

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

PRINTED: 10/15/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185253	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R 10/15/2015
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NAME OF PROVIDER OR SUPPLIER  CARTER NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 250 MCDAVID BLVD GRAYSON, KY 41143
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{F 000}	INITIAL COMMENTS  Based on the facility's acceptable Plan of Correction, the facility was deemed to be in compliance on 10/09/15 as alleged.	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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F 000	INITIAL COMMENTS  A Recertification Survey was initiated on 08/26/15 and concluded on 08/28/15, with deficiencies cited at the highest Scope and Severity of an "D"	F 000	To the best of my knowledge and belief, as an agent of Carter Nursing and Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by provisions of Federal and state law. It is the practice of Carter Nursing & Rehabilitation to notify the residents' physician and responsible party/Power of Attorney regarding any significant change in status. Resident #7's physician and Power of Attorney were notified regarding weight loss via telephone on 8/26/15 by Stephanie Dunn, RN. Resident #7's Power of Attorney was also notified of a change in physician's orders on 8/27/15. The Nursing Unit Managers will review all current resident charts by 10/1/15 to identify other residents having the potential to be affected. If other residents are noted to be affected, the physician and responsible party will be notified by the Nursing Unit Managers by 10/1/15.	10/9/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Danny Joe Brumaid* ADMINISTRATOR  
 TITLE  
 (X6) DATE  
 9/29/15

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F 157	Continued From page 1  This REQUIREMENT is not met as evidenced by: Based on interview, and record review it was determined the facility failed to ensure the Physician and Responsible Party/Power of Attorney (POA) was notified when there was a significant change in the resident's physical status for one (1) of twenty two (22) sampled residents (Resident #7).  Resident #7 was identified to have a significant weight loss of twelve (12) pounds or seven percent (7%) on 08/07/15. Additionally, on 08/15/15 the resident was identified to have further significant weight loss of another 21.8 pounds, thirteen percent (13%) weight loss. However, there was no documented evidence of the resident's Physician or Responsible Party/POA, being notified timely of the weight loss.  The findings include:  Interview with the Director of Nursing (DON), on 08/28/15 at 3:50 PM, revealed the facility did not have a notification policy. She revealed she would expect staff to notify the Physician and POA as soon as possible, if there was a significant weight loss.  Review of Resident #7's medical record revealed the facility admitted the resident on 08/08/13, with diagnoses which included: Dementia, Anxiety, Chronic Obstructive Pulmonary Disease (COPD), Hypertension (HTN), Atrial -Fibrillation, and Parkinson's Disease.	F 157	All licensed nurses will receive education beginning 9/15/15 pertaining to the 483.10(b)(11) NOTIFY OF CHANGES regulation by Registered Nurse Staff Development Coordinator and the Assistant Director of Nursing. All education will be completed by 10/1/15. Newly hired licensed nurses/Agency staff will receive education regarding notification of change during the orientation process prior to working. From hereforward, the Dietary Manager will complete the "Weight Notification Audit" form on all residents with a noted significant weight loss or gain. The Dietary Manager will forward the form to the RN Unit Manager upon completion and he/she will notify the resident's physician and Responsible Party/Power of Attorney. Notification will be documented in the resident's medical record. Weight Notification Audits will be reviewed weekly X 12 weeks in the Daily Clinical Start-up meeting by the IDT to ensure that family and MD notification have occurred. To ensure that solutions are sustained, the Weight Notification Audit's will be forwarded for review monthly X 6 months by the Center's QAPI committee.	

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F 157	<p>Continued From page 2</p> <p>Review of the resident's Annual Minimum Data Set (MDS) Assessment, dated 06/17/15, revealed the facility assessed Resident #7 as having both short term and long term memory loss. Continued review of the MDS revealed, under section K, the facility assessed the the resident's weight as one hundred seventy (170) pounds with no weight loss/gain.</p> <p>Review of Resident's #7's Weight Flow Sheet, revealed on 07/05/15, the resident's weight was recorded as one hundred seventy one (171) pounds, and on 08/07/15 the weight was recorded as one hundred fifty nine (159) pounds, a loss of twelve (12) pounds, which was a seven percent (7%) significant weight loss in one (1) month. Further review, revealed on 08/15/15, the resident's weight was recorded as one hundred thirty seven (137) pounds, a significant weight loss of 21.8 pounds or thirteen percent (13%) weight loss in eight (8) days. Continued review revealed on 08/22/15, the resident's weight maintained at one hundred thirty seven (137) pounds, and on 08/26/15 the resident's weight was one hundred thirty nine (139) pounds, an increase of two (2) pounds.</p> <p>Review of the Dietary Notes for August 2015, revealed the Registered Dietician recommended on 08/07/15, Multivitamin (MVI) with minerals, feed the resident or encourage by mouth (PO) intake due to decreased PO intake, and med pass sixty milliliters 60 ml' s' three (3) times a day.</p> <p>Review of the August, 2015 Nurse's Notes revealed no documented evidence the resident's Physician or POA had been notified of the resident's weight loss. After several requests for</p>	F 157			

