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

RECEIVED
SEP 10 2013
Division of Health Care
Southern Enforcement Branch

PRINTED: 08/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	HIGHWAY 11 BOONEVILLE, KY 41314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on 08/06-08/13. Deficient practice was identified with the highest scope and severity at "D" level.	F 000	**Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.**	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure appropriate treatment and services were provided to prevent an infection of the urinary tract for one of fifteen sampled residents (Resident #2). Facility staff failed to change gloves and wash hands as required during the provision of incontinence care to Resident #2 and failed to secure the catheter tubing appropriately during cleaning of the tubing. The findings include: Review of the policy for "Foley Catheter Care" (dated 02/01/1981), revealed the catheter-meatal junction was a significant portal of entry for bacteria into the urinary tract, potentially causing			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Whitney Yonts	Administrator	9-9-2013

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 315	Continued From page 1 UTI. The policy noted residents would be provided catheter care twice daily and as needed which included a thorough cleansing of the perineal and catheter-meatal areas using soap and water or a product designed for perineal cleansing. The policy further revealed staff would perform handwashing and apply gloves prior to beginning a procedure and would repeat these steps if the gloves became soiled (e.g., with feces). Review of the medical record revealed the facility admitted Resident #2 on 06/01/09 with diagnoses including History of UTI, Failure to Thrive, Total Hip Replacement, and Degenerative Joint Disease. Review of the Minimum Data Set (MDS) dated 05/24/13, revealed the facility assessed Resident #2 to require total assistance with toileting needs and required an indwelling urinary catheter due to a Stage IV pressure sore to the buttock area. Observation of incontinence care was conducted on 08/07/13, at 10:25 AM, with Certified Nursing Assistants (CNAs) #1 and #2. Both CNAs were observed to wash their hands, put on gloves, and place clean towels and washcloths at the resident's bedside. Resident #2 was then positioned on his/her back. CNA #2 obtained a clean wet washcloth and cleaned down the right labia, and then folded the washcloth and cleaned down the left labia with a different section of the washcloth. CNA #2 then obtained a clean dry washcloth, went to the sink, wet the cloth with soap and water, returned to the bedside, and cleaned down the resident's inner labia with the washcloth. CNA #2 again obtained a clean dry washcloth, wet the cloth with soap and water at the sink, and cleaned the indwelling urinary	F 315	**F 315 483.25(d) NO CATHETER PREVENT UTI, RESTORE BLADDER** ***Corrective Actions for Residents Found to Have Been Affected:*** On 8-9-2013 additional education related to proper catheter care and peri-care was provided to the staff member (SRNA #2) who provided care to Resident #2 on 8/7/2013. Return demonstration validated competency with SRNA #2. Resident #2 is no longer a resident at the facility. ***Identification of Other Residents Having the Potential to be Affected:*** All residents have the potential to be affected. Licensed and Certified nursing staff completed education and training on 8-28-2013 on peri-care and catheter care according to the policies and procedures of the facility. Education included a return demonstration to validate competency.	

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F 315	Continued From page 2 catheter tubing approximately 4-6 inches away from the urinary meatus. The CNA also failed to securely hold the catheter tubing to prevent pulling on the tubing during the cleansing process. CNA #2 then obtained a clean washcloth, wet the cloth with water and soap at the sink, and cleaned the resident's perineal area from front to back. Continued observations revealed CNA #2 applied a clean brief to Resident #2 while wearing the soiled gloves. After applying the brief, both CNAs were observed to remove the gloves and wash their hands at the sink. However, the CNAs failed to change gloves and wash their hands after cleansing the labia, prior to obtaining the clean washcloth to clean the catheter tubing and continuing/completing the incontinence care. Interview conducted with CNA #2 on 08/07/13, at 10:35 AM, revealed the CNA had been trained to hold the catheter tubing when cleaning the tubing to prevent pulling. In addition, CNA #2 stated he had been trained to change gloves and perform handwashing each time he obtained a clean washcloth. The Director of Nursing (DON) confirmed in an interview conducted on 08/08/13, at 3:10 PM, the CNA should have secured the catheter tubing when cleaning the tubing to prevent pulling and should have changed gloves and performed handwashing when he/she obtained a clean washcloth. The DON stated she had only been at the facility for four months and had not had the opportunity to observe the nurse aides performing catheter care.	F 315	***Measures or Systemic Changes put into Place to Avoid Recurrence*** Newly hired licensed and certified nursing employees will show return demonstrations on peri-care and catheter care during the facility's orientation process. In-services on proper peri-care and catheter care will be conducted twice a year with return demohstrations. ***Plans to Monitor Performance for Sustained Solutions*** DON and Nurse Management Staff will utilize a Skills Performance Evaluation checklist to monitor and evaluate compliance with peri care and foley catheter care three (3) times a week for one (1) month, then two (2) times a week for one (1) month then weekly until compliance is maintained. Any issues that are identified will be addressed immediately with on the spot education and if appropriate, disciplinary action. All findings will be submitted to the monthly Quality Assurance (QA) meetings for six months or until compliance is achieved for recommendations and follow-up.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		9-09-2013

