

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

PRINTED: 02/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/08/2013
NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754	

(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

A recertification survey was conducted on 02/06/13 through 02/08/13 and a Life Safety Code survey was conducted on 02/07/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for Federal recertification with the highest scope and severity of a "F".

F 176
SS=D

483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE

An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility policy, it was determined the facility failed to assess one resident (#16), in the select sample of 15, for the safe, self-administration of a medication.

Findings include:

A review of the facility's policy for "Self Administration of Medication," dated 01/01/07 and last revised 03/03/10, revealed a resident who expressed a desire to self-administer medication, may do so, if the Interdisciplinary Team and the physician have determined the practice to have been safe, based on the resident's ability to do so. An analysis was to be completed by a licensed staff member and this was to be presented to the Interdisciplinary Care Plan Team (ICP) for evaluation. The resident was to be

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Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.

F 176

F-176
483.10(n) Resident Self-Administer Drugs if Deemed Safe.

It is the normal practice of Spring view Health and Rehab to assess residents for the safe, self-administration of medications.

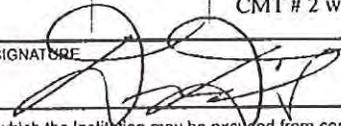
Corrective Measures for Resident Identified in the deficiency:

Resident # 16 was assessed utilizing the self administration analysis form, for self administration of medications on 2/7/13. This was completed by the licensed nurse and presented to the interdisciplinary care plan team and was determined to be safe. The analysis was placed in the medical record. In addition, the resident wrote a statement expressing the wish to self administer the nasal spray only on 2/7/13. The resident did not voice any unusual complaints relating to the nasal spray not being administered fully in the nose. The physician was notified of the occurrence and an order was obtained on 2/7/13 by the licensed nurse to allow self administration of the nasal spray for Resident # 16. This was added to the Interdisciplinary Care Plan on 2/7/13 by the licensed nurse.

CMT # 2 was re-educated on 2/7/13 by the

03/3/13

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



TITLE

Administrator

(X6) DATE

3/4/13

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

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F 176	<p>Continued From page 1</p> <p>made aware of the decision. If the resident was determined capable of self administration, a physician's order was to be obtained and the medications were to be stored, in a secure location. The analysis was to be placed in the medical record and the resident was to be periodically re-evaluated, based on the resident's status.</p> <p>1. A record review revealed Resident #16 was admitted to the facility on 12/28/11 with a diagnosis of Colostomy and a history of a Partial Thyroidectomy and Golter.</p> <p>A review of the physician's orders, dated February 2013, revealed an order for Flonase 0.05%, to be administered as one spray, to each nostril, every 24 hours.</p> <p>An observation during a medication pass, on 02/07/13 at 9:45 AM, revealed Certified Medication Technician (CMT) #2 handed the bottle of Flonase to Resident #16, who self administered the medication and never fully placed the applicator tip in the nostrils, spraying the side of his/her cheeks with each brief spray.</p> <p>An interview with CMT #2, on 02/07/13 at 9:50 AM, revealed she gave the resident the applicator, as the resident would not allow staff to administer the medication and stated there was no physician order for the resident to self-administer the medication. The CMT was unaware of an assessment that was to be completed, prior to the resident self administering any medication, to ensure the resident was able to effectively administer the medication.</p>	F 176	<p>F-176 (con't)</p> <p>LPN Supervisor on self administration policy and procedure.</p> <p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>All nursing staff, Certified Medication Aides were interviewed and asked if any other residents have expressed a desire to self administer their medications on 2/7/13 by the Director of Nursing and LPN supervisor. In addition, all interviewable residents were interviewed and asked if they expressed a desire to self administer their medications. One resident was identified who expressed a desire to self administer her nasal spray on 2/7/13 to the Staff Development Nurse. The resident was assessed utilizing the self administration analysis and reviewed with the interdisciplinary care plan team and deemed to be safe to self administer her nasal spray. The resident also wrote out a request to self administer her nasal spray. The physician was notified of the assessment results and the residents request and an order was obtained from the physician to allow the resident to self administer her nasal spray by the licensed nurse on 2/7/13. This was added to the residents plan of care by LPN Supervisor</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>Re-education was initiated on the self administration of medication policy on 2/11/13 by the staff development nurse, LPN supervisor and the Director of Nursing. This will continue until all the licensed nurses and Certified Medication Aides have been re-educated on the policy.</p>	

F-176 (cont)

The Director of Nursing will be responsible to provide or arranged for re-education for any staff member who is on leave of absence or is unable to attend the re-education.

In addition to the above inservicing a post test will be given to verify understanding of the education provided. This was initiated on 2/25/13. A 100% score will be required to pass the test. All staff members to current have passed the test with a 100% score. The Director of Nursing will be responsible to provide or arrange for the post test to any staff member who has been on leave or unable to take the post test.

The facility will continue to include the education on the policy for self administration of medications during the orientation period, in addition the post test will be added to the orientation process to verify understanding of the education given.

Monitoring Measures to Maintain On-going Compliance:

The Staff development Nurse, LPN Supervisor and Social Services will interview the interviewable residents monthly x 6 months to verify ongoing compliance that all residents expressing a desire to self administer medications have been assessed and evaluated by the Interdisciplinary Care Plan team for the ability to do so.

The results will be reported to the Quality assessment and Assurance committee monthly x 6 months for review of the findings.

If any concerns are identified by the committee the frequency or duration of the audit may be increased. Re-education will be provided on an individual basis if indicated.

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 Administration 3/4/13

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F 176	Continued From page 2 An interview with the Director of Nursing (DON), on 02/07/13 at 2:45 PM, revealed the DON stated the resident had not been assessed for the self-administration of the medication and would have expected this to have been done, as well as obtaining a physician order to that effect.	F 176		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to develop a comprehensive care plan for two residents (#3 and #4), in the selected sample of fifteen	F 279	F-279 <u>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</u> It is the practice of Spring view Health and Rehab Center to use the results of assessments to develop, review and revise the resident's comprehensive plan of care to meet a residents medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. <u>Corrective Measures for Resident Identified in the deficiency:</u> Resident # 4 had a care plan developed and implemented for pain related to Peripheral Neuropathy and potential for UTI's on 2/8/13 by the MDS coordinator. Resident # 3 had a care plan developed and implemented for respiratory care related oxygen use on 2/8/13 by the MDS coordinator. <u>How Other Residents Were Identified Who May Have Been Impacted by the Practice:</u> All residents comprehensive care plans were reviewed by the MDS coordinator, LPN Supervisor, Staff Development Nurse and DON to verify that all residents have a plan of care for their assessed needs which included	03/20/13

