

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # <b>185038</b>	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: <b>10/26/2012</b>
NAME OF PROVIDER OR SUPPLIER <b>PROVIDENCE PAVILION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>401 EAST 20TH STREET COVINGTON, KY</b>		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
<b>F 160</b>	<p><b>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH</b></p> <p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to convey funds promptly within thirty (30) days, for one (1) of five (5) discharged records reviewed. (Unsampled Resident E).</p> <p>The Findings Include:</p> <p>Review of the facility's policy titled "Protection of Resident's Personal Funds", dated 10/19/10, revealed the facility should promptly convey resident's funds and a final accounting of those funds to the individual administering the resident's estate.</p> <p>Review of Unsampled Resident E's personal funds records, on 10/24/12, revealed Unsampled Resident E had expired on 01/04/12; however, there was no documented evidence the final conveyance of five dollars and three cents (\$5.03) was conveyed to Unsampled Resident E's family.</p> <p>Interview with the Accounts Representative, on 10/24/12 at 12:30 PM, revealed after the resident's death, a check for the remaining funds in the resident's account should be issued to the next of kin within thirty (30) days.</p> <p>Interview with the Administrator, on 10/24/12 at 12:30 PM, revealed the normal process was to issue a check to the next of kin within thirty (30) days of the resident's death.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/26/2012
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NAME OF PROVIDER OR SUPPLIER  PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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F 000	INITIAL COMMENTS	F 000	<p>This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Providence Pavilion agrees with the allegations and citations listed on this statement of deficiencies. Providence Pavilion maintains that the alleged deficiencies do not, individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by the regulations. This plan of correction shall operate as Providence Pavilion's written credible allegation of compliance.</p> <p>By submitting this plan of correction, Providence Pavilion does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Providence Pavilion reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action, or proceeding.</p>	
F 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, review of employee files, and a review of the facility's "Abuse, Neglect and Misappropriation" policy, it was determined the facility failed to implement the facility's policy to conduct reference checks on all employees prior to the employee working in the facility. The facility failed to conduct a state nurse aide abuse registry check and validate the license for one (1) of five (5) sampled employees (Registered Nurse #1).</p> <p>The Findings include: A review of the facility's policies titled "Resident Abuse, Neglect and Misappropriation" Policy dated 10/12/11, and the "Recruitment Selection Process", dated 02/11/11, revealed the state nurse aide abuse registry check and a validation of license or certification would be done upon application and prior to hire.</p>	F 226		<p>Providence Pavilion will continue to develop and implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Marcus Allen</i>	TITLE <i>Administrator</i>	(X6) DATE 11-21-12
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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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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F 228	Continued From page 1 Review of employee files, on 10/24/12 at 1:00 PM, revealed Registered Nurse (RN) #1 was hired on 08/24/12. Review of the facility's schedule for September 2012, revealed RN #1 was on schedule to work 09/01/12. Review of RN #1's time card for that date, revealed RN #1 worked 09/01/12, arriving at 6:54 AM and leaving at 3:35 PM. Further review of RN #1's employee file, revealed the state abuse registry check and validation of license was not completed until 09/03/12.  Interview with the Nurse Manager, on 10/24/12 at 1:08 PM, revealed the normal process was to verify license and check the state nurse aid abuse registry prior to hire.  Interview with the Director of Nursing (DON), on 10/26/12 at 5:00 PM, revealed employees were not to be scheduled and work until the state nurse aide abuse registry was checked and the license was verified to be current and active.	F 228	No residents were found to be affected by the deficient practice. Upon interview with HR Manager; it was verified that RN#1 license was checked prior to hire but the verification print off was misplaced. Since printed verification was required the registry was again checked on 9/3/12 HR files from associates hired within the last four months were reviewed on 10/30/12 by the HR Manager to insure and verify that all pre-hire paperwork was in compliance. Associates involved with the hiring process, including all pre-hire requirements were given a refresher on policies and procedures for completing all required checks prior to hiring an associate on 11/8/12 by the administrator. In order to ensure compliance, the business office manager will conduct an audit on new hires' paperwork, including the abuse registry check weekly for all new hires for four weeks and then will randomly audit new hire paperwork monthly for 3 months. Any identified issues will be corrected immediately. Results	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.			