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F 323	Continued From page 3 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy it was determined the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for one of fifteen sampled residents (Resident #9). Resident #9 sustained five falls at the facility from 04/04/13 to 08/06/13 (a timeframe of four months). The facility investigation revealed the resident was able to disarm the bed alarms or move the alarm; however, the facility failed to conduct a thorough investigation after each fall to determine the effectiveness of the alarm intervention and implement new interventions to prevent further falls/injury. The findings include: A review of the facility policy entitled "Fall Management Program," not dated, revealed the safety of each resident would be maintained through thorough assessment to establish fall risks, care planning, and implementation of appropriate interventions to minimize falls and injuries related to falls, and tracking/trending for fall patterns. The policy directed that a fall risk assessment would be completed for all residents	F 323	**F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** ***Corrective Actions for Residents Found to Have Been Affected:*** On 8-9-2013 revised interventions were developed by the Interdisciplinary Care Team (IDT) and the resident's care plan was updated. Resident #9 is receiving care and services according to the Individualized Care Plan and the SRNA Care Plan. ***Identification of Other Residents Having the Potential to be Affected:*** On 8-9-2013 the IDT team completed reviews and revisions of the Individualized Care Plans and the SRNA Care Plans for other residents who are at risk for falls. Appropriate interventions are in place for all other residents. Education was completed on 9-5-2013 to all licensed nurses/ certified CNA regarding fall interventions and the effectiveness of interventions.	

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F 323	Continued From page 4 upon admission, quarterly, and when a significant change in status occurred. The policy directed that after a fall occurred a post fall investigation would be completed by the charge nurse that included a review of causative factors, implementation of appropriate interventions, and any needed changes would be determined. The policy further noted that the Director of Nurses (DON) would review all post fall investigations and decide if other action would be necessary. In addition, the policy revealed the DON would complete an investigation after the incident report was submitted to the DON and findings/recommendations would be submitted to the Interdisciplinary Plan of Care Team (IDT) for revision/implementation of interventions. Review of the medical record revealed the facility admitted Resident #9 on 10/30/12 with diagnoses that included Osteoarthritis, History of left Cerebrovascular Accident, Chronic Back Pain, Seizure Disorder, and Dementia. A review of the Minimum Data Set (MDS) assessment dated 04/24/13 revealed Resident #9 had sustained a fall with injury since the previous assessment had been completed. The MDS also revealed facility staff assessed Resident #9 to require supervision with transfers, toileting, and ambulation and to have a BIMS (Brief Interview for Mental Status) score of 13 indicating the resident was interviewable. Review of the comprehensive care plan dated 05/05/13, revealed the facility identified Resident #9 to be at risk for falls/injuries due to fall history and attempts to be independent, and would not ask for help. The care plan also revealed Resident #9 "tends to turn off alarms." Further review of the care plan revealed interventions in place for fall prevention included to keep the call light within reach to	F 323	***Measures or Systemic Changes put into Place to Avoid Recurrence*** The IDT is monitoring appropriate interventions and effectiveness of interventions for residents at risk for falls daily through routine Unit Manager care rounds, care plan conferences, routine assessments and evaluations. Each incident report will be reviewed during morning IDT meeting for root cause and effective intervention. The IDT will conduct a monthly care plan review and audit for residents at risk for fall to ensure care plan interventions are effective. ***Plans to Monitor Performance for Sustained Solutions*** The results of the random rounds completed by the Unit Managers and the monthly IDT care plan audits are reviewed at the monthly Quality Assurance meetings for recommendations and follow-up.	9-09-2013