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F 279	<p>Continued From page 3</p> <p>residents. The facility failed to develop care plans for Resident #4 related to pain and a history of Urinary Tract Infections (UTI) and for Resident #3 related to respiratory care.</p> <p>Findings include:</p> <p>A review of the facility's "CLINICAL PRACTICE GUIDELINES with TOPIC: COMPREHENSIVE CARE PLANS," dated 06/14/11, revealed " It is the facility policy that residents will have a plan of care for assessed needs. The plan of care will be stated clearly and will identify the resident problem, measurable goals to be achieved, which include timetables to meet resident's needs, and the interventions to be followed by staff in providing the resident care. Each approach will identify the discipline responsible for the care delivery. The comprehensive care plan will be reviewed by the interdisciplinary team at a care plan conference. The resident and/or responsible representative will be encouraged to attend. The plan of care will be reviewed at least quarterly, upon significant condition change, and annually. "</p> <p>1. A record review revealed Resident # 4 was admitted to the facility on 11/19/2012 with diagnosis of Parkinson's, Diabetes Mellitus Type II, Peripheral Neuropathy and General Debility.</p> <p>A review of the Minimum Data Set (MDS) assessment, dated 12/05/2012, revealed the resident had pain and when he/she experienced pain it was at a level of "5" on a pain scale of 1-10. In addition, a review of a lab report, dated 01/11/2013, revealed the resident had a Urinary Tract Infection. However, a review of the</p>	F 279	<p>F-279 (cont)</p> <p>potential for UTI's, pain and oxygen usage to verify compliance.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>The MDS Coordinator was reeducated on the care planning policy and procedure on 2/27/13 by the Quality Management Nurse . Re-education on the care planning policy and procedure to include the licensed staff on the units was initiated on 2/11/13 by the Director of Nursing, Staff Development Nurse and LPN Supervisor. This education will continue until all licensed staff have received the education. The Director of Nursing will be responsible to provide or arrange education for any staff member who is on leave or unable to attend the education sessions.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>The DON and LPN Supervisor will randomly audit three residents care plan from each unit weekly (approximately) 10% to verify that the comprehensive care plan includes all the residents assessed needs. This will continue weekly for 8 weeks, then every 2 weeks for 8 weeks, then monthly x 6 months to verify ongoing compliance. The audit results will be reported to the monthly Quality Assessment and Assurance committee for review and recommendation for 6 months. If any concerns are identified the frequency or duration of the audits may be increased. Re-education will be provided on an individual basis if indicated.</p>	

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F 279	<p>Continued From page 4</p> <p>Comprehensive Care Plan for Resident # 4, dated 12/06/2012, revealed there was no care plan to address the resident's pain or Peripheral Neuropathy and there was no care plan related to Resident #4's UTI or potential for UTI.</p> <p>An interview with the MDS coordinator, on 02/07/13 at 11:40 AM, revealed care plans had not been initiated on admission or since admission even though the resident had complained of pain and had a UTI while at the facility.</p> <p>2. A record review revealed Resident #3 was admitted to the facility on 11/26/12 with diagnoses to include Aspiration Syndrome, Neuropathy, Heart Disease with Chronic Hypertension, and Edema.</p> <p>A review of the initial MDS assessment, dated 12/03/12, revealed Resident #3 was on oxygen.</p> <p>A review of the February 2014 Physician's orders revealed to administer Oxygen at 3 liters a minute per nasal cannula as needed, however, review of Resident #3's Comprehensive Care Plan, dated 12/12/12, revealed there was no care plan to address the resident's respiratory care.</p> <p>An interview with the MDS Coordinator, on 02/08/13 at 4:30 PM, revealed Resident #3 was admitted on 11/26/12 with oxygen. She stated it was triggered on the MDS, but she just missed it and did not develop a care plan for it.</p> <p>An interview with the Director of Nursing (DON), on 02/08/13 at 4:45 PM, revealed there should have been a respiratory care plan implemented</p>	F 279		

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F 279	Continued From page 5 upon admission.	F 279		
F 281 SS=D	<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, resident and staff interviews, and record review it was determined the facility failed to provide a regularly scheduled medication for one resident (#5), in the selected sample of 15, resulting in the resident not receiving Pravastatin for 3 weeks.</p> <p>Findings include:</p> <p>A record review revealed Resident #5 was admitted to the facility on 01/21/13 with diagnoses to include Hypertension, Myocardial Infarction, and Hypercholesterolemia.</p> <p>A review of Resident #5's admission orders, dated 01/21/13, and January 2013 Medication Administration Record revealed an order for Pravastatin 20 mg administered at the hour of sleep, as needed for Hyperlipidemia. There was no evidence the admitting nurse contacted the admitting physician to clarify the order. This resulted in the resident not receiving the Pravastatin for the remaining 10 days in January. A review of the February 2013 MAR, revealed when the change over was made for the month of February, the medication was left off of the</p>	F 281	<p>F-281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>It is the normal practice of Spring view Health and Rehab to provide services or arrange for services that meet professional standards of quality.</p> <p><u>Corrective Measures for those Residents identified in the deficiency:</u></p> <p>Resident # 5's physician was contacted by the Director of Nursing on 2/8/13 and notified of the request for a clarification order on Pravastatin. An order was written for Pravastatin 20 mg po daily at bedtime on 2/8/13. No additional orders were given. Pravastatin 20 mg po at bedtime was administered to Resident # 5 on 2/8/13 by the certified medication technician.</p> <p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>All residents physician orders were reviewed and compared to the Medication Administration Records by the Staff Development Nurse, Director of Nursing, and LPN Supervisor. This was completed on 2/18/13 to verify all orders were transcribed correctly. No issues were identified during the review.</p>	03/03/13

R-281 (cont)

Measures Implemented or Systems Altered
to Prevent Re-occurrence:

All licensed staff were reeducated on the policy and procedure for physician orders by the Director of Nursing, Staff Development Nurse and LPN Supervisor. The Director of Nursing will be responsible to provide or arrange for education for staff who are on leave or unable to attend the education sessions.

All telephone orders will be brought to the Daily AQA meeting and will be double checked by the Director of Nursing, Staff Development Nurse, and LPN Supervisor to verify that all orders are written correctly and transcribed correctly.

The Director of Nursing, Staff Development Nurse and LPN Supervisor will double check the physician orders and Medication Administration Records at the end of the month change over for 6 months to verify ongoing compliance.

Monitoring Measures to Maintain On-going
Compliance:

A random audit of a minimum of 6 residents (approx 10%) physicians orders and medication administration records will be conducted to verify orders are written and transcribed correctly. This will be conducted by the Director of Nursing, LPN Supervisor and Staff Development Nurse. The audit will be done monthly for 3 months.

The findings of the audit will be reported to the Director of Nursing for review and in addition to the Quality Assessment and Assurance Committee for review x 3 months. If concerns are identified the duration or frequency of the audit may be increased and or re-education/discipline may result.

