for Medicare/Medicaid Services (CMS) Standards of Practice for Long Term Care Pharmacy Services, Section C, Sub-section titled "Medication Carts", revealed</p>	F 281	<p>#1 Medications were not given to un-sampled Resident A by licensed nurse on May 12, 2015.</p> <p>Medications were immediately discarded by the licensed nurse on May 12, 2015 and Resident A had no change in condition.</p> <p>Medical Director was informed that Resident A did not receive medications that were left on the cart and was re-educated that only licensed nursing, pharmacists and residents that self-administers medications can supervise and store medication by the Director of Nursing on May 14, 2015, and No new orders noted.</p> <p>All residents have potential to be affected.</p> <p>#2 A one-time audit of all medication storage areas was completed by treatment nurse, Assistant Director of</p>	5/22/15

RECEIVED
MAY 11 2015
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ben Harris</i>	TITLE <i>ED</i>	(X6) DATE <i>6/11/15</i>
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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 LIFE CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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F 281 Continued From page 1
the following: "Medication carts must be supervised at all times by the nurse administering medications".

Review of the facility's "Med Pass Procedure", undated, revealed no medications were to be left unattended on top of the medication cart.

Interview with the Director of Nursing (DON), on 05/14/15 at 6:51 PM, revealed the facility utilized the Lippincott Manual of Nursing Practice as their standard of practice for policy development and expectations for best nursing practice. The facility did not provide an actual reference to a standard of practice related to securing medications on the medication cart. Furthermore, a review of the Lippincott Manual of Nursing Practice, Ninth Edition, revealed no standard of practice related to the topic.

Observation, on 05/12/15 at 4:45 PM, revealed LPN #1 left three (3) pills in a medicine cup on top of an unattended medication cart in the hall when she entered a room to check on a resident that was crying. Continued observation revealed the Health Information Management (HIM) Director approached the medication cart and proceeded to take a Medication Administration Record (MAR) from the book on top of the cart. During the process, she knocked the medicine cup over and spilled the pills. The HIM Director picked up the pills with her fingers, replaced them in the cup, obtained the MAR and left the area. Further observation revealed upon her return to the medication cart, and after intervention by the State Agency Surveyor, LPN #1 disposed of the pills.

Interview with LPN #1 upon her return to the

F 281 Nursing, and MDS Coordinator on May 14, 2015, to identify any issues with proper storage/monitoring of medications. No issues were identified.

Regional Director of Clinical Service and Director of Nursing audited all medication carts and all medication rooms to identify any issues with medication storage and supervision on May 14, 2015. No issues were identified.

A one-time audit of nursing giving medications to 10 residents was completed by the Director of Nursing, Assistant Director of Nursing, and Unit Manager on May 15, 2015, to identify if medications were stored and supervised per policy. No issues were identified.

#3 Regional Director of Clinical Services re-educated Director of Nursing, MDS Coordinator, Assistant Director of Nursing, Business Office Manager, Executive Director, Payroll Clerk, Dietary Manager, Staff Development Coordinator, Maintenance Director, Activity Director, Unit Manager, MDS Assistant, Health Information Manager, Housekeeping Supervisor, Social Services, and Director of Rehab,

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F 281 - Continued From page 2

medication cart, on 05/12/15 at approximately 4:50 PM, revealed she planned to administer the three (3) pills in the medicine cup to the resident for which they were intended. She stated the medication cart was in her view the entire time she was in the resident's room. However, she reported she did not see the HIM Director spill the pills and pick them up and replace them in the cup. LPN #1 further stated she should not have left the medication cart and the open container of pills unattended, but should have locked them inside the cart when she had to walk away. Continued interview revealed LPN #1 thought she could see the cart at all times, but acknowledged that was not the case in this instance.

Interview with the HIM Director, on 05/12/15 at 5:23 PM, revealed she should not have handled the pills that spilled from the cup, and she should have told LPN #1 what happened. She stated the only reason she picked the pills up was she didn't want to leave them "laying loosely" on top of the medication cart.

Interview with the DON, on 05/14/15 at 6:51 PM, revealed she was not aware LPN #1 was not present at the cart. She stated medications should always be in direct sight of the nurse, and, "We shouldn't have distractions while on med cart". Continued interview revealed the HIM Director should not have been in contact with the medications. She stated the pills should have been discarded and not placed back on top of the medication cart.

Interview with the Administrator, on 05/14/15 at 7:05 PM, revealed he had been made aware of the incident at the medication cart on 05/12/15. He stated it was his expectation for all

F 281 regarding storage, handling and monitoring of medications on May 14, 2015.

