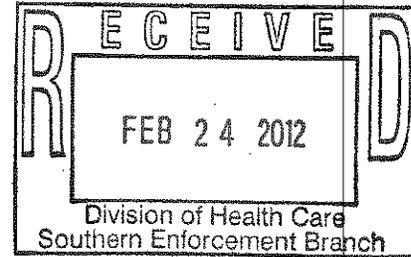


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/16/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  02/02/2012
NAME OF PROVIDER OR SUPPLIER  BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 117 SHELBY STREET, P O BOX 1090 BARBOURVILLE, KY 40906	
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F 000	INITIAL COMMENTS  A standard health survey was conducted on 01/31/12 to 02/02/12. Deficient practice was identified with the highest scope and severity at "F" level.	F 000		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policy, it was determined the facility failed to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one of twenty-four sampled residents (Resident #2). Observations of Resident #2 on 01/31/12, revealed the resident required one-to-one monitoring related to behaviors. Further observations revealed Resident #2 ambulated briskly up and down the hallway, and yelled curse words at facility staff providing the one-to-one monitoring. Continued observations revealed several unsampled residents were also in the hallway area and observed Resident #2's behaviors. Based on interview and record review, there was no evidence the facility had assessed the causative factors or circumstances of the resident's behaviors. In addition, the facility failed to thoroughly develop and implement interventions	F 250		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Janna Partin TITLE: Administrator (X6) DATE: 2/24/12

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

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F 250	<p>Continued From page 1</p> <p>related to the resident's ongoing behaviors, and failed to change the resident's care plan in accordance with the resident's behaviors.</p> <p>The findings include:</p> <p>A review of the facility's policies and protocols for Observing Resident Mood And Behavior revealed facility staff would identify specific behaviors triggered on the resident's record, attempt to identify causative factors, and implement measures to control the resident's behaviors.</p> <p>Review of the medical record revealed the facility admitted Resident #2 on 07/15/09, with diagnoses of Anxiety, Depression, Dementia, and Mood Disorder. Further review of the medical record revealed a quarterly Minimum Data Set (MDS) assessment dated 06/01/11, that revealed the resident had physical and verbal behavior symptoms which occurred one to three days during that assessment period.</p> <p>A review of the Social Services progress notes dated 06/01/11, revealed the facility social worker had documented Resident #2 refused care at times, that the resident had good days and bad days, and that these extremes were baseline for the resident. A review of the Social Services documentation dated 08/30/11, revealed Resident #2 continued to refuse care at times, was short-tempered, and had a history of being verbally abusive to staff, however, no evidence of Social Services intervention was identified.</p> <p>An annual MDS assessment dated 11/23/11, revealed Resident #2 exhibited physical, verbal, and other behavior symptoms one to three days</p>	F 250			

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F 250	<p>Continued From page 2</p> <p>during that assessment period. Social Services notes dated 11/23/11, revealed Resident #2 had refused care, was short-tempered, was verbally and physically abusive to staff, and had episodes of wandering; however, there was no documentation of Social Services interventions identified.</p> <p>Continued review of the facility Social Services notes dated 12/25/11, revealed Resident #2 had become agitated in the hallway of the facility and hit Resident #17's prosthetic leg with a wheelchair. After the resident to resident incident on 12/25/11, a psychiatric evaluation was scheduled for Resident #2 for 12/29/11, and the resident was placed on one-to-one monitoring by facility staff. However, documentation dated 12/29/11, revealed Resident #2 refused to be transported to the appointment and the facility social worker developed an intervention for staff to continue to encourage the resident to be compliant with care routines. Social Services documentation dated 01/04/12, revealed Resident #2's behavior continued to escalate, and as a result Resident #2 was admitted to a "geri-psych" inpatient facility on 01/04/12.</p> <p>Further review of Social Services notes revealed the resident returned to the facility on 01/19/12. On 01/27/12 (eight days after the resident's discharge from the psychiatric facility and readmission to the facility), documentation by Social Services revealed Resident #2 was agitated in the hallway and facility staff was unable to calm the resident. Based on documentation, the resident's physician was notified of the resident's behaviors and he prescribed an anti-anxiety medication that could</p>	F 250		