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F 157 Continued From page 3

documentation that the Physician or POA was notified, the DON and Unit Manager (JM) presented a form titled "Weight Notification Audit " The top three (3) lines was completed with weight loss of twelve (12) pounds and signed at the bottom by the residents Physician, dated 08/11/15, and the residents POA, dated 08/10/15. Although the weight loss was identified on 08/07/15, there was no documented evidence the Physician was notified until 08/11/15, four (4) days later. Also, the Weight Notification Audit did not indicate the POA or Physician was notified of the further weight loss of 21.8 pounds identified on 08/15/15.

Interview with Resident #7's POA on 08/28/15 at 10:45 AM, revealed she was notified of the resident's weight loss on 08/26/15 or 08/27/15, and did not remember being notified of weight loss prior to that. She further stated she was not informed of the resident's weight loss until the resident had lost thirty (30) pounds and would have expected to have been notified as soon as the facility became aware of the weight loss. She stated she was further notified the facility was starting the resident on medication for weight loss. The POA stated she had never been shown any kind of form telling her about the resident's weight loss. When asked who the signature was on the Weight Notification Audit dated 08/10/15, she stated it was her sisters signature who was also the resident's POA.

Interview with Resident #7's Physician on 08/28/15 at 11:00 AM, revealed she was notified of the resident's weight loss when she got the notification form and signed it on 08/11/15. The "Weight Notification Form" was signed by the Physician on 08/11/15, four (4) days after the

F 157

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F 157	Continued From page 4 identification of the first weight loss. The physician stated she could remember discussing the residents weight loss on 08/18/15 also, because they discussed the need for Remeron (antidepressant medication also used to promote weight gain) fifteen Milligrams (15 mg's) for appetite stimulation; however, there was no documented evidence the Physician was notified of the weight loss identified on 08/15/15.  Interview with the Unit Manager (UM) on 08/28/15 at 3:50 PM, revealed she had talked with Resident #7's POA on 08/18/15, and told her about the resident not eating much and informed her the resident was started on Remeron; however, she stated she did not tell the POA about the resident's weight loss.  Further interview with the DON on 08/28/15 at 3:50 PM revealed four (4) days was too long to wait to notify the Physician of a significant weight loss and also there should be documented evidence in the medical record to indicate when the Physician and responsible party was notified of a significant weight loss.  Interview with the Administrator on 08/28/15 at 5:45 PM, revealed, he expected the staff to notify the family/POA and Physician as soon as possible with any change in a residents status such as a significant weight loss.	F 157		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329	It is the practice of Carter Nursing & Rehabilitation Center for each resident's drug regimen to be free from unnecessary drugs. Resident #13's sleep pattern will be monitored and documented by a licensed nurse X 2 weeks. The	10/9/15

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F 329 Continued From page 5  
without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review, and review of facility policy, it was determined the facility failed to ensure residents were free from unnecessary medications for one (1) of twenty two (22) sampled residents (Resident #13). The facility did not monitor and/or continue to assess Resident #13 for the need of the medication for insomnia.

The findings include:

Review of the facility's policy, titled "Medications-Reductions (Unnecessary)", with an effective date of December 1, 2010, revealed the purpose was to ensure the resident's drug

F 329 findings will be reviewed with the resident's physician so a decision can be made regarding the continued use of the medication in question. If the medication is continued, the resident's sleep pattern will continued to be monitored and documented in the medical record.

All resident charts will be audited for duplicate medications by the Director of Nursing Services with the assistance of our consultant pharmacist in an effort to identify other residents that may be affected by 10/1/15.