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Administrator

3/14/13

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F 281	Continued From page 6 February MAR by the 11-7 Charge Nurse which resulted in the resident not receiving the Pravastatin for eight more days. An interview conducted with the Director of Nursing (DON), on 02/08/13 at 1:30 PM revealed the nurse who transcribed the order to the MAR should have called and clarified the order with the physician. The DON contacted the admitting physician and clarified the medication order. The physician gave a verbal order for Pravastatin 20 mg at bedtime daily. The DON stated Resident #5 had not received the Pravastatin 20 mg for 18 days.	F 281		
F 332 SS=D	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: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to ensure it was free of medication error rates of five (5) percent (%) or greater. Observations of four medication passes with three Certified Medication Technicians (CMT) and one Licensed Practical Nurse (LPN), on both hallways and on two different shifts, revealed there were 57 opportunities with three medication errors, which resulted in a six percent (6%) medication error rate. Findings include:	F 332	F-332 <u>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</u> It is the normal practice of Spring view Health and Rehab to ensure the facility is free of medication error rates of five percent or greater. <u>Corrective Measures for Resident Identified in the deficiency:</u> <u>Resident # 17</u> was assessed by the licensed nurse on 2/7/13 and did not have any seizure activity, complaints, or adverse effects related to the error. The physician was notified and an order obtained to give the Trileptal 600 mg upon arrival to the facility. The Trileptal was administered by the nurse on 2/7/13 at 11:30am. <u>Resident # 18</u> The resident did not have any complaints related to the Nystatin Swish and Swallow being given late on 2/6/13 as documented by the licensed nurse. The medication was located in the medication room by the staff development nurse and was	03/20/13

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F 332	<p>Continued From page 7</p> <p>A review of the facility's Medication Administration policy and procedure, dated 09/2010, revealed "medications should be administered in accordance with written orders of the prescriber." And "medications should be given within 60 minutes of the prescribed time frame."</p> <p>1. A record review revealed Resident #17 was admitted to the facility with diagnoses of Dementia and a history of a Cerebral Vascular Accident (CVA.)</p> <p>A review of the February 2013 physician's orders and Medication Administration Record (MAR), revealed an order for Trileptal 600 milligrams (mg) per gastrostomy tube (GT,) two times a day.</p> <p>An observation and interview with LPN #5, during the medication pass, on 02/07/13 at 9:15 AM, revealed the LPN, did not administer Trileptal, as ordered, stating this was not in the medication cart and the pharmacy would have to be informed.</p> <p>An interview with LPN #5, on 02/07/13 at 12:00 PM, revealed the Trileptal was still unavailable. She stated the pharmacy was called, regarding the missing medication and the pharmacist stated the medication had been sent to the facility, on 02/06/13. The LPN stated she would need to call and inform the physician the medication was not given.</p> <p>2. A record review revealed Resident #18 was admitted to the facility, on 01/28/13, with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD.)</p>	F 332	<p>F-332 (cont)</p> <p>administered on 2/6/13 at 8 pm by CMT # 1 to Resident # 18. Resident # 16 was assessed utilizing the self administration analysis form, for self administration of medications on 2/7/13. This was completed by the licensed nurse and presented to the interdisciplinary team and was determined to be safe. The analysis was placed in the medical record.</p> <p>In addition, the resident wrote a statement expressing the wish to self administer the nasal spray only on 2/7/13. The resident did not voice any unusual complaints relating to the nasal spray not being administered fully in the nose. The physician was notified of the occurrence and an order was obtained on 2/7/13 by the licensed nurse to allow self administration of the nasal spray for Resident # 16. This was added to the Interdisciplinary Care Plan on 2/7/13 by the licensed nurse.</p> <p>CMT # 2 was re-educated on 2/7/13 by the staff development nurse on self administration policy and procedure. In addition was re-educated on proper medication administration policy on 2/11/13 by the Director of Nursing.</p> <p>CMT # 1 was re-educated on proper medication administration utilizing the medication administration policy on 2/11/13 by the Director of Nursing.</p> <p>LPN # 5 was re-educated on proper medication administration utilizing the medication administration policy on 2/11/13 by the Director of Nursing.</p> <p><u>How Other Residents Were Identified Who May Have Been Impacted by the Practice:</u></p> <p>Resident residing on 100 and 200 hall have the potential to be effected by the practice.</p>		

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F 332	<p>Continued From page 8</p> <p>A review of the 01/28/13 physician's orders and Medication Administration Record (MAR) revealed an order for Nystatin Swish and Swallow (for the treatment of Thrush,) to be given at five (5) milliliters (ml.) four (4) times a day.</p> <p>An observation during the medication pass, on 02/08/13 at 4:47 PM, revealed Certified Medication Technician (CMT) #1 failed to administer the medication and stated the medication "should be delivered tonight."</p> <p>An interview with the Director of Nursing (DON,) on 02/07/13 at 1:50 PM, revealed if a medication was not in the drawer, the staff members should check both wings and ensure the medication had not been overlooked and call the "back-up pharmacy" and tell them what medication was missing and that the medication was needed within one hour. If the medication had not arrived at the facility within the hour, the staff member was to call the physician and obtain an order to give the medication when available.</p> <p>3. A record review revealed Resident #16 was admitted, on 12/28/11 with a diagnosis of Osteoarthritis and a history of a Partial Thyroidectomy.</p> <p>A review of the physician's orders for February 2013, revealed an order for Flonase 0.05%, ordered to be given as one spray, to each nostril, every 24 hours.</p> <p>An observation during a medication pass, on 02/07/13 at 9:45 AM, revealed CMT #2 gave the bottle of Flonase to Resident #16, who self administered the medication and never fully</p>	F 332	<p>F- 332 (cont) <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>All CMT'S and licensed staff will be re-educated on proper medication administration utilizing the medication administration policy. This was initiated on 2/11/13 by the Director of Nursing, Staff Development Nurse and LPN Supervisor and will continue until all staff have been re-educated. The Director of Nursing will be responsible to provide or arrange education for staff on leave or unable to attend the session.</p> <p>All CMT'S and Licensed staff will have a medication observation conducted every 6 months for 2 years. Then annually ongoing thereafter to verify ongoing compliance. This will be conducted by the Director of Nursing, Pharmacy consultant, and staff development nurse.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>Unannounced medication observations will be conducted by the Staff Development nurse, Pharmacy consultant, Director of Nursing on 3 different staff members per month to include CMT'S and licensed nurses . The observations will be conducted monthly x 3 months to verify ongoing compliance. The results will be reviewed by the Director of Nursing and reported in the monthly Quality Assessment and Assurance Committee x 3 months. If any areas of concern are identified the frequency and duration of the observations will be increased. Re-education will be provided on individual basis if indicated.</p>		

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F 332	Continued From page 9 placed the applicator tip in the nostrils, spraying the side of his/her cheeks, with each brief spray. An interview with CMT #2, on 02/07/13 at 9:50 AM, revealed she gave the resident the applicator as the resident would not allow staff to administer the medication and stated there was no physician order for the resident to self-administer the medication. An interview with the DON, on 02/07/13 at 2:45 PM, revealed the DON stated the resident had not been assessed for the self-administration of the medication and should not have self administered the medication.	F 332			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Observations of the kitchen revealed food on the steam table one hour and 45 minutes prior to serving; a large plastic bag with approximately 20 heads of cabbage lying on the	F 371	F-371 483.35(i)FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY It is the normal practice of Spring view Health and Rehab to store, prepare, distribute and serve food under sanitary conditions. <u>Corrective Measures for those Residents Identified in the deficiency:</u> No residents were identified in the deficiency. <u>How other Residents who may have the potential to be affected were identified:</u> Residents who receive meal trays have the potential to be affected by the practice. One resident was identified as receiving an enteral feeding and does not receive a meal tray.	03/20/13	