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F 250	<p>Continued From page 3</p> <p>be administered every six hours as needed. Documentation revealed Social Service's next written entry in the record was on 01/30/12, and revealed Resident #2 was involved in another resident-to-resident incident and had thrown water on a unsampled resident. Resident #2 was again placed on one-to-one monitoring and an appointment was made for the resident to be taken for a psychiatric evaluation on 02/16/12 (17 days after the incident on 01/30/12). Continued review of facility Social Services progress notes revealed on 02/01/12, Resident #2 continued to have behaviors, and continued to require one-to-one monitoring. Documentation in the medical record revealed facility staff transferred the resident to an outpatient psychiatric center on 02/01/12, to be evaluated for possible inpatient admission/treatment. However, documentation on 02/01/12, revealed the outpatient psychiatric center had determined Resident #2 did not meet criteria for admission to an inpatient facility and Resident #2 was transferred back to the facility on the same day of transfer/evaluation, 02/01/12.</p> <p>A review of the comprehensive care plan for Resident #2 revealed facility staff had identified continued episodes of behavior, resisting care, and being combative with staff as a problem. Further review of the care plan revealed facility staff had implemented interventions such as attempting to redirect the resident and allowing the resident to become calm before staff reapproached the resident during periods of behaviors. Continued review of the plan of care for Resident #2 revealed facility staff had also implemented following up with a psychiatrist as an intervention for the resident's behavior.</p>	F 250			

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F 250	<p>Continued From page 4</p> <p>Observations of Resident #2 on 01/31/12, at 5:45 PM, 6:00 PM, and 6:05 PM, revealed the resident was monitored on a one-to-one basis by facility staff. Further observations revealed Resident #2 ambulated briskly up and down facility hallways and yelled/cursed loudly at facility staff that provided the one-to-one monitoring. Continued observation revealed several unsampled facility residents had observed Resident #2's behaviors.</p> <p>Group interview conducted on 02/01/12, at 4:00 PM, revealed unsampled Resident A and Resident #17 verbalized they were "afraid" of Resident #2.</p> <p>An interview with the facility social worker on 02/02/12, at 4:00 PM, revealed she had not spoken with the staff member at the outpatient psychiatric center that assessed Resident #2 on 02/01/12, and that determined the resident did not meet criteria for inpatient treatment. Further interview with the social worker revealed the facility had identified Resident #2's recurrent behaviors, but had not attempted to identify causative factors for Resident #2's recurrent behaviors. Continued interview with the facility social worker confirmed the facility had failed to implement changes in interventions in an attempt to manage Resident #2's persistent behaviors.</p> <p>An interview with LPN #1 on 01/31/12, at 5:30 PM, revealed Resident #2's behaviors were "different from one day to another." The LPN continued to state the resident had frequently refused scheduled medications and therefore the "as needed" medications were usually unable to be given to assist in controlling behaviors. LPN #1 stated when Resident #2 refused medications,</p>	F 250		

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F 250	Continued From page 5 staff would "give the resident some time" and then would go back and attempt to administer the medications later. The LPN stated it depended on what kind of day the resident was having as to whether staff was successful or not. LPN #1 continued to state the one-to-one monitoring was the intervention which best allowed staff to control the resident's behaviors.  An interview with the Director of Nursing (DON) on 02/02/12, at 4:30 PM, confirmed Resident #2 had been involved in resident-to-resident incidents, and continued to have behaviors of cursing at facility staff in the hallways where other facility residents were present. When the DON was asked if she thought the facility had met the resident's needs related to control of Resident #2's behaviors since admission, the DON stated, "Obviously not, the resident has continued to have the behaviors."	F 250		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		