The Administrator will provide education regarding the Center's policy, titled "Medications-Reductions (Unnecessary) as well as the regulation 483.25(l), F329, DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS to all licensed nurses, the consultant pharmacist, and the Medical Director beginning 9/15/15 and all will be completed by 10/1/15.

Newly hired licensed nurses/Agency staff will receive education regarding Medications-Reductions (unnecessary) and F-329 Regulation during the orientation process prior to working.

The consultant pharmacist will review all resident orders monthly for unnecessary medications and provide communication to the Director of Nursing Services and the resident's physician.

Pharmacy recommendations will be

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F 329	Continued From page 6 regimen would be free from unnecessary drugs. Continued review of the policy revealed the facility would evaluate each resident so that appropriate differential diagnosis of behavioral symptoms and the underlying cause of the symptoms was identified and treated appropriately. Further review of the Policy, revealed the facility would evaluate each resident in order to prevent the use of psychopharmacological drugs when the behavioral symptom was caused by conditions such as 1) environmental stressors; 2) psychosocial stressors; and 3) treatable medical conditions.  Review of Resident #13's medical record revealed the facility admitted the resident on 08/08/13 with diagnoses which included; Depressive Disorder, Hypertension, Hypothyroidism, and Arthropathy. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 07/28/15, revealed the resident had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which was indicative of being cognitively intact.  Review of the resident's "Consultant Pharmacist Communication to the Physician" Form, dated 12/05/13, revealed the pharmacist communicated to the physician, the resident was on duplicate Antidepressant Drugs including Zoloft (antidepressant medication) and Remeron (antidepressant medication). The Form further revealed, the use of two (2) or more antidepressants simultaneously may increase the risk of side effects, and required additional documentation concerning the rationale under Center for Medicare and Medicaid (CMS) F-329. The resident's physician responded by reporting the duplicate agents were being used for different	F 329	reviewed monthly in QAPI X 3 months to ensure that a diagnosis and continued assessment and monitoring are in place for those residents receiving duplicate therapy as an effort to monitor performance and ensure that solutions are sustained.		

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F 329 Continued From page 7  
indications, stating the Zoloft was for "depression" and the Remeron was for "insomnia."

Review of Resident #13's Physician Orders, dated August 2015, revealed the resident did not have a diagnosis of "insomnia" listed and Remeron was prescribed 15 milligrams (mg) Soltab one (1) by mouth at bedtime.

Review of the "Electronic Medication Administration Record", dated August 2015 revealed the resident was administered Remeron 15 mg Soltab one (1) by mouth at 9:00 PM every night.

Review of the Physician's Notes, dated 02/24/15 at 3:21 PM, and 04/29/15 at 6:45 PM revealed the resident was eating and sleeping well; however, there was no mention of the resident being monitored for his/her insomnia nor a diagnosis listed for insomnia within the Physician's notes. Further record review revealed there was no documented evidence of monitoring the resident's insomnia in order to evaluate if the Remeron was effective for insomnia.

Interview with Resident #13, on 08/27/15 at approximately 5:00 PM, revealed he/she sometimes had trouble sleeping when his/her roommate kept him/her up at night. Resident #13 reported he/she was unaware he/she had a diagnosis of insomnia.

Interview with Licensed Practical Nurse (LPN) #1, on 08/28/15 at 10:13 AM, revealed Resident #13 had mentioned to her that he/she had trouble sleeping because of his/her roommate keeps him/her up. LPN #1 further stated the resident never revealed to her that he/she needed

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F 329 Continued From page 8

"medicine" to sleep and did not think the resident had a diagnosis of "insomnia". Continued interview with LPN #1 revealed, when the clarification for the Remeron was reported on the Pharmacist Communication to the Physician Form, nursing staff should have put the diagnosis in the Physician's Orders and added the diagnosis to the computer. Further interview with LPN #1 revealed, someone should have added the resident's diagnosis to the medication/diagnosis sheet so the resident could have been monitored and assessed for the effectiveness of the medication.

Interview with LPN #2, on 08/28/15 at 10:15 AM, revealed if the resident had a diagnosis of insomnia, it should have been charted/documented that the resident was having difficulty sleeping. Continued interview with LPN #2 revealed Resident #13 did not express to her he/she was having difficulty sleeping. She stated the resident's Remeron should have been re-assessed and monitored.

