

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

PRINTED: 07/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185396	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/03/2013
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted on 07/01/13 through 07/03/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest scope and severity of a "E".	F 000		
F 162 SS=D	483.10(c)(8) LIMITATION ON CHARGES TO PERSONAL FUNDS The facility may not impose a charge against the personal funds of a resident for any item or services for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.) During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services: Nursing services as required at §483.30 of this subpart. Dietary services as required at §483.35 of this subpart. An activities program as required at §483.15(f) of this subpart. Room/bed maintenance services.	F 162	Tag# F162 • 15 Residents had the potential to be affected by this deficient practice. None of these residents were found to be affected. • A process for resident's rights to basic personal laundry services while admitted to facility was added to policy # 600-TC-200 "Resident Rights". Process will include the following steps: • The process for resident basic personal laundry services has been added to facility admission packet • Resident basic personal laundry process: ▪ Basic personal laundry services is performed through contractual agreement with a local laundry service. ▪ When resident requests basic personal laundry services, courier is contacted to deliver resident's laundry to contracted laundry service and to return clean laundry to facility. ▪ Resident's clean laundry will be returned to resident within 24 hours.	8/14/13



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

Joy Wilby

TITLE

Director

(X6) DATE

7-30-13

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

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

PRINTED: 07/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/03/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 162	<p>Continued From page 1</p> <p>Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry. Medically-related social services as required at §483.15(g) of this subpart.</p> <p>Listed below are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:</p> <ul style="list-style-type: none"> Telephone. Television/radio for personal use. Personal comfort items, including smoking materials, notions and novelties, and confections. Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare. Personal clothing. Personal reading matter. Gifts purchased on behalf of a resident. Flowers and plants. Social events and entertainment offered outside the scope of the activities program, provided under §483.15(f) of this subpart. Noncovered special care services such as 	F 162	<ul style="list-style-type: none"> • Residents will receive no additional charges for basic personal laundry service. • Staff will be educated on policy/process for resident's right to basic personal laundry. • New process will be monitored as follows: <ul style="list-style-type: none"> ○ A resident personal laundering log will be kept. Documentation on log will include the identifiers of resident name & date of birth, list of items to be laundered, date sent/list of returned items and date received. Date & resident signature/initial when laundered items are returned to resident. ○ Log will be maintained by Transitional Care Center clinical supervisors. 	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/03/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 162	<p>Continued From page 2</p> <p>privately hired nurses or aides. Private room, except when therapeutically required (for example, isolation for infection control). Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by §483.35 of this subpart.</p> <p>The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident. The facility must not require a resident (or his or her representative) to request any item or services as a condition of admission or continued stay. The facility must inform the resident (or his or her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide basic personal laundry services which are included in the Medicare or Medicaid payment. Observation of the interior of the facility, on 07/01/13, revealed there was no laundry services available for resident's basic personal clothing and linens.</p> <p>Findings include: Observations during a tour of the facility, on 07/01/13, revealed there was no laundry services available for resident's basic personal clothing and linens however, a washer and dryer were located in the laundry department.</p>	F 162		

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

PRINTED: 07/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185386	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/03/2013
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 162	Continued From page 3 Interview with Registered Nurse (RN) #1, on 07/02/13 at 2:00 PM, revealed a washer and dryer were located in the therapy department but were not installed for use. She additionally stated there was no projected date for the installation of the washer and dryer. Interviews with Occupational Therapy Assistant (OTA) #1 and #2 and Physical Therapy Assistant (PTA) #1, on 07/02/13 at 3:00 PM, revealed a washer and dryer were located in the therapy department for working with residents for motion of loading and unloading, as therapy. The washer and dryer were non-functional as far as actually laundering clothing. They stated someone had been up to look and see if the dryer could be vented according to code but they were unaware of any plans to install the washer and dryer to actually function. An interview with the Administrator, on 07/02/13 at 10:00 AM, revealed there was no laundry service installed in the new Transitional Care Unit when the building was recently constructed. The Administrator stated the families took resident's basic personal laundry home for laundering.	F 162		
F 371 SS=E	483.35(l) 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	F 371	7/1/13 F 371 (Broom & Dustpan on floor in food prep area) • None of the residents were found to be affected by this deficient practice. To address the deficiency, the soiled broom was immediately removed from the area. The soiled broom was removed immediately from the food handling area.	8/14/13