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F 431	<p>Continued From page 6</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure all drugs were labeled in accordance with currently accepted professional principles. During observations of the medication carts, unpackaged/unlabeled pills were observed in the medication drawers.</p> <p>The findings include:</p> <p>An interview with the Director of Nursing (DON) on 02/02/12, at 5:00 PM, revealed the facility did not have a policy related to medication storage.</p> <p>Observations of the medication carts at 2:30 PM on 02/02/12, revealed three of the four facility medication carts contained loose pills that were not packaged or labeled. On the Skilled Unit,</p>	F 431		

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F 431	Continued From page 7 medication cart 1 was observed to have one-half of a pill in a drawer that was not packaged or labeled. Medication cart 2 had one loose pill in a drawer that was not packaged or labeled, and medication cart 3 had one-half of a pill inside a drawer that was not packaged or labeled. On the Intermediate Care Unit, medication cart B was observed to contain seven loose pills within the drawers that were not packaged or labeled.  An interview with Licensed Practical Nurse (LPN) #2 at 2:30 PM on 02/02/12, revealed nurses were responsible to ensure his/her medication cart was neat and in order. LPN #2 was unaware of the loose pills in the medication cart.  Continued interview with the Director of Nursing (DON) on 02/02/12, at 5:00 PM, revealed nurses had the responsibility to maintain the medication carts in an acceptable manner. According to the DON, staff was not to leave loose/unlabeled medications in the drawers of the medication carts and stated staff "should have known better."	F 431		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the environment was sanitary for residents. Observations of the facility's five medication carts revealed the carts were soiled	F 465		

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F 465	Continued From page 8 and contained pill debris.  The findings include:  An interview with the Director of Nursing (DON) conducted on 02/02/12, at 5:00 PM, revealed there was no facility policy regarding medication cart sanitation.  Observations of the medication room on the "skilled" unit on 02/02/12, at 2:30 PM, revealed all five carts contained pill residue and grit inside the drawers. Cart 3 was observed to have a dark, dried sticky substance in the drawer that was used to store liquid medications.  Observations of the medication room on the "intermediate care" unit on 02/09/12, at 2:40 PM, revealed both medication carts contained pill debris and grit inside the drawers.  An interview with Licensed Practical Nurse (LPN) #2 on 02/02/12, at 2:40 PM, during the medication room/cart inspection revealed nurses were to clean the medication carts assigned for his/her use when they administered medications to the residents.  Continued interview with the DON on 02/02/12, at 5:00 PM, revealed the facility did not have a specified cleaning schedule for cleaning/sanitizing the medication carts.	F 465		
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS  The facility must equip corridors with firmly secured handrails on each side.	F 468		

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F 468	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure handrails in the facility were firmly secured. On 02/01/12, several handrails on both units in the facility were observed to be loose and not firmly attached to the wall.</p> <p>The findings include:</p> <p>An interview with the Maintenance Supervisor on 02/02/12, revealed the facility did not have a specific maintenance policy and that staff was to submit written requests for repairs.</p> <p>Observations during a facility tour on 02/01/12, at 12:00 PM, revealed the following handrails were loose and not securely attached to the walls:</p> <ul style="list-style-type: none"> <li>-A handrail was loose by the day room on the "skilled unit" and inside the facility's elevator.</li> <li>-Handrails were loose next to the elevator and the exit door on the "intermediate care" unit.</li> <li>-Handrails between and/or adjacent to the following resident rooms were observed to be loose: between resident rooms 205 and 209; between resident rooms 203 and 205; next to resident rooms 202 and 203; by the storage room on the intermediate care unit; between resident rooms 212 and 214; next to resident room 216; between resident rooms 220 and 222; between resident rooms 224 and 226; between resident rooms 228 and 230; between resident rooms 219 and 221; between 217 and 219; between resident rooms 211 and 213; and between resident room</li> </ul>	F 468		

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F 468	Continued From page 10 211 and the women's shower room.  Continued interview with the Maintenance Supervisor on 02/02/12, revealed he had recently checked the handrails, and the attachment to the wall was tight, but the attachments to the rails were not and he was not aware of how to tighten them.	F 468			