Interview with the Pharmacist, on 08/27/15 at 1:32 PM, revealed Remeron was being used more often to treat increased appetite. He reported Remeron was occasionally used for insomnia, but insomnia was not the most common use for the drug. The Pharmacist revealed, the "Consultant Pharmacist Communication to the Physician" Form, dated 12/05/13, was asking for justification as to "why" the resident was on two (2) antidepressants and indicating there should have been more documentation to support the use of the Remeron.

Interview with the Medical Director (MD), on

F 329

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F 329	<p>Continued From page 9</p> <p>08/27/15 at 6:25 PM, revealed every medication a resident takes should have a diagnosis to support the medication. She stated, a resident's diagnoses were determined when a resident was admitted and/or remitted to the facility and all of the residents medications were reviewed at those times. Further interview with the MD revealed staff would normally monitor a resident's diagnosis through charting which she reviewed. She stated, she communicated with Pharmacy by e-mails and they would communicate to her the side effects of any resident's medications including antidepressants. She reported she would then discuss the continuation for the resident's medications in the Quality Assurance and Process Improvement (QAPI) meetings with the staff. In regards to Resident #13, the MD reported she recalled the resident being admitted to the facility on Remeron and the resident was upset over his/her roommate of whom was keeping him/her up at night. She further stated that since the resident was no longer having difficulty sleeping, the resident's diagnosis should have been discussed further in the QAPI meeting.</p> <p>Interview with the Director of Nursing (DON), on 08/28/15 at 2:50 PM, revealed she thought the physician would have added a diagnosis of "insomnia" to the resident's record; however, stated the nurses could have added the diagnosis in the computer from the "Pharmacy Communication" Sheet. Further interview with the DON revealed, without staff monitoring the Remeron for insomnia, it would be an unnecessary drug without proper documentation to prove the medication was effective.</p> <p>Interview with the Administrator, on 08/28/15 at 3:00 PM, revealed, it would have been his</p>	F 329		

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

PRINTED: 09/14/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185253	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/28/2015
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NAME OF PROVIDER OR SUPPLIER  CARTER NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 250 MCDAVID BLVD GRAYSON, KY 41143
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 329 Continued From page 10  
 expectation for staff to monitor the resident's sleep pattern if given the diagnosis of insomnia. He reported staff should have assessed the need and the effectiveness of the medication with supporting documentation to back up the diagnosis.

F 329

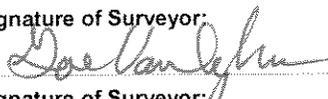
**State Form: Revisit Report**

(Y1) Provider / Supplier / CLIA / Identification Number 100571	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 10/15/2015
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Name of Facility CARTER NURSING & REHABILITATION CENTER	Street Address, City, State, Zip Code 250 MCDAVID BLVD GRAYSON, KY 41143
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <b>B0005</b> Reg. # <b>902 KAR 20:200-3(2)</b> LSC	Correction Completed 10/09/2015	ID Prefix <b>B0009</b> Reg. # <b>902 KAR 20:200-7</b> LSC	Correction Completed 10/09/2015	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: 	Date: 10/15/15
State Agency _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 8/28/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/15/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185253	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - <b>MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  R 10/09/2015
NAME OF PROVIDER OR SUPPLIER  <b>CARTER NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>250 MCDAVID BLVD GRAYSON, KY 41143</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	INITIAL COMMENTS  : Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/09/15 as alleged.	{K 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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

Post-Certification Revisit Report

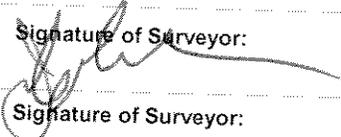
Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number: 185253  
 (Y2) Multiple Construction: A. Building 01 - MAIN BUILDING 01, B. Wing  
 (Y3) Date of Revisit: 10/9/2015

Name of Facility: CARTER NURSING & REHABILITATION CENTER  
 Street Address, City, State, Zip Code: 250 MCDAVID BLVD, GRAYSON, KY 41143