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F 278	<p>Continued From page 3</p> <p>and followed the MDS 3.0 User Manual instead of having an actual policy and procedure specific to the facility.</p> <p>Record review revealed the facility admitted Resident #10's on 01/12/1990 with diagnoses which included Encephalopathy, Convulsions, and Aphasia.</p> <p>Review of Resident #10's Annual MDS Assessment dated 09/13/12, revealed the facility assessed the resident as having severe cognitive impairment. Review of Section E (Behavior), revealed the facility assessed the resident as exhibiting no behavior symptoms for the timeframe under review. Review of Section G (Functional Status), revealed the facility assessed the resident as totally dependent on staff to complete all Activities of Daily Living (ADLs), including one person assist when eating. Continued review of the MDS Section K (Swallowing/Nutritional Status) revealed the facility assessed the resident as requiring a mechanically altered diet.</p> <p>Review of the CAAS, which was generated from the MDS assessment, revealed Resident #10 did not trigger as having behavior symptoms, nor was the Resident triggered as needing a care plan to address behavioral symptoms.</p> <p>Review of Resident #10's Comprehensive Care Plan, revealed there was a problem initiated on 08/14/12 which stated the resident had potential alteration in mood and/or behavior and may scratch others during care. Further review of the Comprehensive Plan of care, revealed there was no documented evidence the resident exhibited</p>	F 278	<p>Providence Pavilion will continue to ensure that resident assessment accurately reflect the resident's status.</p> <p>12-10-12</p>

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F 278	<p>Continued From page 4</p> <p>any other types of behaviors.</p> <p>Review of the Physicians orders, dated 10/15/12, revealed Resident #10 was ordered a pureed diet.</p> <p>Observation of Resident #10 while dining in Providence Unit, on 10/25/12 at 5:26 PM, revealed Resident #10 picked up a bowl of apple sauce from his/her tray while being fed by State Registered Nursing Assistant (SRNA) # 5 and threw the substance in the floor. Continued observation revealed the resident continuously reached for items on the food tray while being fed by SRNA #5.</p> <p>Continued observation of Resident #10 while dining in Providence Unit, on 10/25/12 at 5:45 PM, revealed SRNA #5 wiped Resident #10's mouth with a napkin, and Resident #10 tore a large piece of the napkin off and placed it in his/her mouth. Although SRNA #5 and Licensed Practical Nurse (LPN) #2 were both present in the diningroom at the time of the incident, they were unaware until surveyor intervention. LPN #2 proceeded to place a gloved hand in Resident #10's mouth; however, was unable to retrieve the napkin as Resident #10 had swallowed the napkin.</p> <p>Interview with SRNA #5, on 10/25/15 at 5:50 PM, revealed she did not realize Resident #10 had taken the napkin from her hand until surveyor intervention. Further interview revealed Resident #10 required close supervision due to grabbing objects from his/her tray and she also reported she usually used an actual towel clothing protector to clean the resident's mouth, but had</p>	F 278			