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F 371	<p>Continued From page 10</p> <p>floor of the walk-in refrigerator; two boxes containing opened bags of frozen vegetables in the freezer; mops stored on the floor and the dumpster lids left open and overflowing with trash.</p> <p>A review of the census and condition, dated 02/06/13, revealed there were 65 residents in the building with one of those residents being tube fed and not utilizing the kitchen facilities.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. An observation of the kitchen service area, on 02/08/13 at 10:00 AM, revealed the steamer vat to contain Pollock Fish, prepared for the noon meal, with the tray line to start at 11:45 AM. <p>An interview with the Dietary Aide/Cook, on 02/08/13 at 10:05 AM, revealed the reason for placing the fish in the steamer was for the fish "to stay moist."</p> <p>An interview with the Dietary Manager, on 02/08/13 at 10:40 AM, revealed the policy of the facility was not to have any food on the steamer more than 30 minutes, prior to serving and she would have expected this to have been followed.</p> <ol style="list-style-type: none"> 2. An observation of the kitchen, on 02/06/13 at 10:35 AM, revealed approximately 20 heads of cabbage, in a large clear bag, lying on the walk-in refrigerator floor. <p>An interview with the Dietary Manager, on 02/06/13 at 10:40 AM, revealed the delivery truck had just dropped off a load of vegetables and the kitchen staff still needed to bag the cabbage</p>	F 371	<p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>The Fish was immediately removed from the steam table, wrapped and placed in the oven at 225 degrees. Re-education of the Dietary Staff was initiated 2/8/13 on not placing any food on the steam table more than 30 minutes prior to serving. This was conducted by the Dietary Manager. The education will continue until all Dietary Staff have completed the education. The Dietary Manager will be responsible to provide or arrange education to any staff member who is on leave or unable to attend the sessions.</p> <p>On 2/6/13 the cabbage in the large clear bag was removed from the refrigerator floor by the Dietary Manager. The Dietary Staff were re-educated on the delivery of food items being received to the cooler freezer and dock area must be promptly labeled, stored, dated and placed in the refrigerator. This was conducted by the Dietary Manager on 2/7/13. This will continue until all dietary staff have been re-educated. The Dietary Manager will be responsible to provide or arrange for inservicing for staff on leave or unable to attend the education sessions. On 2/8/13 the bags of frozen mixed vegetables were sealed and the lids of the boxes were closed by the Dietary Manager. Re-education was initiated for the dietary staff on 2/8/13 that all food items must be kept sealed when not in a resealable container. The education was conducted by the Dietary Manager and will continue until</p>		

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F 371	<p>Continued From page 11</p> <p>heads in individual bags, prior to placing them on the shelves. She also stated the delivery drivers had been made aware not to leave such items on the floor.</p> <p>3. Observations of the walk-in freezer, on 02/06/13 at 10:45 AM and 02/08/13 at 10:30 AM, revealed two boxes containing frozen mixed vegetables, with the flaps of the boxes and the inside plastic bags, containing the vegetables, open to air.</p> <p>An interview with the Dietary Manager, on 02/06/13 at 10:50 AM and 02/08/13 at 10:30 AM, revealed the opened bags should have been secured to prevent freezer burn and the dietary staff had been trained to do this.</p> <p>4. Observations of the mop and broom storage, on 02/06/13 at 10:50 AM and 02/08/13 at 10:30 AM, revealed mops and brooms stored on the floor. An overhead hanging rack, for the storage of mops and brooms was mounted on the wall, above the mops, and was empty.</p> <p>An interview with the Dietary Manager, on 02/08/13 at 10:30 AM, revealed the storage area had some recent maintenance work completed and just had the mounting rack replaced. She stated she would have expected the dietary staff to utilize the rack.</p> <p>5. Observations of the dumpster area, on 02/06/13 at 10:50 AM and 02/08/13 at 10:20 AM, revealed on 02/06/13, three out of eight lids to the dumpster were open, due to an overflow of trash and poorly fitting lids. On 02/08/13, one lid, out of eight was open and the container was almost</p>	F 371	<p>F-371 (cont)</p> <p>all dietary staff have been re-educated. The Dietary Manager will be responsible to provide education to any staff member who is on leave or unable to attend the education session.</p> <p>On 2/8/13 the mop was removed from the mop bucket by the Dietary Manager and placed on the rack for proper storage.</p> <p>Re-education was initiated on 2/8/13 for the Dietary Staff in regards to the proper placement of mops, brooms, dust pans and must be hung up immediately after use. This was conducted by the Dietary Manager. The re-education will continue until all Dietary Staff have been re-educated. The Dietary Manager will be responsible to provide or arrange education for any staff member who is on leave or unable to attend the education session.</p> <p>The auditing of proper placement of mops, brooms, dust pans has been added to the kitchen audit tool and will be conducted daily by the Dietary manager and Kitchen staff.</p> <p>On 2/6/13 the dumpster was emptied by the Sanitation Department. New lids were placed on the dumpster by the Sanitation Department on 2/6/13 and the lid closed. The dumpster lid was re-closed on 2/8/13 by the Dietary Manager. Re-education for the Dietary Staff was initiated on 2/6/13 by the Dietary Manager that the dumpster lids must be closed at all times. This will continue until all the staff are re-educated. The Dietary Manager will be responsible to provide or arrange for education for those on leave or unable to attend the education session. Re-education was initiated on 3/1/13 for the remaining disciplines in the facility on dumpster lids being closed at all times when not in use. The education is being conducted by Dietary Manager and Maintenance Director. The education will continue until all staff are re-educated. The Dietary Manager and</p>		

F-371 (cont)

Maintenance Director will be responsible to provide or arrange education for staff on leave or unable to attend the education session.

Monitoring Measures to Maintain On-going Compliance:

The placement of food on the steam table will be audited daily for one week by the Dietary Manager, then 3 times per week for 4 weeks, then monthly 6 months to verify ongoing compliance. The results will be reported the Quality Assessment and Assurance Committee monthly x 6 months for review. If any areas of concern are identified the frequency and or duration of the audit may be increased. Re-education will be provided on an individual basis if indicated.

A monitoring tool was developed and will be completed on stock delivery days to the facility to ensure that the produce is not placed on the refrigerator floor. This was initiated on 2/12/13 by the Dietary Manager. This will be ongoing and added to the routine kitchen auditing process and completed by the Dietary Manager and Kitchen Staff. Auditing of the freezer was added to the Kitchen audit tool by the Dietary Manager on 3/1/13 and will be checked daily ongoing by the Dietary Manager and Kitchen staff to verify ongoing compliance with the proper storage of frozen foods. The results will be reported the Quality Assessment and Assurance committee monthly for 6 months for review and further recommendations if indicated.

Monitoring for proper placement of mops, brooms, dust pans, was added to the kitchen audit tool and will be checked daily ongoing by the Dietary Manager and kitchen staff to verify ongoing compliance. Results will be reported to Quality Assessment and Assurance committee monthly for 6 months for review and further recommendations if indicated.

Monitoring of the dumpster to verify the lids are closed and in good condition when not in use was added to the kitchen audit tool. The dumpster lids will be checked 3 times daily for 4 weeks, then daily ongoing thereafter. This was initiated on 2/8/13 by the Dietary Manager. The audit will be completed by the Dietary Manager and Kitchen staff. The results will be reported to the Quality Assessment and Assurance Committee on a quarterly basis.