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

PRINTED: 07/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185398	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/03/2013
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy and procedure review it was determined the facility failed to ensure food was stored and prepared under sanitary conditions. A broom and dust pan was observed sitting on the floor in a food prep area. Additionally, opened milk was observed in walk in refrigerator without the proper label to indicate opened date.</p> <p>Findings include:</p> <p>Review of a facility policy titled, "Miscellaneous Food Service Policies-Sanitation Safety", last revised 12/10/12, revealed there was no information related to storage of brooms and dustpans. Interview with the Registered Dietician, on 07/03/13 at 10:30 AM, revealed she was not sure if there was a specific policy related to labeling of food items or storage of brooms and dustpans.</p> <p>An initial tour of the facility kitchen, on 07/01/13 at 11:30 AM, revealed:</p> <ol style="list-style-type: none"> an opened, partly empty, container of milk without a label to indicate what date the milk had been opened in the walk in refrigerator. a broom and dust pan on the floor, propped against the wall in the food preparation area of the kitchen. <p>An interview with the Food Services Director, on 07/01/13 at the time of the observations revealed</p>	F 371	<ul style="list-style-type: none"> 15 residents had the potential to be affected by this deficient practice. No residents were found to have been affected. The soiled broom was removed immediately from the food handling area. The following corrective action was taken by the Director, Assistant Director/Patient Service and Executive Chef: Policy 8052-705 Sanitation Safety was revised to include proper storage of brooms, mops, and dust pans. Staff were educated on Revised Policy 8052-705/Sanitation Safety. In addition to education, revised policy, with revisions highlighted, was posted on the utility storage room door. An inspection will be completed daily X 4 months, or until 4 months of sustained compliance is met, by the dietary manager/supervisor/designee to ensure no soiled items are placed in clean food handling locations. Dietary Manager will report audit results to Transitional Care Manager. Transitional Care Manager will report audit results to Transitional Care Quality Assurance Committee and Owensboro Health Performance Improvement Oversight Committee. <p>(Opened Milk observed in walk in refrigerator without proper label to indicate opened date)</p> <ul style="list-style-type: none"> None of the residents were found to be affected by this deficient practice. Undated/expired food items were 		

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

PRINTED: 07/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/03/2013
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 5 opened containers of food and beverages should always be labeled to reflect the date opened. She stated it would be impossible to determine how long the partly used container of milk had been opened. Additionally, the Food Services Director stated brooms, mops and dust pans should never be stored in food preparation areas and should be stored in the cleaning closet hung on the appropriate hangers to keep them off the floor.	F 371	removed immediately. Other food storage areas were checked for undated items -- no additional undated food items noted. • Potential existed for 15 residents to be affected by this deficient practice. No residents were found to be affected. • Dietary Sous Chef educated production staff on food storage chart. Education Included: o Any opened/stored food items must be labeled with expiration date.	
F 441 SS-D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (a) Infection Control Program 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. (b) Preventing Spread of Infection (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.	F 441	• An inspection/audit will be performed by the dietary manager/supervisor/designee to identify any stored, undated open food/liquid. Audit will be performed daily X 4 months, or until 4 months of sustained compliance is achieved. • Dietary Manager will report audit results to Transitional Care Manager. Transitional Care Manager will report audit results to Transitional Care Quality Assurance Committee and Owensboro Health Performance Improvement Oversight Committee.	

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

PRINTED: 07/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/03/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 5 opened containers of food and beverages should always be labeled to reflect the date opened. She stated it would be impossible to determine how long the partly used container of milk had been opened. Additionally, the Food Services Director stated brooms, mops and dust pans should never be stored in food preparation areas and should be stored in the cleaning closet hung on the appropriate hangers to keep them off the floor.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (a) Infection Control Program 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. (b) Preventing Spread of Infection (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.	F 441 #441 #1-	<ul style="list-style-type: none"> Resident #3 was found to be affected. Resident #3's central line dressing Right Chest was changed. Dressing was dated and initialed. Two additional residents were identified as having the potential to be affected, but were not affected, by this same deficient practice. These two residents' IV dressing changes were noted to be dated and initialed. Re-education <ul style="list-style-type: none"> Staff will be re-educated on policy # 600-081 "Central Line Care and Blood Sampling". Education will include the following points: <ul style="list-style-type: none"> Change transparent dressing every 7 days or PRN if dressing becomes wet or loose using sterile technique, if a dressing has gauze under it must be changed every 24 hour. All dressings should be clearly labeled with date and initials of nurse. Post test will be administered for competency validation. 	8/14/13