The Health Information Manager and licensed nurse who was at the medication cart during observation of Resident A were immediately re-educated on May 12, 2015 by the Director of Nursing related to storage, handling and monitoring of medications per policy.

Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator/Unit Manager/MDS Coordinator to re-educate all staff, which includes licensed nurses, nursing assistants, housekeeping, dietary, therapy, and maintenance, regarding storage and monitoring of medications. This will be completed by May 17, 2015. Any staff member not educated by May 17, 2015, will not be allowed to work beginning May 18, 2015, until they are educated.

All newly hired staff, which includes licensed nurses, nursing assistants, housekeeping, dietary, therapy, department heads, and maintenance, will be educated regarding medication storage, handling and monitoring per

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F 281 Continued From page 3
medications to be safely stored, handled and administered according to accepted professional standards.

F 281 policy by the SDC, ADON or UM beginning May 18, 2015.

#4 DON/ADON/SDC/UM/MDS Assistant to observe licensed nurses during times of administering medications to 10 residents a week for 4 weeks, then 5 residents a week for 4 weeks, beginning week of May 17, 2015, to ensure only licensed nurses, pharmacist and residents that self-administers medication are supervising or storing medications during medications pass, which will be documented on the medication pass audit form.

QA Team (consisting of Executive Director, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Unit Manager, Dietary Manager, Activity Director, and the Medical Director) to review all audits and make recommendations related to findings weekly x 2 weeks beginning May 15, 2015 then at least monthly until this issue is considered resolved. Continued QA monitoring of medication pass audits by DON, ADON, UM or SDC to ensure handling, monitoring and storage per policy will be on going in monthly QA at least quarterly.

#5 Date of Compliance: May 22, 2015

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100376	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 05/14/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MOREHEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351		
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			<p>#4 DON/ADON/SDC/UM/LN to monitor 10 residents a week for 4 weeks, then 5 residents a week for 4 weeks, beginning week of May 17, 2015, to ensure only licensed nursing, pharmacist and residents that self-administers medication are supervising or storing medications during medications pass.</p> <p>QA Team (consisting of Executive Director, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Unit Manager, Dietary Manager, Activity Director, and the Medical Director) to review all audits and make recommendations related to findings weekly x 2 weeks beginning May 15, 2015 then at least monthly until this issue is considered resolved. Continued QA monitoring of medication pass audits by DON, ADON, UM or SDC to ensure handling, monitoring and storage per policy will be on going in monthly QA at least quarterly.</p> <p>#5 Date of Compliance: May 18, 2015</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 02/26/2015
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F 000 INITIAL COMMENTS

A Recertification and Abbreviated Survey, investigating KY00022790, was initiated on 02/10/15 and concluded on 02/12/15. KY00022790 was unsubstantiated with no deficiencies cited. Deficiencies were cited on the Recertification Survey.

F 323 SS=E 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.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and, review of the facility's policy and procedures and Material Safety Data Sheets (MSDS), it was determined the facility failed to ensure residents' environment remained as free from accident hazards as possible. Observation during the environmental tour revealed the facility failed to ensure Virex disinfectant cleaner and Tena care wash cream were secured/locked and not accessible to residents.

The finding include:
Review of the facility policy entitled Hazardous Materials Storage Program, dated 09/19/13, revealed the facility would provide for safe storage of hazardous materials and to protect the

F 000

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F 323

#1 On February 11, 2015, a security entry door lock keypad was placed on South Wing Central Storage Closet and South Wing Central Supply Closet by maintenance to ensure the facility is free from accident hazard as possible.

Medical Director was notified of door being unlocked on February 12, 2015 by April Gayheart, Director of Nursing, no new orders noted.

No resident was affected. All residents have the potential to be affected.

#2 On March 2, 2015, all areas of the facility was checked by the housekeeping supervisor/Executive Directive to identify any unlocked door that contains any chemicals or supplies (including shower rooms, any closet and/or storage room). No issues were identified.

On March 4, 2015, Staff Development Coordinator completed a walking review of all resident rooms to identify any chemicals or hazards. No issues were noted.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bruce Adams</i>	TITLE <i>ED</i>	(X6) DATE <i>3/15/15</i>
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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.

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

PRINTED: 02/26/2015
FORM APPROVED
OMB NO. 0938-0399

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MOREHEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351		
(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 1
safety and health of all associates, residents and associates of outside contractors.