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F 371	Continued From page 12 empty.	F 371			
F 441 SS=D	<p>An interview with the Dietary Manager, on 02/08/13 at 10:30 AM, revealed several disciplines utilized the dumpster area, yet they had all been trained to secure this area and stated she would have expected staff to secure the area.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p><u>(a) Infection Control Program</u> The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p><u>(b) Preventing Spread of Infection</u> (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which</p>	F 441	<p>F-441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility has an established infection control program that is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p><u>Corrective Measures for those Residents identified in the deficiency:</u></p> <p>Resident # 3 's oxygen tubing was placed in a plastic storage bag on 2/8/13 by the Director of Nursing for proper storage.</p> <p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>Twenty Two residents in the facility were identified as utilizing oxygen by the Director of Nursing on 2/8/13. All twenty two residents were reviewed to verify that all oxygen tubing was properly stored in a plastic bag. This was completed by the DON on 2/8/13.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>All Nursing Staff will be re-educated on the</p>	03/20/13	

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F 441	<p>Continued From page 13</p> <p>hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the facility's Clinical Practice guidelines, the facility failed to ensure infection control procedures were followed, regarding proper storage of oxygen tubing, for one resident (#3), in a selected sample of fifteen.</p> <p>Findings Include:</p> <p>A review of the facility's Clinical Practice Guidelines for Oxygen Therapy Concentrator Set-Up, dated 01/01/2007, revealed if the cannula, mask, or other device was not in use, it should be stored in a plastic bag or container to decrease risk of contamination.</p> <p>A record review revealed Resident #3 was admitted to the facility on 11/26/12 with diagnoses to include Hypertension, Heart Disease and Chronic Edema.</p> <p>Observations of Resident #3's oxygen tubing, on 02/06/13 at 10:30 AM, 12:00 noon, 2:00 PM and 2:30 PM, on 02/07/13 at 9:45 AM, 1:35 PM, 3:00 PM and 6:25 PM and on 02/08/13 at 9:15 AM and 2:15 PM revealed unbagged oxygen tubing was</p>	F 441	<p>F-441 (cont)</p> <p>Infection Control and Oxygen Therapy concentrator set up Policy and Procedure with emphasis placed on proper storage of oxygen tubing. This was initiated on 2/11/13 by the staff development nurse. The education will continue until all staff are re-educated. The Director of Nursing will be responsible to provide or arrange for education for any staff on leave or unable to attend the scheduled sessions.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>Audits of all residents receiving oxygen will have the tubing checked for proper storage in a plastic bag. This audit will be conducted daily x 4 weeks then 3 x per week for 4 weeks, then weekly thereafter x 6 months to verify ongoing compliance with proper storage of oxygen tubing. The audits will be conducted by the staff development nurse, LPN Supervisor and charge nurses. Results of the audits will be reported to the Director of Nursing for review. In addition the results will be reported to the Quality Assessment and Assurance Committee x 6 months. If any concerns are identified, the duration or frequency of the audit may be increased. Re-education will be provided on individual basis if indicated.</p>	

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F 441	<p>Continued From page 14</p> <p>observed lying in a chair on a soiled chux or on the floor.</p> <p>An interview with Certified Nurse Aide (CNA) #1 and CNA #2, on 02/08/13 at 2:30 PM and 2:35 PM respectively, revealed all oxygen tubing should be bagged when not in use and if found on the floor should be thrown away and new tubing should be obtained.</p> <p>An interview with Staff Development Coordinator, on 02/08/13 at 2:45 PM, revealed the staff have been inserviced that when oxygen tubing is not in use it should be bagged in a plastic clear bag and attached to the compressor or cylinder tank attached to the back of the wheel chair. She stated "we don't have a policy regarding tubing storage, it's just our practice. The staff should have known to bag the tubing if not in use, as they have been inserviced on it."</p> <p>An interview with the Director of Nursing (DON,) on 02/08/13 at 2:55 PM, revealed all staff have been inserviced in the proper storage of oxygen tubing when not in use. She stated she would have expected the staff to have placed the tubing in a clear plastic bag and attached the bag to the compressor or cylinder tank on the back of the wheel chair. We don't have a policy regarding storage of tubing, "its just our practice."</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754	
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1992, 2008</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is propane.</p> <p>A standard Life Safety Code survey was conducted on 02/07/13. Spring View Health and Rehab Center was found in non-compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire). The facility is certified for seventy one (71) beds with a census of sixty five (65) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000		

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

TITLE

(X6) DATE

[Handwritten Signature] Administrator 2/14/13

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

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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is submitted solely because it is required by the provision of federal and state law.	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ 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 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors protecting corridor openings were constructed to resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke	K 018	<u>K-018</u> It is the normal practice of Spring view Health and Rehab Center to ensure doors protecting corridor openings are constructed to resist the passage of smoke in accordance with NFPA standards. <u>Corrective Measures for those Residents identified in the deficiency:</u> No residents were identified in this deficiency <u>How other residents who may have been affected by this practice were identified:</u> Residents in 1 of 4 smoke compartments have the potential to be affected by the practice. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> New doors were ordered on 2/7/13 for rooms #103,108,113,114, and 115 by the administrator. The new doors will be installed by 3/20/13 by the Maintenance Director. A new latch was placed on room # 116 by the Maintenance Director on 2/27/13. All remaining doors in the facility were checked on 2/7/13 by the Maintenance Director to verify no other doors were in need of replacement. None were identified.	03/22/13

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K 018	<p>Continued From page 2</p> <p>compartments, residents, staff and visitors. The facility has seventy one (71) certified beds with a census of sixty five (65) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/07/13 between 9:00 AM and 2:00 PM, with the Maintenance Director revealed the corridor doors to rooms #103, #108, #113, #114, and #115 had a gap at the top of the door that would not resist the passage of smoke. Further observation revealed the corridor door to room #116 would not latch when tested.</p> <p>Interview, on 02/07/13 between 9:00 AM and 2:00 PM, with the Maintenance Director revealed he was not aware the doors had a gap too large. Further interview revealed he was not aware the door to room #116 would not latch.</p> <p>Interview, on 02/07/13 at 2:00 PM, with the Administrator revealed she was aware of the requirement for corridor doors; however, she was not aware of the doors that had too large of a gap at the top of the door to room #116 would not latch.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>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</p>	K 018	<p>K-018 (cont)</p> <p>The Maintenance Director was re-educated on 3/4/13 by the administrator on the requirement of gaps on corridor doors to resident rooms.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>The Maintenance Director or Maintenance assistant will audit all the corridor doors to the resident rooms once every quarter to verify a gap has not occurred at the top of the door. The results of the audit will be reported to the administrator and to the Quality Assessment and Assurance Committee on a quarterly basis to validate ongoing compliance for a minimum of one year.</p>		

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K 018	Continued From page 3 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 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 NFPA standards.	K 018		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted	K 025	K 025 It is the normal practice of Spring view Health and Rehab Center to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. <u>Corrective Measures for those Residents identified in the deficiency:</u> No residents were identified in this deficiency.	03/5/13