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

PRINTED: 07/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105396	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/03/2013
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 6</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which 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, interview, record review, and review of the facility's policy/procedure it was determined the facility ensure the Infection Control Program was implemented to provide a safe, sanitary, and comfortable environment for two (2) residents (#3 and #7) in the selected sample of eight (8) residents and one (1) resident (#9) not in the selected sample. The facility failed to date and label an intravenous line (IV) dressing on the initiation of the site for Resident #3 and IV tubing for fluids and/or medications for Residents #7 and #9.</p> <p>Findings include: A review of the facility's "Central Line and Blood Sampling Policy", dated 12/13/12, revealed "all dressings should be clearly labeled with the date and initials of nurse".</p> <p>1. A record review revealed Resident #3 was admitted to the facility on 06/28/13 with diagnosis of Hematuria.</p>	F 441	<p>Audit</p> <ul style="list-style-type: none"> o Clinical Supervisors will audit for the documentation of date & nurse initials on all central line dressings on a monthly basis X 4 months or until sustained 100% compliance is achieved X 4 months. The audit report will be reviewed with Manager. Further identified educational needs or performance issues will be addressed. Transitional Care Manager will report audit results to Transitional Care Quality Assurance Committee and Owensboro Health Performance Improvement Oversight Committee. <p>2 -</p> <ul style="list-style-type: none"> • Resident #7 was found to be affected. Resident #7's unlabeled IV tubing was discarded. • One additional resident was identified as having the potential to be affected, but was not affected, by this same deficient practice. This additional resident's tubing was found to be labeled with date, time and initial. • Re-education <ul style="list-style-type: none"> o Staff will be re-educated on policy # 600-508 "IV Patient Management". Education will include: <ul style="list-style-type: none"> ▪ Primary and secondary continuous IV tubing shall be changed every 72 hours and immediately upon suspected contamination or when the integrity of the product or system has been compromised. Intermittent IV tubings shall be changed every 24 hours (example; patients with saline lock receiving intermittent IV infusions) and immediately 	

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

PRINTED: 07/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186386	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/03/2013
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 7</p> <p>Observation of Central line dressing on the right chest of Resident #3 which was covered with a transparent dressing, on 07/01/13 at approximately 12:35 PM, revealed there was no date or initials of the nurse initiating the dressing.</p> <p>Interview with Assistant Director of Nursing (ADON), on 07/03/13 at 11:00 AM, revealed the IV team was responsible to ensure the dressing on a central line was dated and labeled by the clinician initiating the IV access according to the facility's policy/procedure.</p> <p>A review of the facility's IV Patient Management Protocol, dated 11/13/12, revealed the primary and secondary IV tubing should be changed every 72 hours and immediately upon suspected contamination or when the integrity of the product or system has been compromised, intermittent IV tubing shall be changed every 24 hours (example saline lock receiving intermittent IV infusions) and immediately upon suspected contamination or the integrity of the product of system has been compromised. All tubings shall be changed using aseptic technique and observing Standard Precautions. Label tubing with date and time and nurse's initials.</p> <p>2. A record review revealed Resident #7 was admitted to the facility on 06/20/13 with diagnoses to include Multiple Myeloma and Acute Encephalopathy.</p> <p>A review of Resident #7's Physician's order, dated 06/22/13, revealed Lovaquin 500 mg. IVPB should have been administered once a day for 5 days with the last dose on 6/26/13.</p>	F 441	<p>upon suspected contamination or when the integrity of the product or system has been compromised. All tubings shall be changed using aseptic technique and observing Standard Precautions. Label tubing with date, time, and nurse's initials.</p> <ul style="list-style-type: none"> ▪ Keypoint: TPN and Lipid tubing shall be changed every 24 hours. ○ Post test will be administered for competency validation • Audit <ul style="list-style-type: none"> ○ Clinical Supervisors will perform IV tubing audit monthly X 4 or until 100% sustained compliance is achieved X 4 months. The audit report will be reviewed with Manager. Further identified educational needs or performance issues will be addressed. Transitional Care Manager will report audit results to Transitional Care Quality Assurance Committee and Owensboro Health Performance Improvement Oversight Committee. <p>#3 -</p> <ul style="list-style-type: none"> • Resident #9 was found to be affected. Resident #9's unlabeled IV tubing was discarded. • One additional resident were identified as having the potential to be affected, but was not affected, by this same deficient practice. This additional resident's IV tubing was found to be labeled with date, time and initial. • Re-education 		