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F 278	<p>Continued From page 5 used a paper napkin that day.</p> <p>Interview with LPN #2, on 10/25/12 at 6:02 PM, revealed Resident #10 required close supervision related to unpredictable behaviors and grabbing random things and placing them in his/her mouth. LPN #2 also reported she believed SRNA #5 should have monitored Resident #10 more closely during dining.</p> <p>Interview with SRNA # 6, on 10/26/12 at 10:11 AM, revealed "Everything he/she gets goes to his/her mouth." SRNA #6 also reported Resident #10 required close supervision when eating. She also added that his/her tray had to be out of reach at all times due to grabbing behaviors.</p> <p>Interview with SRNA #7, on 10/26/12 at 10:20 AM, revealed Resident #10 was known to grab items and place them in his/her mouth, so the facility had purchased large items for the Resident to keep in his/her room to prevent him from choking. In addition, she reported Resident #10 required interventions such as holding one of his/her hands while dining to prevent him/her from grabbing or knocking the food off the table.</p> <p>Interview with Registered Nurse (RN) #2, on 10/26/12 at 10:30 AM, revealed Resident #10 did require very close supervision when dining, and that he/she normally wore a towel/clothing protector instead of using a paper napkin. However, she was unaware of why Resident #10 was not wearing a towel/clothing protector on 10/25/12. RN #2 was unaware if he/she had a care plan addressing this behavior, but stated they would now create one since he/she had swallowed part of a napkin. RN #2 did report that</p>	F 278		

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F 278	Continued From page 6 Resident #10 was known to place items in his/her mouth, but to her knowledge he/she had never actually swallowed any of them.  Interview with the MDS Coordinator, on 10/26/12 at 2:30 PM, revealed she was aware Resident #10 had behaviors that included grabbing items and placing them in his/her mouth. However, she stated the behavior sections of the MDS had been completed by Social Services and that she was unaware as to why behaviors had not triggered for this resident.  Interview with Director of Social Services, on 10/26/12 at 2:50 PM, revealed she had conducted the behavior sections of Resident #10's MDS dated 09/13/12 and obtained information to complete the MDS from Nurse's Notes, and Interviews with staff. She stated that she was aware Resident #10 placed items in his/her mouth through her observations, and this behavior should have been reflected on the MDS.	F 278			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timelables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279	Providence Pavilion will continue to develop comprehensive care plan for each resident that accurately reflect the resident assessment. Resident 10's care plan was reviewed and updated on 10/26/12 to include a care plan for history of placing non food items into their mouth (PICA). A review of behaviors was completed with nursing staff on 10/26/12.	12-10-12	

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F 279	<p>Continued From page 7</p> <p>highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by:                      Based on observation, interview, and record review, it was determined the facility failed to ensure an individualized Plan of Care was developed for one (1) of fifteen (15) sampled residents (Resident #10) related to behaviors of placing objects in his/her mouth. On 10/25/12 during dinner, Resident #10 was observed to swallow a piece of his/her napkin; however, staff present were not aware until surveyor intervention.</p> <p>The findings include:</p> <p>Interview with the Nursing Supervisor, on 10/26/12 at 11:46 AM, revealed the facility did not have a written policy or procedure that addressed Comprehensive Plans of Care.</p> <p>Review of Resident #10's medical record revealed he/she was admitted, on 01/12/90 with diagnoses which included Encephalopathy, Convulsions, and Aphasia.</p> <p>Review of Resident #10's Annual Minimum Data Set (MDS) Assessment, dated 09/13/12, revealed the facility assessed the resident as having severe cognitive impairment. Review of the</p>	F 279	<p>To ensure no other residents were affected, the Nurse Manager and MDS nurse reviewed with the nursing staff, the residents who exhibited behaviors to ensure behaviors were accurately on the plan of care on October 26, 2012. Nurses and nurse aides will be re-educated on or before December 7, 2012 by the Director of Nurses and/or designee regarding proper reporting of resident behaviors and necessary follow up regarding assessments so that the information can be accurately placed on the resident care plan. In order to ensure compliance, Director of Nurses or Nurse Designee will audit resident care plans and nursing charting to ensure proper behavior documentation on four residents for 4 weeks and randomly thereafter for 3 months. Results will be reviewed at the Quality Assurance Committee meeting for further recommendation and determination of frequency of future monitoring</p>	12-10-12	