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed 10/09/2015	ID Prefix	Correction Completed 10/09/2015	ID Prefix	Correction Completed 10/09/2015
Reg. # NFPA 101 LSC K0029		Reg. # NFPA 101 LSC K0062		Reg. # NFPA 101 LSC K0076	
ID Prefix	Correction Completed 10/09/2015	ID Prefix	Correction Completed 10/09/2015	ID Prefix	Correction Completed
Reg. # NFPA 101 LSC K0144		Reg. # NFPA 101 LSC K0147		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_ Signature of Surveyor:  Date: 9-28-15  
 State Agency: \_\_\_\_\_  
 Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_ Signature of Surveyor: \_\_\_\_\_ Date: \_\_\_\_\_  
 CMS RO: \_\_\_\_\_

Followup to Survey Completed on: 8/26/2015  
 Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185253	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  08/26/2015
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NAME OF PROVIDER OR SUPPLIER  CARTER NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 250 MCDAVID BLVD GRAYSON, KY 41143
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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  CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1985 Survey under: 2000 existing Facility type: SNF/NF Type of structure: One story Type III. Smoke Compartment: Five smoke compartments Fire Alarm: Complete fire alarm system. Panel upgraded in 2006. Sprinkler System: Complete automatic (dry/wet) sprinkler system. System installed in 1985. Generator: Type II  A standard life safety code survey was conducted on 08/26/15. Carter Nursing and Rehabilitation Center was found not be in compliance with the requirements for participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). The census on the day of the survey was one hundred six (106). The facility is licensed for one hundred twenty (120) beds.  The Highest Scope and Severity deficiency was an "F" level.	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed	K 029	It is the practice of Carter Nursing & Rehabilitation Center that no penetrations will be present in smoke barrier walls. It is also the practice of Carter Nursing & Rehabilitation that the laundry room doors will have automatic closures that will latch properly without any gaps.	10/9/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Danny Joe Bransard, Administrator TITLE Administrator (X8) DATE 9/24/15

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185253	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  08/26/2015
NAME OF PROVIDER OR SUPPLIER  CARTER NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 250 MCDAVID BLVD GRAYSON, KY 41143	

(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 029	<p>Continued From page 1 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, twenty-six (26) residents, staff and visitors.</p> <p>The findings included:</p> <p>Observation on 08/26/15 at 2:07 PM, with the Regional Maintenance Director, revealed the laundry room which contained gas fueled appliances had penetrations in the wall area above the drop ceiling. Further observation revealed, the laundry room doors would not latch properly and the doors had a gap of ¼ Inch. Interview with the Maintenance director, revealed the facility does check smoke barriers for penetrations, but not the area above the laundry room. Further interview revealed, the facility checks doors monthly and the laundry room doors was not identified as having a problem with latching or gaps.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in</p>	K 029	<p>The following corrective action has been accomplished for those residents found to have had the potential to be affected by the deficient practice: The Maintenance supervisor repaired the noted penetrations on 8/28/15 and a new door closure was installed on the laundry room door by the Maintenance supervisor on 8/28/15. The Administrator will provide re-education to the Regional Maintenance Director and the Center's Maintenance Supervisor regarding the K029 LIFE SAFETY CODE STANDARD by 10/1/15. To identify other residents having the potential to be affected by the same deficient practice, the Regional Maintenance Director and the Center's Maintenance Supervisor checked all other smoke barriers for penetrations on 8/27/15 and no other penetrations were noted. The Maintenance supervisor will perform monthly door audits and present findings to the Center's QAPI committee monthly X 3 months to ensure compliance.</p>	
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NAME OF PROVIDER OR SUPPLIER  CARTER NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 250 MCDAVID BLVD GRAYSON, KY 41143	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 2 accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	It is the practice of Carter Nursing & Rehabilitation Center that the automatic sprinkler system will be continuously maintained in reliable operating condition and will be inspected and tested periodically. The Administrator will provide re-education regarding the K062 LIFE SAFETY CODE STANDARD to the Regional Maintenance Director and the Center's Maintenance Supervisor by 10/1/15.	10/9/15

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NAME OF PROVIDER OR SUPPLIER  CARTER NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 250 MCDAVID BLVD GRAYSON, KY 41143	

(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 062 Continued From page 3

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure automatic sprinkler systems were maintained, according to National Fire Protection Association (NFPA). The deficiency had the potential to affect one (1) of five (5) smoke compartments, twenty-six (26) residents, staff and visitors.