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

PRINTED: 07/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185398	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/03/2013
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 8</p> <p>Observation of Resident #7, on 07/01/13 at 1:32 PM, revealed an empty Intravenous Piggy Back (IVPB) bag of Levaquin (antibiotic) 500 milligrams (mg.), with a date of 08/26/13, hanging on an IV pole with the IV tubing threaded through the infusion pump without a dated label on the tubing.</p> <p>3. A record review revealed Resident 39 was admitted to the facility on 06/21/13.</p> <p>A review of Resident #9's Physician order, dated 08/28/13, revealed 0.9% Normal Saline (NS) IV to infuse until 08/30/13.</p> <p>Observation of Resident #9, on 07/01/13 at 1:44 PM, revealed the IV tubing was not dated or labeled.</p> <p>Interview with the ADON, on 07/03/13 at 11:00 AM, revealed the IV tubing labeling and dating was an important infection control issue in the Transitional Care Area and he was aware staff were not dating or labeling the tubing.</p>	F 441	<ul style="list-style-type: none"> o Staff will be re-educated on policy # 600-508 "IV Patient Management". Education will include: <ul style="list-style-type: none"> ▪ Primary and secondary continuous IV tubing shall be changed every 72 hours and immediately upon suspected contamination or when the integrity of the product or system has been compromised. Intermittent IV tubings shall be changed every 24 hours (example; patients with saline lock receiving intermittent IV infusions) and immediately upon suspected contamination or when the integrity of the product or system has been compromised. All tubings shall be changed using aseptic technique and observing Standard Precautions. Label tubing with date, time, and nurse's initials. <p><u>Keypoint:</u> TPN and Uplid tubing shall be changed every 24 hours.</p> o Post test will be administered for competency validation • Audit – <ul style="list-style-type: none"> o Clinical Supervisors will perform IV tubing audit monthly X 4 or until 100% sustained compliance is achieved X 4 months. The audit report will be reviewed with Manager. Further identified educational needs or performance issues will be addressed. Transitional Care Manager will report audit results to Transitional Care Quality Assurance Committee and Owensboro Health Performance Improvement Oversight Committee. 		

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

PRINTED: 07/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185396	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - THE TRANSITIONAL CARE CENTER OF OWENSBORO B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2013
--	--	---	--

NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 2010</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF</p> <p>TYPE OF STRUCTURE: Ninth Floor of a nine (9) story, Type I (332)</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type I generator, fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 07/02/13. The Transitional Care Center of Owensboro was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for thirty (30) beds with a census of fifteen (15) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Wendy R. ...* TITLE: Administrator DATE: 7-30-13

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

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

PRINTED: 07/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185396	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - THE TRANSITIONAL CARE CENTER OF OWENSBORO B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2013
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		
K 025 SS=E	<p>Deficiencies were cited with the highest deficiency identified at an "E" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one-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 in approved 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 heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3</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 two (2) of three (3) smoke compartments, residents, staff and visitors. The facility is certified for thirty (30) beds with a census of fifteen (15) on the day of the survey.</p> <p>The findings include: Observations, on 07/02/13 at 10:00 AM, with the Safety and Security Manager revealed the smoke</p>	K 025	<p>K025 Observation on 7/2/13 at 10am, revealed smoke barrier...had 4 inch by 4 inch cut in drywall....</p> <p>Completion Date 081413</p> <ol style="list-style-type: none"> 1. Date Corrected: 7/2/13 2. Specific measures to correct the violation: The four inch by four inch hole cut in the drywall was patched with appropriate materials by Owensboro Health maintenance. Reference work order #383682. 3. Specific measures to ensure violation will not recur: An inspection of all fire/smoke barriers, on Transitional Care Unit, was completed by Owensboro Health maintenance. Maintenance Technicians were in-serviced on by the maintenance supervisor, on inspecting 	8/14/13