**Barbourville Health & Rehabilitation Center**

**Plan of Correction**

**February 2012, Survey**

**F-250**

- 1. Resident # 2 was immediately re-assessed for alterations in mood & behaviors and a care plan was developed for the behavior symptom. Interventions were put in place to maintain her highest level of psychosocial, mental, and physical well-being. Resident #2 has a "Mood and Behavior record" that is utilized each shift, the charge nurse will review this record each shift and prn, and interventions will be put in place as deemed necessary related to the causative factors. These interventions will be evaluated prn for effectiveness and changed as needed. An attempt to control resident #2's behaviors will be attempted however these behaviors are part of her baseline status. At this time, we are awaiting admission to psychiatric facility for further psychiatric evaluation.**
- 2. The facility's "Protocol for Observing Resident Mood and Behavior" policy is in effect for all residents of the facility. Mood and Behavior Observation Records will be initiated for all admissions and readmission. The Charge Nurse will review the record each shift, and attempt to identify causative factors, interventions and measures to control and prevent the resident behaviors will be initiated and an evaluation of the resident's treatment plan will be performed bi-weekly by the facilities CQI Team.**
- 3. In-services were conducted with all staff by the Administrator and the Director of Nursing regarding the facility's "Protocol for Observing Resident Mood and Behavior" including assessment & documentation of mood/behavior indicators, interventions based on causative factors of the behavior, importance of reporting any behaviors to nurse immediately, completing social service referral form, social service director assisting in the interventions as well as documenting these interventions , and evaluation of the effectiveness of the interventions. In-services will be completed by March 10<sup>th</sup>, 2012.**
- 4. The Director Of Nursing will review 3 charts from each unit weekly for one month then monthly for one quarter to monitor for compliance with the "Protocol for Observing Resident Mood and Behavior" including assessment & documentation of mood/behaviors, and evaluation of the effectiveness of interventions. In-services will be completed by March 10<sup>th</sup>, 2012.**
- 5. Date of Completion: March 10<sup>th</sup>, 2012**

## PROTOCOL FOR OBSERVING RESIDENT MOOD AND BEHAVIOR

A Mood and Behavior Observation Record will be initiated for all admissions and re-admissions. The charge nurse will review the record each shift, assess and intervene as necessary. This form will be kept in the CNA Flow Sheet Binder until the end of the current month. It will then be transferred to the resident's clinical record. During the facility's CQI Team Meeting, the Mood and Behavior Records of each resident will be reviewed at least every 2 weeks. This review will consist of an attempt to identify causative factors, implementation of measures to control the resident's behaviors and an evaluation of the treatment plan. Should it be determined by the Interdisciplinary Team that the residents behavior is not consistent with the goals set for the resident, an updated plan of care will be initiated. *(It should be noted that a resident may have a behavior that is "baseline" for the resident which cannot be altered. A goal for this residents would be "Behavior Maintenance" instead of "Behavior Minimization")*

**Barbourville Health & Rehabilitation Center**

**Plan of Correction**

**February, 2012**

**F431**

- 1. All loose, unpackaged, and unlabeled medications were disposed of immediately.**
- 2. All medication carts were checked by the clinical coordinators on each unit for any medications that were loose, unpackaged, and unlabeled.**
- 3. In-services were held with nursing staff by the Administrative Nurses regarding proper packaging, proper storage and proper labeling of all medications.**
- 4. The Clinical Coordinator on each unit will conduct random audits of medication carts on both units weekly for one month and then monthly for one quarter. Any irregularities will be corrected immediately and reported to the CQI committee for further follow up.**
- 5. Completion March 10<sup>th</sup>, 2012**