The findings include:

Observation on 08/26/15 at 1:09 PM, with the Regional Maintenance Director, revealed an automatic sprinkler head was obstructed by a piece of piping from the hot water heater. Interview, at the time of observation, revealed the facility relied on an outside contractor to ensure automatic sprinkler systems are maintained.

The findings were acknowledged by the Administrator during the exit conference.

Reference: NFPA 13 (1999 Edition).

5-5.5.3.1 Sprinklers shall be installed under fixed obstructions over 4 ft (1.2 m) wide such as ducts, decks, open grate flooring, cutting tables, and overhead doors.

5-5.5.2.1 Continuous or non-continuous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 5-5.5.2.

5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from

K 062

The following corrective action has been accomplished for those residents found to have had the potential to be affected by the deficient practice: The sprinkler head that was previously obstructed was moved away from the hot water heater piping by Sentry Fire on 9/16/15.

All sprinkler heads in the Center were inspected by the Maintenance Supervisor on 8/27/15 to determine if other residents have the potential to be affected by the same deficient practice. No other sprinkler heads were noted to be obstructed. Sentry Fire will conduct sprinkler inspections annually at a minimum. Sprinkler inspection reports will be maintained by the Center's Maintenance Supervisor and reviewed monthly by the Center's QAPI committee X 3 months.

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NAME OF PROVIDER OR SUPPLIER  CARTER NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 250 MCDAVID BLVD GRAYSON, KY 41143
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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 062 Continued From page 4

obstructions such as truss webs and chords, pipes, columns, and fixtures.

Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)

Distance from Sprinklers to side of Obstruction (A). Maximum Allowable Distance of Deflector above Bottom of Obstruction (in.) (B)

Side of Obstruction (A)	Obstruction (in.) (B)
Less than 1 ft	0
1 ft to less than 1 ft 6 in.	2 1/2
1 ft 6 in. to less than 2 ft	3 1/2
2 ft to less than 2 ft 6 in.	5 1/2
2 ft 6 in. to less than 3 ft	7 1/2
3 ft to less than 3 ft 6 in.	9 1/2
3 ft 6 in. to less than 4 ft	12
4 ft to less than 4 ft 6 in.	14
4 ft 6 in. to less than 5 ft	16 1/2
5 ft and greater	18

For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m.  
Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).

Reference: NFPA 25 (1998 Edition)

2-2.1.1\* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.

Exception No. 1:\* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection.

K 062

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NAME OF PROVIDER OR SUPPLIER  CARTER NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 250 MCDAVID BLVD GRAYSON, KY 41143	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 5  Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062		
K 076 SS=D	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b> Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, twenty-six (26) residents, staff and visitors.  The findings included:  Observation on 08/26/15 at 1:41 PM, with the Regional Maintenance Director, revealed three	K 076	It is the practice of Carter Nursing & Rehabilitation Center for Medical Gas storage and administration to be protected in accordance with NFPA 99, Standards for Health Care Facilities. The following corrective action has been accomplished for those residents found to have had the potential to be affected by the deficient practice: The oxygen storage location has been re-located to a secured closet designated for medical gas storage only. The new storage area meets the storage regulation regarding proximity of combustibles. The oxygen cylinders will be stored in the area in proper cylinder stands/carts. No other residents were found to have the potential to be affected. To ensure the deficient practice will not recur, the Administrator will provide education to all clinical staff (Nursing & Therapy) and maintenance staff regarding the NFPA 101 LIFE SAFETY CODE STANDARD regarding medical gas storage by 10/1/15. The medical gas storage closet will be audited twice daily by	10/9/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185253	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  08/26/2015
NAME OF PROVIDER OR SUPPLIER  CARTER NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 250 MCDAVID BLVD GRAYSON, KY 41143	
(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 076	Continued From page 6 (3) unsecured oxygen cylinders and a total of fifteen (15) oxygen cylinders which was less than five (5) feet from combustible items (medical supplies in cardboard boxes). Interview, with the Regional Maintenance Director, revealed staff is trained to secure oxygen cylinders and the individual who delivers oxygen to the facility must have left the oxygen cylinders unsecured. Further interview revealed, the facility was unaware oxygen cylinders must be stored at least five (5) feet from combustible items.  Reference: NFPA 99 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m <sup>3</sup> (300 ft <sup>3</sup> ) but less than 85 m <sup>3</sup> (3000 ft <sup>3</sup> ) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. Freestanding cylinders shall be properly chained	K 076	maintenance staff/RN supervisor to ensure that all cylinders are secured. Audit findings will be reviewed monthly by the Center's QAPI committee X 3 months to ensure that compliance is sustained.	