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K 025	<p>Continued From page 4</p> <p>heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy one (71) beds with a census of sixty five (65) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 02/07/13 between 8:00 AM and 9:00 AM, with the Maintenance Director revealed the smoke barriers, extending above the ceiling had penetrations of pipes and the use of unrated material. The penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. The smoke partition located by room #118 had been sealed with unrated expanding foam. The smoke partition located by restorative dining had a penetration around the main sprinkler pipe.</p> <p>Interview, on 02/07/13 between 8:00 AM and 9:00 AM, with the Maintenance Director revealed he was not aware of the penetrations.</p> <p>Interview, on 02/07/13 at 2:00 PM, with the Administrator revealed she was aware of the requirements for smoke barriers but not aware of</p>	K 025	<p><u>K-025 (cont)</u></p> <p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>Residents in 3 of 4 smoke compartments have the potential to be affected by the practice.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>The smoke partition located by room #118 was resealed with red fire caulk on 3/1/13. The penetration located by the restorative dining area around the main sprinkler pipe was repaired with red fire caulk on 3/1/13. These repairs were completed by the Maintenance Director. All remaining smoke barriers were checked on 2/7/13 by the Maintenance Director and no issues were identified. The Maintenance Director was re-educated by the administrator on 3/4/13 on utilizing the required caulking for penetrations and no areas of penetration can be present.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>The smoke barriers will be audited monthly by the Maintenance Director and the Maintenance employee to validate ongoing compliance that proper caulking is being utilized and no areas of penetration are present. The results will be reported to the Quality Assessment and Assurance committee for review for one year to verify ongoing compliance.</p>	

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K 025	Continued From page 5 the penetrations. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025			
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are	K 027	<u>K027</u> It is the normal practice of Spring view Health and Rehab Center to ensure that cross -corridor doors will resist the passage of smoke in accordance with NFPA standards.	03/5/13	

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K 027	<p>Continuod From page 6</p> <p>not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy one (71) beds with a census of sixty five (65) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/07/13 at 1:38 PM, with the Maintenance Director revealed the two (2) sets of cross-corridor doors, located in the Main Hall would not close completely when tested. This was due to the doors not having a coordinator to ensure the door without the t-astragal would close first after the initial close.</p> <p>Interview, on 02/07/13 at 1:38 PM, with the Maintenance Director revealed he was not aware the doors needed a coordinator to ensure the doors would close properly in the event of an emergency.</p> <p>Interview, on 02/07/13 at 2:00 PM, with the Administrator revealed she was not aware the doors needed a coordinator to ensure the doors would close properly in the event of an emergency.</p>	K 027	<p>K-027 (cont)</p> <p><u>Corrective Measures for those Residents identified in the deficiency:</u></p> <p>No residents were identified in this deficiency.</p> <p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>Residents in 3 of 4 smoke compartments have the potential to be affected by the practice.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>The two sets of cross-corridor doors located in the main hall had coordinators installed by the Maintenance Director on 3/4/13 to ensure the door without the t-astragal will close first after the initial close. The Maintenance Director was re-educated by the Administrator on 3/4/13 on the requirement for doors to have a coordinator to ensure doors would close in the event of an emergency.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>The Maintenance Director will audit all the cross-corridor doors to ensure that all are self closing, latch independently of each other and resist the passage of smoke. This will be conducted on a monthly basis ongoing. The results will be reported the Quality Assessment and Assurance Committee for one year to verify ongoing compliance.</p>	

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K 027	Continued From page 7 NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke. Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 027			
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	K 029	<u>K-029</u> <u>Corrective Measures for those Residents identified in the deficiency:</u> No residents were identified in this deficiency. <u>How other residents who may have been affected by this practice were identified:</u> Residents in 2 of 4 smoke compartments have the potential to be affected by the practice. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> On 2/12/13 the 100 hall Janitor closet, 100 hall clean room, Server Room, and the 200 Hall Housekeeping Supply Room had Self-closures installed. These were installed by the Maintenance Director and the Maintenance employee.	03/5/13	

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K 029	<p>Continued From page 8</p> <p>determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy one (71) beds with a census of sixty five (65) on the day of the survey. The facility failed to provide self-closing devices for doors protecting hazardous areas.</p> <p>The findings include:</p> <p>Observation, on 02/07/13 between 9:00 AM and 2:00 PM, with the Maintenance Director revealed rooms required to be self-closing or containing a hazardous amount of combustibles did not have self-closing devices to keep the door closed. The rooms identified as hazardous requiring a self-closing device were the 100 Hall Janitor Closet, 100 Hall Clean Room, Server Room, and the 200 Hall Housekeeping Supply Room .</p> <p>Interview, on 02/07/13 between 9:00 AM and 2:00 PM, with the Maintenance Director revealed he was not aware the doors to these rooms were required to be self-closing.</p> <p>Interview, on 02/07/13 at 2:00 PM, with the Administrator revealed she was aware of the requirements for doors protecting hazardous areas.</p> <p>8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8.</p>	K 029	<p>K-029 (cont)</p> <p>The Maintenance Director was re-educated on the requirement for self-closers for rooms protecting hazardous combustibles on 3/4/13 by the Administrator.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>Rooms that contain hazardous combustibles will be monitored to verify that self closures are present on the doors. This will be conducted monthly by the Maintenance Director and the Maintenance employee. The results of the findings will be reported to the Quality Assessment and Assurance committee for a minimum of one year to validate ongoing compliance.</p>		

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K 029	Continued From page 9 Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than	K 029			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 10	K 029		
K 045	48 in. (122 cm) above the bottom of the door.	K 045		
SS=D	NFPA 101 LIFE SAFETY CODE STANDARD illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy one (71) beds with a census of sixty five (65) on the day of the survey. The findings include: Observation, on 02/07/13 at 1:05 PM, with the Maintenance Director revealed an exterior exit with only one light bulb outside to light the egress path. The exit with only one light was located next to room #215. Interview, on 02/07/13 at 1:05 PM, with the Maintenance Director revealed he was not aware the exit did not have the required illumination for egress lighting. Interview, on 02/07/13 at 2:00 PM, with the Administrator revealed she was not aware the exit did not have the required illumination for		K-045 It is the normal practice of Spring view Health and Rehab Center to ensure exits were equipped with lighting in accordance with NFPA standards. <u>Corrective Measures for those Residents Identified in the deficiency:</u> No residents were identified in this deficiency. <u>How other residents who may have been affected by this practice were identified:</u> Residents in 1 of 4 smoke compartments have the potential to be effected. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> The light by the exit door by room # 215 had a dual light installed on 2/12/13 by the Maintenance Director. The Maintenance Director was re-educated by the Administrator on 3/4/13 on the requirement for illumination of means of egress is arranged so that failure of a single light will not leave the area in darkness. <u>Monitoring Measures to Maintain On-going Compliance:</u> All lighting by the exits for egress will be monitored quarterly by the Maintenance Director to verify ongoing compliance. The audit results will be reported to the Quality Assessment and Assurance Committee quarterly for 1 year.	03/5/13

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NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42734		
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K 045	<p>Continued From page 11 egress lighting.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.2.6 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8.</p> <p>7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way.</p> <p>7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units.</p>	K 045		