Review of the facility's "Residents Wander Identifier Lost" list updated 01/15/15 revealed five (5) of the facility's eighty-eight (88) residents were on the wander list, and one (1), Unsampled Resident A, resided on the South wing hall.

Observation on 02/11/15, at 9:45 AM, revealed a central storage closet and a central supply closet in the hallway of the South wing of the facility were unsecured/unlocked. Observation of the central storage closet revealed it contained several boxes of one gallon bottles of Virex disinfectant cleaner of which two (2) boxes were opened and stored on the lower shelf of the closet. Continued observation of the Virex disinfectant cleaner label revealed in bold letters it stated, "Do Not Drink", and had a warning label to stating the product was hazardous to humans. Observation of the central supply closet revealed two gallon bottles of Tena care cream were stored on the middle shelf of the closet, and several boxes were stored on the floor of the closet. Continued observation of the Tena care cream label revealed it stated to "get immediate medical attention if ingested".

Review of the facility's MSDS sheet for the Virex revealed it stated to avoid contact with skin, eyes and clothing and wash thoroughly after handling. In addition, it noted to keep out of the reach of children.

Review of the facility's MSDS sheet for the Tena care wash cream revealed it stated if the product was exposed to the eyes to get medical attention and, if ingested to get immediate medical

F 323 #3 On March 2, 2015, Housekeeping Supervisor was educated by the Executive Director that hazardous materials should be stored in a safe location to ensure that the resident's environment is free of accident hazard as possible.

On March 3, 2015, housekeeping staff were educated by the Housekeeping Supervisor that hazardous materials need to be stored in a safe location/any closet or storage area locked to ensure that the resident's environment is free of accident hazard as possible.

On March 3, 2015, all staff were re-educated by the Staff Development Coordinator regarding chemical storage, ensuring all closets/supply rooms and shower rooms are locked and ensuring resident environment is free of hazard as possible.

An audit of all storage rooms will be completed weekly times 4 weeks, beginning week of March 2, 2015, then monthly times 2 months by the Housekeeping Supervisor to ensure items are being stored in a location that the resident's environment is free of accident hazard as possible.

Staff Development Coordinator to audit all resident rooms 2 x week times 4 weeks beginning the week of March 2, 2015, then 1 x week times 4 weeks, to ensure chemicals are secure and environment is free of hazards.

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

PRINTED: 02/26/2015
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OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MOREHEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351	

(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 Continued From page 2 attention.

Review of the medical record revealed the facility admitted Unsampld Resident A on 06/13/13, with diagnoses which included Dementia with Behavioral Disturbances, Depressive Disorder, Anxiety and Schizophrenia. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 01/12/15, revealed the facility assessed Unsampld Resident A to have a Brief Interview for Mental Status (BIMS) score of four (4), which indicated severe cognitive impairment.

Interview, on 02/11/15, at 9:55 AM, with Housekeeper #1 revealed she worked on the North hall; however, she stated all closets were to be locked at all times.

Interview, on 02/11/15, at 10:00 AM, with Housekeeper #2 revealed she did not know why the supply closet doors were open. Continue interview revealed all supply doors were supposed to be locked, as the chemicals could harm the residents if swallowed.

Interview, on 02/11/15, at 10:15 AM, with the Environmental Supervisor revealed both closet doors should have been locked. She stated she was not sure who left them unlocked. Per interview, leaving the closet unlocked placed the facility's residents at risk of being harmed if they accessed the chemicals stored there.

Interview, on 02/11/15, at 3:30 PM, with the Executive Director revealed it was his expectation for all staff to keep all chemicals secured behind locked doors. Continued interview revealed a wandering resident could get the solutions and drink it causing them harm and the need for

F 323

#4 Results of the audit of storage areas will be reported to the Performance Improvement Committee (which includes Executive Director, Director of Nursing, Housekeeping Supervisor, Medical Director and Social Services) monthly times 3 months or until committee determines issue resolved, to review results of all audits and to make recommendation/revisions to current plan if needed.

#5 Completion Date March 12, 2015.

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

PRINTED: 02/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/12/2015
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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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, Continued From page 3
medical attention.

F 323

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185155	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 05/13/2015
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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{K 000}

INITIAL COMMENTS

{K 000}

Based upon observation, interview and record review during the onsite revisit, the deficiencies were determined to be corrected on 05/09/15 as alleged.

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

TITLE

(X6) DATE

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.