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F 323	Continued From page 5 remind resident to call for help, to encourage the resident to wear good supportive shoes when out of bed, to provide staff supervision/assistance with transfers as the resident allowed, and to provide a wheelchair sensor pad alarm and wall sensor alarm. A review of the Fall Risk Evaluation completed by facility staff on 04/25/13 revealed Resident #9's fall risk score was 15. According to the fall risk evaluation, a total score of 10 or above indicated a resident was at high risk for falls. A review of the Resident Incident/Investigation Report, dated 04/04/13, revealed Resident #9 sustained a fall from the wheelchair when he/she attempted to stand up without staff assistance. The investigation noted the alarm was in place but had not sounded because the resident had turned the alarm off. According to the report, the resident sustained no injuries as a result of the fall. Further review of the report revealed staff would be re-educated to check the alarm every two hours and to re-educate the resident not to turn off the alarm. A review of the Resident Incident/Investigation Report dated 05/20/13 (26 days after the previous fall on 04/04/13), revealed the resident sustained a fall while transferring without staff assistance and no injury was identified. The investigation further revealed the bed alarm had sounded; however, based on the report staff discontinued the bed alarm and implemented a wall sensor alarm. A review of the Resident Incident/Investigation Report, dated 05/30/13 (10 days after the previous fall on 05/20/13) revealed Resident #9	F 323		

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F 323	Continued From page 6 sustained a fall when the resident attempted to go to the bathroom unassisted and the resident was assessed not to have injuries. The investigation revealed the alarm was found underneath the resident's bed, and was not sounding when staff discovered the resident on the floor. Preventative measures to prevent further falls/injury were to check the resident every two hours to ensure the alarm was in place. Review of the Resident Incident/Investigation Report, dated 08/02/13 (64 days after the previous fall on 05/30/13), revealed the resident attempted to ambulate across the room to turn off the television and fell to the floor. Resident #9 was assessed to have a "small bump" on the back of his/her head. The investigation further revealed staff found the alarm to be unplugged and not sounding when the fall occurred. Preventative measures included to move the television close to the resident and to plug the alarm back in. Review of the Resident Incident/Investigation Report, dated 08/06/13 (four days after the previous fall on 08/02/13) revealed facility staff found the resident sitting on the floor in front of the resident's sink. The investigation revealed the alarm was sounding when staff found the resident on the floor and no injuries were identified. The resident's physician was notified regarding the fall and requested the resident be monitored by staff. However, the resident verbalized complaints of right hip/leg pain shortly after the fall, the physician was again contacted, and x-rays were ordered to be obtained of both of the resident's lower extremities. A review of the x-ray report dated 08/07/13 revealed a non-displaced fracture of the inferior ramus of the	F 323		

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F 323	Continued From page 7 right pubic bone with an undetermined age of the fracture. Observation of Resident #9 on 08/6/13, at 11:45 AM, revealed staff assisting the resident to the bathroom facilities. A sensor pad alarm was noted to be present on the resident's wheelchair. On 08/06/13, at 4:00 PM, Resident #9 was observed sitting in a wheelchair with a chair alarm attached. The resident stated he/she had right hip pain due to a fall; however, the resident was not able to state when the fall occurred. Interviews on 08/08/13, at 12:50 PM with Certified Nurse Aide (CNA) #1, and at 1:05 PM with CNA #2, revealed Resident #9 had a history of falls when attempting to transfer/toilet without help. The CNAs stated Resident #9 had used bed alarms, wheelchair alarms, and sensor alarms; however, the resident was able to remove or unplug these alarms. Both CNAs stated they had reported this to the facility nurses. Interview on 08/08/13, at 1:40 PM, with Registered Nurse (RN) #1 revealed an investigation/incident report was to be completed by the nurse when a resident sustained a fall. RN #1 stated the nurse was responsible to attempt to determine causative factors for the resident's fall. RN #1 further added the nurse was responsible to make sure the current interventions were in place and working properly. RN #1 stated Resident #9 had a history of noncompliance with the alarms used to alert staff for assistance when the resident was rising from the bed/chair in an effort to prevent falls. Interview conducted with Unit Manager (UM) #1 on 08/08/13, at 2:00 PM, revealed she was aware	F 323		