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K 045	Continued From page 12 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045			
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation, and interview it was determined the facility failed to test emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy one (71) beds with a census of sixty five (65) on the day of the survey. The facility failed to provide emergency battery lighting for the transfer switch located inside the building.	K 046	K-046 It is the normal practice of Spring view Health and Rehab Center to test emergency lighting in accordance with NFPA standards. <u>Corrective Measures for those Residents Identified in the deficiency:</u> No residents were identified in this deficiency. <u>How other residents who may have been affected by this practice were identified:</u> Residents in 4 of 4 smoke compartments have the potential to be affected by the practice.	03/5/13	

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K 046	<p>Continued From page 13</p> <p>The findings include:</p> <p>Observation, on 02/07/13 at 8:50 AM, with the Maintenance Director revealed the facility did not have documentation for monthly testing, or the annual testing of emergency battery lighting located in the facility.</p> <p>Interview, on 02/07/13 at 8:50 AM, with the Maintenance Director revealed he was not aware documentation was to be kept on emergency battery light testing.</p> <p>Interview, on 02/07/13 at 2:00 PM, with the Administrator revealed she was not aware of the requirement for emergency battery light testing.</p> <p>Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required</p>	K 046	<p>K-046 (cont)</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>Testing for the emergency lighting for the facility was completed on 2/20/13 by the Maintenance Director. An audit tool was developed for testing to be conducted for 30 seconds monthly and also annually. The Maintenance Director was re-educated by the administrator on 3/4/13 on the requirement for documentation of testing of emergency lighting in the facility.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>The Maintenance Director or Maintenance employee will conduct the emergency lighting testing in the facility monthly and annually. The results will be documented on the Maintenance audit tool. Results of the audits will be reported to the Quality Assessment and Assurance Committee on a monthly basis and will continue for a minimum of 1 year to verify ongoing compliance.</p>	

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K 046	Continued From page 14 battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046			
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy one (71) beds with a census of sixty five (65) on the day of the survey. The facility failed to ensure exits were clearly recognizable with proper exit signage. The findings include:	K 047	K-047 It is the normal practice of Spring view Health and Rehab to ensure exit signs are maintained in accordance with NFPA standards. <u>Corrective Measures for those Residents identified in the deficiency:</u> No residents were identified in this deficiency. <u>How other residents who may have been affected by this practice were identified:</u> Residents in 1 of 4 smoke compartments have the potential to be affected by the practice. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> The electrician was contacted by the Maintenance Director and has been contracted to install proper exit signage above the doors in the kitchen this was completed on 2/28/13. All exit doors were checked on 2/7/13 to verify that the	03/5/13	

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K 047	Continued From page 15 Observation, on 02/07/13 at 1:17 PM, with the Maintenance Director revealed the exit doors located in the Kitchen did not have an exit sign above the door making the path of egress clearly recognizable. Interview, on 02/07/13 at 1:17 PM, with the Maintenance Director revealed he was not aware the exits did not have proper signage. Interview, on 02/07/13 at 2:00 PM, with the Administrator revealed she was not aware the exits did not have proper signage. Reference: NFPA 101 (2000 edition) 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.	K 047	K-047 (cont) appropriate exit doors had signage posted over the doors by the Maintenance Director. Re-education was provided to the Maintenance Director by the administrator on 3/4/13 on the requirement for proper exit signage. <u>Monitoring Measures to Maintain On-going Compliance:</u> The exit signage in the facility will be audited by the Maintenance Director or Maintenance employee on a monthly basis ongoing to verify compliance. The results of the audit will be reported to the Quality Assessment and Assurance Committee monthly for a minimum of 1 year.	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on smoke detector testing record review and interview, it was determined the facility failed to ensure smoke detectors were inspected and tested in accordance with NFPA Standards. The	K 054	K-054 It is the normal practice of Spring view Health and Rehab Center to ensure that smoke detectors are inspected and tested in accordance with NFPA standards. <u>Corrective Measures for those Residents identified in the deficiency:</u> No residents were identified in this deficiency. <u>How other residents who may have been affected by this practice were identified:</u>	03/5/13

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K 054	Continued From page 16 deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy one (71) beds with a census of sixty five (65) on the day of the survey. The facility failed to ensure that the battery powered smoke detectors in the facility were being properly tested and cleaned. The findings include: Smoke detector testing record review, on 02/07/13 at 9:20 AM, with the Maintenance Director, revealed the facility failed to provide documentation of Smoke Detector weekly testing or monthly cleaning of the battery operated smoke detectors located throughout the facility. Interview, on 02/07/13 at 9:20 AM, with the Maintenance Director revealed he was not aware the facility was required to keep documentation on the battery operated smoke detectors. Interview, on 02/07/13 at 9:20 AM with the Administrator, revealed she was not aware of the requirement. Reference: NFPA 72 (1999 ed.) 7-4.1 Fire alarm system equipment shall be maintained in accordance with the manufacturer's instructions. The frequency of maintenance shall depend on the type of equipment and the local ambient conditions.	K 054	K-054 (cont) Residents in 4 of 4 smoke compartments have the potential to be affected by the practice. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> All smoke detectors in the facility were tested and cleaned on 2/20/13 by the Maintenance Director and the Maintenance employee. An audit tool was developed for weekly testing and monthly cleaning of all smoke detectors to be completed by the Maintenance Director and Maintenance employee. The Maintenance Director was re-educated on 03/4/13 by the Administrator on the requirement for conducting proper testing and cleaning of smoke detectors and maintaining documentation. <u>Monitoring Measures to Maintain On-going Compliance:</u> All smoke detectors in the facility will be tested weekly and monthly cleaning conducted and documented on the audit tool by the Maintenance Director and Maintenance employee to verify that all smoke detectors are cleaned monthly and tested weekly. The results will be reported in the monthly Quality Assessment and Assurance committee for one year to verify ongoing compliance.		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard	K 056	K-056 It is the normal practice of Spring view Health and Rehab Center to ensure the building has a	03/20/13	

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K 056	<p>Continued From page 17</p> <p>for the installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system installed, in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy one (71) beds with a census of sixty five (65) on the day of the survey. The facility failed to ensure the sprinkler heads were not blocked by light fixtures.</p> <p>The findings include:</p> <p>Observation, on 02/07/13 at 1:40 PM, with the Maintenance Director revealed a sprinkler head was blocked by a light fixture located in the room #203, and the bathroom of room # 201.</p> <p>Interview, on 02/07/13 at 1:40 PM, with the Maintenance Director revealed he was not aware of the blocked sprinkler head.</p>	K 056	<p>K-056 (cont)</p> <p>complete sprinkler system installed in accordance with NFPA standards.</p> <p><u>Corrective Measures for those Residents identified in the deficiency:</u></p> <p>No residents were identified in this deficiency.</p> <p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>Residents in 1 of 4 smoke compartments have the potential to be affected by the practice.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>The sprinkler heads will be replaced by the fire sprinkler company by 3/20/13 to prevent blockage of the sprinkler heads in room #203 and the bathroom in #201. All sprinklers in the facility were audited by the Maintenance Director on 2/7/13 to verify that other sprinkler heads were not blocked by lighting fixtures. A monthly audit tool was developed for auditing of sprinklers to ensure no blockages are present. The Maintenance Director was re-educated by the Administrator on 3/4/13 on the requirement for proper placement of sprinklers so as to prevent blocking of sprinkler heads.</p>		