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

PRINTED: 02/26/2015
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185155	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/10/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MOREHEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Survey under: NFPA 101 (2000 Edition) Plan approval: 1967, 1970 Facility type: SNF/NF Type of structure: Type III Protected Smoke Compartment: Eight (8) Fire Alarm: Complete fire alarm with heat and smoke detectors in corridors and resident rooms on North and South Wings, all corridors on East and West Wing (software upgrade: 2011) Sprinkler System: Complete sprinkler system (dry) Generator: Type II powered by Natural Gas with Propane backup. A Standard Life Safety Code Survey was conducted on 02/10/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was eighty-seven (87). The facility is licensed for ninety-seven (97) beds. The highest Scope and Severity was at an "F" level. The following demonstrate non compliance: NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than	K 000		
K 018 SS=D		K 018		

IDENTIFIED
ELR-5 2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bill Adams TITLE: EA (X8) DATE: 3/5/15

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 018	<p>Continued From page 1</p> <p>required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors would resist the passage of smoke, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, twelve (12) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation on 02/10/2015 at 3:36 PM, with the Maintenance Director, revealed resident room doors 308, 309, 307, and 306 had a gap greater than ½ inch between the door facing and door</p>	K 018	<p>#1 The gap between the door facing and door jamb at top of the door of rooms 306, 307, 308, and 309 will be corrected by or before March 12, 2015, by the facility maintenance department.</p> <p>Room 316 and 325 doors were repaired on February 11, 2015, by maintenance and are able to latch.</p> <p>#2 On March 4, 2015, all resident room doors were checked to ensure doors would resist the passage of smoke and latch properly.</p> <p>#3 Maintenance Director and Maintenance Assistant were educated on March 2, 2015, by the Executive Director that all doors should resist the passage of smoke and latch.</p> <p>On March 3, 2015, all staff was educated on completing work orders for maintenance if doors are not latching properly by the Staff Development Coordinator.</p> <p>An audit of twenty doors will be completed weekly times 4 weeks, beginning week of March 2, 2015, then monthly times 2 months by the Maintenance Director or Maintenance Assistant ensure the doors resist the passage of smoke and latch properly.</p>	

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K 018	Continued From page 2 jamb at the top of the doors. Resident room doors 316 and 325 failed to latch when closed. Interview with the Maintenance Director revealed the doors were checked for compliance but maintenance had not identified the doors as having any problems. The findings were confirmed with the Administrator during the exit conference. Reference: NFPA 101 (2000 Edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the	K 018	#4 Results of the audit of the doors will be reported to the Performance Improvement Committee monthly times 3 months to ensure the doors resist the passage of smoke and latch properly. #5 Completion Date March 12, 2015.		

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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K 018	Continued From page 3 door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Centers for Medicare and Medicaid Survey and Certification (S&C) Letter 07-18.	K 018		
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, it was determined the facility failed to ensure hazardous areas were protected, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of	K 029	#1 Central Supply office door was equipped with a self-closure on February 12, 2015. The penetrations in the ceiling of the Central Supply office were repaired and closed on February 10, 2015, when the Maintenance Director was made aware of the issue. #2 On March 2, 2015, all storage rooms/offices were checked by the Maintenance Director or Maintenance Assistant to ensure all areas being used as storage have doors equipped with a self-closure, with no other concerns.	

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K 029 Continued From page 4
eight (8) smoke compartments, twenty-eight (28) residents, staff and visitors.

The findings include:

Observation on 02/10/2015 at 2:56 PM, with the Maintenance Director, revealed the Central Supply office was being used for storage of medical supplies in boxes. Further observation revealed the room was not equipped with a self-closer, and contained multiple penetrations of the ceiling from the removal of a light fixture. Interview with the Maintenance Director revealed he was not aware the door needed a self-closer since the facility considered the room an office and not a storage room.

The findings were confirmed with the Administrator during the exit conference.

Reference: NFPA 101 (2000 edition)
8.2.4.1 Where required elsewhere in this Code, smoke partitions shall be provided to limit the transfer of smoke.

8.2.4.2 Smoke partitions shall extend from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above suspended ceilings, and through interstitial structural and mechanical spaces.

Exception:* Smoke partitions shall be permitted to terminate at the underside of a monolithic or suspended ceiling system where the following conditions are met:

(a) The ceiling system forms a continuous membrane.

K 029

On March 2, 2015, a facility audit of all rooms/offices was completed by the Maintenance Director or Maintenance Assistant checking for penetrations, with no other concerns.

#3 Maintenance Director and Maintenance Assistant were educated on March 2, 2015, by the Executive Director that all storage rooms/offices that are used as storage must have a self-closure on the door.