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F 323	Continued From page 8 Resident #9 would remove the wheelchair alarm, but was not aware the resident had turned off/removed the bed alarm. UM #1 stated the alarms were not effective to prevent falls for Resident #9 but only alerted staff when a fall had occurred. The UM stated each fall incident/investigation report was reviewed during the daily clinical meetings with the DON, Administrator, and MDS Nurse. The UM stated the current fall interventions were reviewed during the meeting and new interventions were discussed. UM #1 stated the resident's ability to disarm/remove the alarms had been discussed in the clinical meetings; however, this had not been considered regarding implementation of new intervention to prevent further falls for Resident #9. Interview on 08/08/13, at 2:30 PM, with Licensed Practical Nurse (LPN) #2 revealed the LPN was also aware the resident was able to remove/disarm the alarms used for fall prevention. LPN #2 stated the resident "had a habit" of taking the alarms off and putting them under the resident's bed. LPN #2 further stated the alarms had not been effective to prevent falls for Resident #9. The LPN stated the nurse was responsible to evaluate the interventions when conducting the fall investigation but felt if the nurse aides were checking on the resident every two hours the alarms would be "ok." Interview conducted with the Director of Nurses (DON) on 08/08/13, at 3:10 PM, revealed she was responsible to review the incident/investigation reports daily during the clinical meetings conducted with the Administrator, UMs, and MDS Nurse. The DON stated even though the resident was able to	F 323		

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F 323	Continued From page 9 disarm/remove the alarms, the team had not identified the alarms were not effective in an effort to implement new interventions.	F 323		
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. (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. (c) Linens Personnel must handle, store, process and	F 441	**F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** ***Corrective Actions for Residents Found to Have Been Affected:*** On 8-9-2013 additional education related to handwashing and infection control was provided to RN #4. On 8-7-2013 additional education related to handwashing and infection control was provided to SRNA #4. Knowledge and understanding of appropriate handwashing and infection control policies were successfully tested by the use of return demonstrations by RN #4 and SRNA #4.	

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F 441	Continued From page 10 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure staff followed appropriate handwashing procedures to prevent the development and transmission of disease and infection for two of fifteen sampled residents (Residents #2 and #4). Staff failed to perform handwashing procedures appropriately when providing wound care for Resident #2, and when providing indwelling urinary catheter and incontinence care for Resident #4. The findings include: 1. Review of the Wound Care policy (no date), revealed standard precautions and strict handwashing protocols would be followed for all wound care and/or resident contact. Review of the Standard Precautions policy (no date), revealed standard precautions would be observed to prevent contact with blood or other potentially infectious materials. The policy further noted handwashing would be considered the most important way to prevent the transmission of infection. In addition, the policy revealed all employees were required to wash their hands after every unprotected contact with blood or other potentially infectious materials and after removing gloves. Review of the medical record revealed the facility	F 441	***Identification of Other Residents Having the Potential to be Affected:*** All residents have the potential to be affected and on 8-21-2013 handwashing and infection control education were completed for all facility staff and testing completed through the use of return demonstrations. ***Measures or Systemic Changes put into Place to Avoid Recurrence*** Handwashing and infection control inservices have been increased to three per year and is included in the new hire orientation. Return demonstrations will be utilized with new hires.	

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F 441	Continued From page 11 admitted Resident #2 on 06/01/09 with diagnoses including History of Urinary Tract Infection (UTI), Failure to Thrive, Total Hip Replacement, and Degenerative Joint Disease. Review of the Minimum Data Set (MDS) dated 05/24/13, revealed the facility assessed Resident #2 to require extensive to total assistance with all activities of daily living (ADLs). The assessment also revealed Resident #2 had two Stage II pressure sores and one Stage IV pressure sore. Wound care observation was conducted on 08/07/13, at 10:25 AM, with Registered Nurse (RN) #4. The RN was observed to remove non-sterile 4 x 4 gauze sponges and two containers of Dakin's Solution (cleaning agent) from the treatment cart and take these items into Resident #2's room. RN #4 washed her hands, put on gloves, and proceeded to remove the soiled dressing on Resident #2's left buttock area revealing a Stage IV pressure sore. RN #2 changed the gloves without performing handwashing and cleaned the pressure sore with Dakin's solution and 4 x 4 gauze. The RN then changed gloves without washing her hands in between the glove changes and packed the pressure sore with 4 x 4 gauze sponges dampened with Dakin's Solution. RN #4 then covered the pressure sore with clean 4 x 4 gauze sponges while wearing the soiled gloves. Interview conducted with RN #2 on 08/07/13, at 3:40 PM, revealed the RN had been trained to perform handwashing and put on clean gloves when initiating wound care for a resident. RN #4 stated she had also been trained to perform handwashing and to change gloves before and after removing soiled dressings, cleaning wounds, and packing/applying clean dressings to	F 441	***Plans to Monitor Performance for Sustained Solutions*** The Director of Nursing will test competencies of all facility staff by completing handwashing and infection control audits. 10% of the employees will be tested each month until compliance is achieved and annually thereafter. Audits will be submitted to the Quality Assurance Committee that meets monthly for recommendations and follow-up.	9-09-2013