**Barbourville Health & Rehabilitation Center**

**Plan of Correction**

**February, 2012**

**F 465**

- 1. All medication carts were cleaned by the Nursing staff immediately.**
- 2. All five medication carts were checked by the clinical coordinator of each unit for pill debris and soiled areas in drawers.**
- 3. In-services were held with the nursing staff by the Administrative Nurses regarding cleaning of the medication carts. Each nurse is responsible for cleaning their medication cart at the end of their shift. In addition, the 11-7 nurse is responsible for checking to ensure the medication carts are clean and clean if necessary. 11-7 nurse will document on check off sheet when this is completed. In-service was held on February 2<sup>nd</sup> and 3<sup>rd</sup>, 2012.**
- 4. The Clinical Coordinator's on each unit will conduct random audits of medication carts on both units weekly for one month and then monthly for the next quarter. Any irregularities will be corrected immediately and reported to the CQI committee for further follow-up.**
- 5. Completion March 10<sup>th</sup>, 2012.**

**Barbourville Health & Rehabilitation Center**

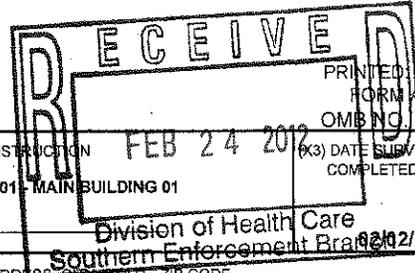
**Plan of Correction**

**February, 2012**

**F468**

- 1. The handrail by the day room on 100 unit and inside the elevator, next to elevator and exit door on the 200 unit, between and/or adjacent to the following residents rooms 205 and 209, between residents room 203 and 205, next to residents rooms 202 and 203; by the storage room on the 200 unit, between resident rooms 212 and 214, next to residents rooms 216, between resident rooms 224 and 226, between resident rooms 228 and 230, between residents rooms 219 and 221, between 217 and 219, between 211 and 213, and between resident room 211 and the women's shower room were tightened by the maintenance supervisor, though all were firmly affixed to the wall.**
- 2. All handrails in the facility have been checked by the Maintenance Supervisor to ensure there are no loose handrail and that all handrails are firmly affixed to the wall.**
- 3. Maintenance Supervisor has been in-serviced by the Administrator on February 3<sup>rd</sup>, 2012 on checking for loose handrail weekly and if found, to repair immediately. Maintenance Supervisor will document on a check sheet when these weekly checks are performed.**
- 4. The Maintenance Supervisor will monitor for loose handrail weekly for one month and then monthly for the next quarter. Any irregularities will be corrected immediately and reported to the CQI committee for further follow up.**
- 5. Completion March 10th, 2012.**

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



PRINTED: 02/16/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED FEB 24 2012
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NAME OF PROVIDER OR SUPPLIER  BARBOURVILLE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 117 SHELBY STREET, P O BOX 1090 BARBOURVILLE, KY 40906
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS  BUILDING: 01  PLAN APPROVAL: 1985  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: Two story, Type 11 (000)  SMOKE COMPARTMENTS: Five  COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM  FULLY SPRINKLED, SUPERVISED (WET SYSTEM)  EMERGENCY POWER: Type II Natural Gas Generator  A life safety code survey was initiated and concluded on 02/02/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.  Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA	K 052		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Janna Partin TITLE: Administrator (X6) DATE: 2/24/12

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

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NAME OF PROVIDER OR SUPPLIER  BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 117 SHELBY STREET, P O BOX 1090 BARBOURVILLE, KY 40906	
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K 052	Continued From page 1 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the building fire alarm system functioned as required by NFPA standards. This deficient practice affected five of five smoke compartments, staff, and all the residents. The facility has the capacity for 119 beds with a census of 115 on the day of the survey.  The findings include:  During the Life Safety Code survey on 02/02/12, at 9:10 AM, with the Director of Maintenance (DOM), a test of the fire alarm automatic dialer panel sent a trouble signal to a continuously occupied location within the facility, however, the monitoring station did not contact the facility of this phone line failure as required. A call to the monitoring station at 9:23 AM on 02/02/12, by the DOM revealed the monitoring station did not receive this phone line failure signal.  A test of the fire alarm system on 02/02/12, at	K 052		