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K 076	Continued From page 7 or supported in a proper cylinder stand or cart and comply	K 076		
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 documentation and interview, it was determined the facility failed to ensure emergency generators were inspected according to National Fire Protection Association (NFPA). The deficiency had the potential to affect five (5) of five (5) smoke compartments, one hundred twenty (120) residents, staff and visitors.  The findings included:  Record review of the emergency generator logs on 08/26/15 between 3:37 PM and 3:56 PM, with the Maintenance Director, revealed the generator had not been placed under load for the months of June, July and August. Further observation revealed, during the load testing for November that it had taken fifteen (15) seconds for the emergency generator to switch over to emergency power. Interview, with the Regional Maintenance Director, revealed the facility had a	K 144	It is the practice of Carter Nursing & Rehabilitation to inspect generators weekly and exercise under load for 30 minutes per month in accordance with NRPA 99. The following corrective action has been accomplished for those residents found to have had the potential to be affected by the deficient practice: The Administrator will provide education regarding K144 NFPA 101 LIFE SAFETY CODE STANDARD regarding Generators to the Regional Maintenance Director and the Center's maintenance staff by 10/1/15. The Center's Maintenance Supervisor will perform weekly generator inspections and exercise under load X 6 weeks then resume the monthly schedule. The Maintenance Supervisor has been made aware contact Palco in the event that any test takes longer than 10 seconds to switch over to emergency power. The generator inspection and exercise reports will be reviewed by the Center's QAPI committee monthly X 3 months to ensure compliance is sustained.	10/9/15

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K 144 Continued From page 8  
system to ensure the emergency generator was inspected properly and was unsure why the emergency generator was not tested under load or the excessive transfer time taken care of since the last maintenance director that performed the inspections was not working at the facility anymore.  
  
Reference: NFPA 99 (1999 Edition)  
  
3-5.3.1 Source. The emergency system shall be installed and connected to the alternate source of power specified in 3-4.1.1.2 and 3-4.1.1.3 so that all functions specified herein for the emergency system will be automatically restored to operation within 10 seconds after interruption of the normal source.  
  
NFPA 110 (1999 Edition)  
6-4.1\* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.  
Exception: If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded.  
6-4.2\* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of thirty (30) minutes, using one of the following methods:  
(a) Under operating temperature conditions or at not less than thirty (30) percent of the EPS nameplate rating  
(b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer

K 144

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K 144 Continued From page 9  
The date and time of day for required testing shall be decided by the owner, based on facility operations.

K 144

6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at twenty-five (25) percent of nameplate rating for thirty (30) minutes, followed by fifty (50) percent of nameplate rating for thirty (30) minutes, followed by seventy-five (75) percent of nameplate rating for sixty (60) minutes, for a total of two (2) continuous hours.

K 147 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=D  
Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

K 147 It is the practice of Carter Nursing & Rehabilitation Center for electrical wiring and equipment to be in accordance with NRPA 70, National Electrical Code. 9.1.2.

10/9/15

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure electrical equipment was maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, twenty-six (26) residents, staff and visitors.

The findings include:

Observation on 08/26/15 at 1:57 PM, with the Maintenance Director, revealed one (1) electrical wiring junction box located in the laundry room was missing the cover. Interview, with the

The following corrective action has been accomplished for those residents found to have had the potential to be affected:  
A cover was placed on the electrical wiring junction box located in the laundry room on 8/28/15 by the Maintenance Supervisor.  
The Regional Maintenance Director and Center's Maintenance Supervisor inspected all electrical wiring junction boxes on 8/27/15 to ensure no other junction boxes were missing covers. None were noted upon inspection.  
The Maintenance Supervisor will perform monthly checks of electrical wiring junction boxes to ensure that covers are in place.

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K 147	Continued From page 10 Regional Maintenance Director, revealed he was not aware the electrical wiring junction box did not have the cover.  Reference: NFPA 70 (1999 edition) 370-25. Covers and Canopies. In completed installations, each box shall have a cover, faceplate, or fixture canopy.	K 147	The inspection reports will be reviewed by the Center's QAPI committee monthly X 3 months to ensure that compliance is sustained.	