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	185273	A. BUILDING _____ B. WING _____	08/08/2013

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F 441	Continued From page 12 the wound. The Director of Nursing (DON) stated in interview conducted on 08/08/13, at 3:10 PM, that staff had been trained to perform handwashing and glove changes before and after removing a soiled dressing, cleaning a wound, and applying a clean dressing. The DON stated she had conducted wound care in-service training and had conducted observations of all nurses performing wound care to ensure their competency and had not identified any problems. The DON stated the facility had provided RN #4 an in-service training on 02/25/13 related to wound care and had determined the RN to be competent in the skill. 2. A review the facility policy for Foley catheter care (undated) revealed employees were required to remove gloves and wash hands after providing catheter care before returning the resident to a comfortable position and before returning resident equipment to the appropriate place. Additional review of the policy revealed if gloves become contaminated with feces, etc., the gloves should be changed prior to continuing care. Observations conducted on 08/07/13, at 2:00 PM, revealed State Registered Nurse Aide (SRNA) #4 failed to remove her gloves and wash her hands prior to touching Resident #4's linens, overbed table, and bed alarm during the provision of incontinence care. SRNA #4 confirmed in interview conducted on 08/07/13, at 2:35 PM, that she "forgot" to change her gloves and wash her hands after her hands had become contaminated when she provided indwelling urinary catheter and incontinence care	F 441		

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F 441	Continued From page 13 to Resident #4. The SRNA stated she "was nervous and just forgot." An interview conducted with the DON on 08/08/13, at 2:05 PM, revealed the facility evaluated employees at the time of their employment during the orientation process to determine their competency related to handwashing, universal precautions, and cross contamination prevention. A review of the facility's orientation and competency evaluation of SRNA #4 revealed the SRNA had successfully completed the facility's orientation program on 03/14/13, and the facility had determined the SRNA was competent in handwashing, universal precautions, and cross contamination prevention on 03/25/13.	F 441		

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AUG 30 2013
Division of Health Care
Southern Enforcement Branch

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	185273	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/06/2013

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Survey under: NFPA 101 (2000 Edition) Plan approval: 1980, 1999 Facility type: SNF/NF Type of structure: One story, Type V (unprotected) Smoke Compartments: 6 Fire Alarm: Complete fire alarm smoke detectors in corridors and dining room, heat detectors in kitchen and laundry room. Sprinkler System: Complete sprinkler system (dry). Generator: Type 2 generator powered by diesel installed 2011. A standard Life Safety Code survey was conducted on 08/06/13. Owsley County Health Care Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	**Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.** **<u>K 050 NFPA 101 Life Safety Code Standard</u>** ***Corrective Actions for Residents Found to Have Been Affected:*** All Residents have the potential to be affected. See ***Identification of Other Residents Having the Potential*** to be Affected below.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.	K 050		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: W Whitney Counts — TITLE: Administrator — (X6) DATE: 8/30/13

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 program participation.

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K 050	Continued From page 1 The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to conduct fire drills to ensure that staff was prepared for response to incidence of fire under different staffing levels and conditions to include resident levels of alertness. This failure affected all residents and staff in the facility. The facility has the capacity for 99 beds with a census of 66 on the day of the survey. The findings include: During the Life Safety Code survey on 08/06/13 at 2:45 PM with the Employee Relations Director (ERD) (new maintenance staff accompanied the surveyor), a record review revealed the facility had not been performing fire drills at unexpected times and varying conditions on the second shift as follows: five fire drills on the second shift from 07/30/12 to 07/31/13, were conducted between 3:08 PM and 3:34 PM. An interview with the ERD revealed she was aware the fire drills should be conducted at unexpected times and conditions and that she would try harder to do so. The findings were revealed to the Administrator upon exit.	K 050	***Identification of Other Residents Having the Potential to be Affected:*** On 9-9-2013 the Maintenance Staff and the Safety Committee including the Employee Relations Director were educated by the Administrator on the Safety Policies of the facility to include the fire drills, how they are to be conducted, and that they be unexpected. ***Measures or Systemic Changes put into Place to Avoid Recurrence*** The Administrator will review fire drills monthly to assure that drills are in compliance with K 050. ***Plans to Monitor Performance for Sustained Solutions*** The Safety Committee will review fire drill compliance at their monthly meeting to include that the drills be unexpected.	9-11-2013