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

PRINTED: 07/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185396	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - THE TRANSITIONAL CARE CENTER OF OWENSBORO B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2013
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303	
(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 025	Continued From page 2 barrier extending above the ceiling, located at the cross corridor doors from 9B to 9C, had a four(4) inch by four (4) inch hole cut in the drywall penetrating the smoke partition. Interview, on 07/02/13 at 10:00 AM, with the Safety and Security Manager revealed he was not aware of the penetration. 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	and ensuring that smoke barrier penetrations are sealed appropriately. Maintenance will inspect the Transitional Care Unit fire/smoke partitions once per month for three months to ensure compliance. Weekly environmental Safety Rounds will be conducted as part of routine maintenance mechanics job responsibilities/duties. Any identified issues noted on facility rounds will be reported to maintenance manager/supervisor. One component of these safety rounds will include the confirmation of maintained integrity of fire and smoke partitions.	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

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

PRINTED: 07/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185398	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - THE TRANSITIONAL CARE CENTER OF OWENSBORO B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2013
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303	
(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 038	Continued From page 3 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, residents, staff and visitors. The facility is certified for thirty (30) beds with a census of fifteen (15) on the day of the survey. The facility failed to maintain signage for doors equipped with delayed egress locks. The findings include: Observation, on 07/02/13 at 9:00 AM, with the Safety and Security Manager revealed the cross corridor doors to 9C and 9B by the elevators were equipped with delayed egress locks; however, the doors were not equipped with proper signage indicating the doors would open in fifteen (15) seconds. Interview, on 07/02/13 at 9:00 AM, with the Safety and Security Manager revealed he was not aware the delayed egress signage had been overlooked. Reference: NFPA 101 (2000 edition)	K 038	K038 Cross corridor doors 9C and 9B were equipped with delayed egress locks...without proper signage...within 15 seconds. Completion Date 081413 1. Date Corrected: 7/2/2013 2. Specific measures to correct the violation: Temporary signage, with proper verbiage, was placed at each cited location, on 7/2/2013 by the construction contractors that read, "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". 3. Specific measures to ensure violation will not recur: Permanent signage has been ordered and will be permanently mounted/secured to the delayed egress doors, by 8/5/2013.	8/14/13

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

PRINTED: 07/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185396	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - THE TRANSITIONAL CARE CENTER OF OWENSBORO B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2013
--	--	---	--

NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303
---	---

(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 038	<p>Continued From page 4</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.8.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (87 N) nor be required to be continuously applied</p>	K 038	<p>Weekly environmental Safety Rounds will be conducted as part of routine maintenance mechanics job responsibilities/duties. Any identified issues noted on facility rounds will be reported to maintenance manager/supervisor. One component of these safety rounds will include verification that all required signage remains intact for doors equipped with delayed egress.</p>	

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

PRINTED: 07/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186396	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - THE TRANSITIONAL CARE CENTER OF OWENSBORO B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2013
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303	
(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 038	Continued From page 5 for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. 7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or	K 038		

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

PRINTED: 07/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185398	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - THE TRANSITIONAL CARE CENTER OF OWENSBORO B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2013
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42003	
(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 038	<p>Continued From page 6</p> <p>draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met:</p> <p>(a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress.</p> <p>(b) They are installed across an opening that is at least 8 ft (1.8 m) in width.</p> <p>(c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.</p> <p>7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open</p>	K 038		

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

PRINTED: 07/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185398	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - THE TRANSITIONAL CARE CENTER OF OWENSBORO B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2013
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303	
(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 038	Continued From page 7 spaces, or other portions of the extl discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop extl discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23.	K 038		