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K 056	Continued From page 18 Interview, on 02/07/13 at 2:00 PM, with the Administrator revealed she was not aware of the blocked sprnkler head. Reference: NFPA 13 (1999 Edlton) 5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (11f) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklars shall be positioned in accordance with the minimum distances and spacial exceptions of Sections 5-6 through 5-11 so that they are located sufficiently	K 056			

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K 058	Continued From page 19 away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)	K 056																										
	<p style="text-align: center;">Maximum Allowable Distance</p> <table border="0"> <tr> <td style="text-align: right;">Distance from Sprinklers to above Bottom of Side of Obstruction (A)</td> <td style="text-align: right;">of Deflector Obstruction (in.)</td> </tr> <tr> <td>(B)</td> <td></td> </tr> <tr> <td>Less than 1 ft</td> <td style="text-align: center;">0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td style="text-align: center;">21/2</td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td style="text-align: center;">31/2</td> </tr> <tr> <td>2 ft to less than 2 ft 6 in.</td> <td style="text-align: center;">51/2</td> </tr> <tr> <td>2 ft 6 in. to less than 3 ft</td> <td style="text-align: center;">71/2</td> </tr> <tr> <td>3 ft to less than 3 ft 6 in.</td> <td style="text-align: center;">91/2</td> </tr> <tr> <td>3 ft 6 in. to less than 4 ft</td> <td style="text-align: center;">12</td> </tr> <tr> <td>4 ft to less than 4 ft 6 in.</td> <td style="text-align: center;">14</td> </tr> <tr> <td>4 ft 6 in. to less than 5 ft</td> <td style="text-align: center;">161/2</td> </tr> <tr> <td>5 ft and greater</td> <td style="text-align: center;">18</td> </tr> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</p>	Distance from Sprinklers to above Bottom of Side of Obstruction (A)	of Deflector Obstruction (in.)	(B)		Less than 1 ft	0	1 ft to less than 1 ft 6 in.	21/2	1 ft 6 in. to less than 2 ft	31/2	2 ft to less than 2 ft 6 in.	51/2	2 ft 6 in. to less than 3 ft	71/2	3 ft to less than 3 ft 6 in.	91/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	161/2	5 ft and greater	18			
Distance from Sprinklers to above Bottom of Side of Obstruction (A)	of Deflector Obstruction (in.)																											
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4 ft 6 in. to less than 5 ft	161/2																											
5 ft and greater	18																											
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 062	K-062 It is the normal practice of Spring view Health and Rehab Center to maintain the sprinkler system in accordance with NFPA standards. <u>Corrective Measures for those Residents Identified in the deficiency:</u> No residents were identified in this deficiency.	03/20/13																								

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

PRINTED: 02/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185309	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/07/2013
NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754	
(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 062	Continued From page 20 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy one (71) beds with a census of sixty five (65) on the day of the survey. The facility failed to ensure sprinkler heads located were not blocked by curtains which prevented the water pattern from fully developing. The findings include: Observation, on 02/07/13 between 9:00 AM and 2:00 PM, with the Maintenance Director revealed the sprinkler heads located in rooms #104, #115, #116, #118, and #214 were blocked by privacy curtains when the curtains were not in use and stored against the wall. Interview, on 02/07/13 between 9:00 AM and 2:00 PM, with the Maintenance Director revealed he was not aware the curtains were blocking the sprinkler heads when in the stored position. Interview, on 0/07/13 between 9:00 AM and 2:00 PM, with the Administrator revealed she was not aware the sprinkler heads were blocked by the privacy curtains when in the stored position. Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous	K 062	K-062 (cont) <u>How other residents who may have been affected by this practice were identified:</u> Residents in 2 of 4 smoke compartments have the potential to be affected by the practice. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> The privacy curtain tracks in rooms #104, # 105, #116, #118, #214 had a clip installed in the track to prevent the privacy curtains from being pushed back to far when not in use and blocking the sprinkler heads. This was completed on 3/8/13 by the Maintenance Director. All rooms in the facility were checked to verify no other sprinkler heads were blocked by the privacy curtains on 2/7/13 by the Maintenance Director. The Maintenance Director was re-educated on the requirement that sprinkler heads must be in a position to avoid obstruction by the Administrator on 3/4/13. <u>Monitoring Measures to Maintain On-going Compliance:</u> All sprinklers in the facility will be audited monthly on an ongoing basis by the Maintenance Director and Maintenance employee to verify sprinklers are free from blockage. The findings will be reported to the Quality and Assessment and Assurance Committee on a quarterly basis for 1 year to validate ongoing compliance.	

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NAME OF PROVIDER OR SUPPLIER SPRING VIEW HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754		
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K 062	Continued From page 21 obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 5-5.5.2.	K 062			
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff, and visitors. The facility is certified for seventy one (71) beds with a census of sixty five (65) on the day of the survey. The facility failed to maintain proper space around electrical panels, and proper use of equipment requiring a ground fault outlet. The findings include: Observations, on 02/07/13 between 9:00 AM and 2:00 PM, with the Maintenance Director revealed storage in front of electrical panels located in the Mechanical Room outside of the Kitchen. Further observation revealed a hydrocollator located in the Therapy Storage Room was not plugged into a ground fault protected outlet. Interview, on 02/07/13 between 9:00 AM and 2:00 PM, with the Maintenance Director revealed he	K 147	K-147 It is the normal practice of Spring view Health and Rehab to ensure electrical wiring is maintained in accordance with NFPA standards. <u>Corrective Measures for those Residents identified in the deficiency:</u> No residents were identified in this deficiency. <u>How other residents who may have been affected by this practice were identified:</u> Residents in 2 of 4 smoke compartments have the potential to be affected by the practice. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> The storage in front of the electrical panels located in the mechanical room outside of the kitchen was removed on 2/8/13 by the Dietary Manager and Maintenance employee. A ground fault protected outlet was installed in the therapy storage room on 2/12/13 by the Maintenance Director. The Maintenance Director was reeducated on storage requirements by electrical panels and proper use of equipment requiring a ground fault outlet by the Administrator on 3/4/13. <u>Monitoring Measures to Maintain On-going Compliance:</u> The mechanical room outside the kitchen will be audited monthly for 6 months by the	03/5/13	

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K 147	<p>Continued From page 22</p> <p>was not aware the storage in the Mechanical Room was too close to the electrical panels. Further interview revealed he was not aware the hydrocollator was to be plugged into a ground fault protected outlet.</p> <p>Interview, on 02/07/13 at 2:00 PM, with the Administrator revealed she was aware of the requirements for storage around electrical panels, but was not aware the hydrocollator was not plugged into a ground fault protected outlet.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p>	K 147	<p>K-147(cont)</p> <p>Maintenance Director to verify that there is no storage near the electrical panels. Equipment will be audited in the facility on a monthly basis for 6 months to verify that equipment is utilized in a proper ground fault outlet by the Maintenance Director or Maintenance employee.</p> <p>The findings of the audits will be reported to the Quality Assessment and Assurance Committee monthly to verify ongoing compliance for a minimum of 6 months.</p>		