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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 interview and record review, the facility failed to maintain the fire alarm system by NFPA standards. This deficient practice affected six of six smoke compartments, staff, and all the residents. The facility has the capacity for 99 beds with a census of 66 on the day of the survey. The findings include:	K 054	**K 054 NFPA 101 Life Safety Code Standard** ***Corrective Actions for Residents Found to Have Been Affected:*** All Residents have the potential to be affected. See ***Identification of Other Residents Having the Potential*** to be Affected below. ***Identification of Other Residents Having the Potential to be Affected:*** On 9-3-2013 a sensitivity test was completed on the smoke/heat detectors. On 9-9-2013 the Maintenance Staff and the Safety Committee including the Employee Relations Director were educated by the Administrator on the Sensitivity Testing requirements to include frequency of sensitivity testing. ***Measures or Systemic Changes put into Place to Avoid Recurrence*** The Administrator will review sensitivity testing on smoke/heat detectors monthly to assure that sensitivity testing is in compliance with K 050.	
	During the Life Safety Code survey on 08/06/13 at 2:55 PM, with the Employee Relations Director (ERD) (new maintenance staff accompanied the surveyor), a record review revealed the last sensitivity testing of the smoke/heat detectors was completed on 06/30/11. This type of testing is due every two years to ensure the smoke/heat detectors are operating as intended. An interview on 08/06/13 at 2:55 PM, with the ERD revealed the facility had changed contractors and the sensitivity testing was overlooked. The findings were revealed to the Administrator upon exit. Reference: NFPA 72 (1999 Edition). 7-3.2.1*			

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K 054	Continued From page 3 Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method	K 054	***Plans to Monitor Performance for Sustained Solutions*** The Safety Committee will review sensitivity testing of smoke/heat detectors at their monthly meeting to assure that this testing occurs every two years per K 054.	9-11-2013
	(2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced. Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and			

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K 054	Continued From page 4 Table 7-2.2. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector. 7-3.2.2 Test frequency of interfaced equipment shall be the same as specified by the applicable NFPA standards for the equipment being supervised. 7-3.2.3 For restorable fixed-temperature, spot-type heat detectors, two or more detectors shall be tested on each initiating circuit annually. Different detectors shall be tested each year, with records kept by the building owner specifying which detectors have been tested. Within 5 years, each detector shall have been tested.	K 054		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on interview, the facility failed to maintain the generator set by NFPA standards. This deficient practice affected six of six smoke compartments, staff, and all the residents. The facility has the capacity for 99 beds with a census	K 144	**K 144 NFPA 101 Life Safety Code Standard** ***Corrective Actions for Residents Found to Have Been Affected:*** All Residents have the potential to be affected. See ***Identification of Other Residents Having the Potential*** to be Affected below. ***Identification of Other Residents Having the Potential to be Affected:*** On 8-14-2013 training was provided to the Maintenance Department on manually testing the generator transfer switch.	

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K 144	Continued From page 5 of 66 on the day of the survey. The findings include: During the Life Safety Code survey on 08/06/13 at 12:25 PM, with the Employee Relations Director (ERD) (new maintenance staff accompanied the surveyor), an interview with the ERD and maintenance staff at the generator set revealed the generator transfer switch was not being manually tested on a monthly basis. This testing helps ensure the transfer switch is operating as intended. Staff was not aware the generator transfer switch should be tested on a monthly basis as required. The findings were revealed to the Administrator upon exit. Reference: NFPA 110 (1999 Edition). 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.	K 144	This training was completed by the company who installed the generator and a certified generator technician. The generator transfer switch is manually tested monthly per the NFPA guidelines and in compliance with K 144. On 9-9-2013 the Maintenance Staff and the Safety Committee including the Employee Relations Director were educated by the Administrator on the Sensitivity Testing requirements to include frequency of sensitivity testing. ***Measures or Systemic Changes put into Place to Avoid Recurrence*** The Administrator will review monthly the testing of the manual test of the generator transfer switch to assure that the facility is in compliance with K 144. ***Plans to Monitor Performance for Sustained Solutions*** The Safety Committee will review at its monthly meetings the manual testing of the generator transfer switch to assure compliance with K 144.	9-11-2013