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NAME OF PROVIDER OR SUPPLIER  BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 117 SHELBY STREET, P O BOX 1090 BARBOURVILLE, KY 40906		
(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 052	<p>Continued From page 2</p> <p>9:25 AM, with the DOM revealed the fire doors could be reset while in the silent mode to the open position while the system was still showing fire conditions. An interview with the DOM on 02/02/12, at 9:25 AM, revealed the DOM was not aware fire doors should not be able to be reset while the fire alarm system was still showing fire conditions.</p> <p>Reference: NFPA 72 (1999 Edition).</p> <p>5-2.6.1.4 Upon receipt of trouble signals or other signals pertaining solely to matters of equipment maintenance of the fire alarm systems, the central station shall perform the following actions: (1) *Communicate immediately with persons designated by the subscriber A-5-2.6.1.4(1) The term immediately in this context is intended to mean "without unreasonable delay." Routine handling should take a maximum of 4 minutes from receipt of a trouble signal by the central station until initiation of the investigation by telephone.</p> <p>5-5.3.2.1.6.2 The following requirements shall apply to all combinations in 5-5.3.2.1.6.1: (1) Both channels shall be supervised in a manner approved for the means of transmission employed. (3) The failure of either channel shall send a trouble signal on the other channel within 4 minutes. (8) Failure of telephone lines (numbers) or cellular service shall be annunciated locally.</p>	K 052			

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NAME OF PROVIDER OR SUPPLIER  BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 117 SHELBY STREET, P O BOX 1090 BARBOURVILLE, KY 40906	
(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 052	Continued From page 3 3-9.6.3 All door hold-open release and integral door release and closure devices used for release service shall be monitored for integrity in accordance with 3-9.2.	K 052		
K 130 SS=D	NFPA 101 MISCELLANEOUS  OTHER LSC DEFICIENCY NOT ON 2786  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain gas clothes dryers. This deficient practice affected one of five smoke compartments, staff, and approximately twenty-five residents. The facility has the capacity for 119 beds with a census of 115 on the day of the survey.  The findings include:  During the Life Safety Code tour on 02/02/12, at 10:10 AM, with the Director of Maintenance (DOM), sensors for two clothes dryers' burner boxes were observed to be disconnected and lying on the bottom of the cabinets. These sensors ensure the dryers operate safely as intended. An interview with the DOM on 02/02/12, at 10:10 AM, revealed the DOM was unaware of why the sensors were disconnected.	K 130		

**Barbourville Health & Rehabilitation Center**

**Plan of Correction**

**February, 2012**

**K 052**

- 1. The fire alarm system was corrected by Superior Protection immediately.**
- 2. The fire alarm system has been checked by Superior Protection to ensure the automatic dialer is working properly and the fire doors were checked to ensure they cannot be reset during silent mode.**
- 3. Maintenance Supervisor has been in-serviced by the Administrator on February 3<sup>rd</sup>, 2012 on checking to ensure the fire alarm system is working properly on a weekly basis and if any issues found, they will be repair immediately. Maintenance Supervisor will document on a check sheet when these weekly checks are performed.**
- 4. The Maintenance Supervisor will monitor to ensure the fire alarm system is working properly weekly for one month and then monthly for one quarter. Any irregularities will be corrected immediately and reported to CQI committee for further follow up.**
- 5. Completion March 10<sup>th</sup>, 2012**

**Barbourville Health & Rehabilitation Center**

**Plan of Correction**

**February, 2012**

**K 130**

- 1. The clothes dryer's sensors were replaced and attached immediately by Larry's Laundry Service.**
- 2. All clothes dryers were checked by the Maintenance Supervisor to ensure sensors were attached.**
- 3. Maintenance Supervisor has been in-serviced by the Administrator on February 3<sup>rd</sup>, 2012 on ensuring the sensors are attached weekly and if problems found, to repair immediately.**
- 4. The Maintenance Supervisor will monitor the clothes dryer sensors weekly for one month then monthly for the next quarter. Any irregularities will be corrected immediately and reported to CQI committee for further follow up.**
- 5. Completion February 7<sup>th</sup>, 2012**