Maintenance Director and Maintenance Assistant were educated on March 2, 2015 by the Executive Director that all penetrations are repaired immediately.

On March 3, 2015, all staff were educated on completing work orders for maintenance if storage rooms/offices are being used as storage and do not have a self-closure on the door and if they notice a penetrations in the facility.

An audit of twenty rooms will be completed weekly times 4 weeks, beginning week of March 2, 2015, then monthly times 2 months by the Maintenance Director or Maintenance Assistant, to ensure that all storage rooms/offices being used as storage have self-closures on the doors.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 02/26/2015
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MOREHEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351		
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K 029	<p>Continued From page 5</p> <p>(b) A smoketight joint is provided between the top of the smoke partition and the bottom of the suspended ceiling.</p> <p>(c) The space above the ceiling is not used as a plenum.</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 jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. <p>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</p>	K 029	<p>An audit of twenty rooms will be completed weekly times 4 weeks, beginning week of March 2, 2015, then monthly times 2 months by the Maintenance Director or Maintenance Assistant, to ensure that all storage rooms/offices are free of penetrations.</p> <p>#4 Results of the audit of storage rooms/offices used as storage and audit of storage rooms/offices for penetrations will be reported to the Performance Improvement Committee monthly times 3 months to ensure all storage rooms/offices have self-closures on the door and they are free of penetrations.</p> <p>#5 Completion Date March 12, 2015.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 02/26/2015
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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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K 029 Continued From page 6 door.

K 029

K 062 SS=F NFPA 101 LIFE SAFETY CODE STANDARD

K 062

Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5

#1 The interior pipe inspection for the automatic sprinkler system was completed by Landmark Sprinkler Company on March 3, 2015. (see attachment A)

This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure automatic sprinkler systems were inspected, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, ninety-seven (97) residents, staff and visitors.

#2 On March 3, 2015, the interior pipe inspection for the automatic sprinkler system was completed by Landmark Sprinkler Company, with no concerns.

The findings include:

#3 Maintenance Director and Maintenance Assistant were educated on March 2, 2015, by the Executive Director that interior pipe inspection for automatic sprinkler system are to be conducted every 5 years.

Record review of the automatic sprinkler inspection and maintenance reports on 02/10/2015 at 4:30 PM, with the Maintenance Director, revealed the last interior pipe inspection for the automatic sprinkler system was performed on 09/02/09. Interview with the Maintenance Director revealed he had discussed having an interior pipe inspection performed for the automatic sprinkler system, but the outside contractor had failed to conduct the required inspection.

The Executive Director will monitor the completion of the interior pipe inspection to ensure it is completed every 5 years.

The findings were confirmed with the Administrator during the exit conference.

#4 Results of the interior pipe inspection for the automatic sprinkler system will be reviewed in the Performance Improvement Committee.

#5 Completion Date March 12, 2015.

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

PRINTED: 02/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185155	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/10/2015
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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K 062	Continued From page 7 Reference: NFPA 25 (1998 Edition) 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.	K 062		
K 064 SS=E	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 it was determined the facility failed to ensure fire extinguishers were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, fifty-two (52) residents, staff and visitors. The findings include: Observation on 02/10/2015 at 2:45 PM, revealed a fire extinguisher near room 325 which did not have a six (6) year service tag. Further observation revealed the fire extinguisher was	K 064	#1 The six-year maintenance was completed by Collins Fire Protection on February 13, 2015, as well as placing "verification of service" collar around the neck of the two fire extinguishers out of compliance. (see attachment B) #2 On March 2, 2015, all fire extinguishers were checked by the Maintenance Director or Maintenance Assistant to ensure all the facility's fire extinguishers had the six-year maintenance completed within the last six-years, with "verification of service" collars located around the neck of the container, with no concerns.	

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K 064 Continued From page 8
dated 2007. Interview with the Maintenance Director, at the time of observation, revealed he relied on an outside contractor to perform maintenance and yearly inspection of fire extinguishers. He stated he was unaware the fire extinguishers were out of compliance for the six (6) year maintenance.

Observation on 02/10/2015 at 2:56 PM, revealed a fire extinguisher near the Housekeeping Supply room which did not have a six (6) year service tag. Further observation revealed the fire extinguisher was dated 2007. Interview with the Maintenance Director, at the time of observation, revealed he relied on an outside contractor to perform maintenance and yearly inspection of fire extinguishers. He stated he was unaware the fire extinguishers were out of compliance for the six (6) year maintenance.

The findings were confirmed with the Administrator during the exit conference.

Reference: NFPA 10 (1998 Edition).

4-4.3* Six-Year Maintenance. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. The removal of agent from halon agent fire extinguishers shall only be done using a listed halon closed recovery system. When the applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall begin from that date.

K 064

#3 Maintenance Director and Maintenance Assistant were educated on March 2, 2015, by the Executive Director that all of the facilities fire extinguishers are to have maintenance every six-years and each fire extinguisher is to have a "verification of service" collar located around the neck of the container.

An audit of the facilities fire extinguishers will be completed weekly times 4 weeks, beginning week of March 2, 2015, then monthly times 2 months by the Maintenance Director and Maintenance Assistant, to ensure that all of the facilities fire extinguishers have "verification of service" collar located around the neck of container with proper dates.

#4 Results of the audit of the six-year maintenance of the facilities fire extinguishers will be reported to the Performance Improvement Committee monthly times 3 months to ensure all of the facilities fire extinguishers have "verification of service" collar located around the neck of container with proper dates.

#5 Completion Date March 12, 2015.

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K 064 Continued From page 9
Exception: Nonrechargeable fire extinguishers shall not be hydrostatically tested but shall be removed from service at a maximum interval of 12 years from the date of manufacture. Nonrechargeable halon agent fire extinguishers shall be disposed of in accordance with 4-3.3.3.

4-4.4* Maintenance Recordkeeping. Each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed and that identifies the person performing the service.

4-4.4.1* Fire extinguishers that pass the applicable 6-year requirement of 4-4.3 shall have the maintenance information recorded on a suitable metallic label or equally durable material having a minimum size of 2 in. 3 1/2 in. (5.1 cm 8.9 cm). The new label shall be affixed to the shell by a heatless process, and any old maintenance labels shall be removed. These labels shall be of the self-destructive type when removal from a fire extinguisher is attempted. The label shall include the following information:

(a) Month and year the maintenance was performed, indicated by a perforation such as is done by a hand punch

(b) Name or initials of person performing the maintenance and name of agency performing the maintenance.

4-4.4.2* Verification of Service (Maintenance or Recharging). Each extinguisher that has undergone maintenance that includes internal examination or that has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The

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K 064 Continued From page 10
collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch.

Exception No. 1: Fire extinguishers undergoing maintenance before January 1, 1999.

Exception No. 2: Cartridge/cylinder-operated fire extinguishers do not require a "Verification of Service" collar.

K 064

K 143 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D
Transferring of oxygen is:

(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;

(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and

(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2

K 143

#1 The oxygen supply room door was replaced on February 26, 2015, by the facilities maintenance with a 3-hour fire rated door that properly latches.

#2 On February 26, 2015, the oxygen supply room door was replaced with a door with a 3-hour fire rating.

On March 3, 2015, the oxygen supply room door was checked to ensure latching properly.

No other room in the facility is used to store oxygen.

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K 143 | Continued From page 11

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure oxygen supply rooms were protected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, twenty-eight (28) residents, staff and visitors.

The findings include:

Observation on 02/10/2015 at 3:05 PM, with the Maintenance Director, revealed the oxygen supply room was being used for storage and transferring of liquid oxygen. Further observation revealed the room was equipped with a 20 minute fire rated door that failed to latch properly. Interview, revealed the Maintenance Director was unaware the door was not latching properly and was not the correct fire rating.

The findings were confirmed with the Administrator during the exit conference.

Reference: NFPA 99 (1999 Edition)
8-6.2.5.2 Transferring Liquid Oxygen.
Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:
(a) Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour

K 143 |

#3 Maintenance Director and Maintenance Assistant were educated on March 2, 2015, by the Executive Director that the oxygen supply room door needs to have a fire rating of at least 45-minutes and the door needs to latch properly.

On March 3, 2015, all staff was educated on completing work orders for maintenance if the oxygen room door is not latching correctly.

An audit of the oxygen supply room door will be completed weekly times 4 weeks, beginning week of March 2, 2015, then monthly times 2 months by the Maintenance Director or Maintenance Assistant, to ensure that the door is latching properly.

#4 Results of the new oxygen supply room door will be reviewed in the Performance Improvement Committee.

Results of the audit of the oxygen supply room door will be reported to the Performance Improvement Committee monthly times 3 months, to ensure the door is latching properly.

#5 Completion Date March 12, 2015.

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K 143 Continued From page 12
fire-resistive construction; and
(b) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and
(c) The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted.

Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be used for Respiration, and adhering to those procedures. The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.

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