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F 279	<p>Continued From page 8</p> <p>Behavior Section (E), revealed the facility assessed the resident as exhibiting no behavior symptoms for the timeframe under review. Review of the Functional Status Section (G), revealed the facility assessed the resident as totally dependent on staff to complete all Activities of Daily Living (ADLs), including one person assist when eating. Further review of the MDS Swallowing/Nutritional Status Section (K) revealed the facility assessed the resident as requiring a mechanically altered diet.</p> <p>Review of Resident #10's Care Area Assessment Summary (CAAS), generated from the Minimal Data Set (MDS) assessment, revealed the resident did not trigger as having behavior symptoms, nor was the resident triggered as needing a care plan to address behavioral symptoms.</p> <p>Review of Resident #10's Comprehensive Plan of Care, revealed a problem initiated on 09/14/12 which stated the resident had potential alteration in mood and/or behavior and may scratch others during care. The goal stated the would cause no serious injury to self or others. Further review of the Care Plan, revealed there was no documented evidence of interventions for any other behavioral symptoms.</p> <p>Review of Physicians orders, signed 10/15/12, revealed Resident #10 was ordared a pureed diet.</p> <p>Observation of Resident #10 during dinner meal in Providence Unit dining room, on 10/25/12 at 5:26 PM, revealed Resident #10 picked up a bowl of apple sauce from hjs/her tray while being fed</p>	F 279		

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F 279	<p>Continued From page 9</p> <p>by State Registered Nursing Assistant (SRNA) #5 and threw the substance in the floor. Continued observation revealed he/she continuously reached for objects on the food tray while being fed by SRNA #5.</p> <p>Observation of Resident #10 while dining in Providence Unit, on 10/25/12 at 5:45 PM, revealed SRNA #5 wiped Resident #10's mouth with a napkin, and Resident #10 removed a large piece of the napkin and placed it in his/her mouth. SRNA #5 and Licensed Practical Nurse (LPN) #2 were both present but were unaware of the incident until surveyor intervention. After being informed of the incident by the surveyor, LPN #2 placed a gloved hand in Resident #10's mouth, but was unable to find the napkin. It was concluded, Resident #10 had swallowed the napkin.</p> <p>Interview with SRNA #5, on 10/25/15 at 5:50 PM, revealed she was not aware Resident #10 had taken the napkin from her hand until surveyor intervention occurred. Further Interview of SRNA #5 revealed Resident #10 required close supervision while dining due to grabbing items off of his/her tray. She also reported she usually used an actual towel clothing protector to clean the resident's mouth, but had used a paper napkin today for unknown reasons.</p> <p>Interview with LPN #2, on 10/25/12 at 6:02 PM, revealed Resident #10 required close supervision by staff related to unpredictable behaviors and grabbing random things. LPN #2 also stated she believed SRNA #5 should have monitored Resident #10 more closely during dining.</p>	F 279		

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F 279	<p>Continued From page 10</p> <p>Interview with SRNA # 6 in Resident #10's room, on 10/26/12 at 10:11 AM, revealed "Everything he/she gets goes to his/her mouth." SRNA #6 also reported Resident #10 required close supervision when eating due to these behaviors. Furthermore, she added that his/her tray had to be out of reach at all times due to grabbing behaviors.</p> <p>Interview with SRNA #7 in Resident #10's room, on 10/26/12 at 10:20 AM, revealed Resident #10 was known to grab items and place them in his/her mouth, so the facility had purchased large items for the Resident to keep in his/her room that would prevent choking. In addition, she reported Resident #10 required interventions such as holding one of his/her hands while dining to prevent him/her from grabbing or knocking items off the table.</p> <p>Interview with Registered Nurse (RN) #2, on 10/26/12 at 10:30 AM, revealed Resident #10 did require very close supervision when eating, and that he/she normally wore a towel/bib instead of using a paper napkin. She was unaware of why Resident #10 was not wearing a towel/bib on 10/25/12. RN #2 was unaware if he/she had a current care plan addressing this behavior, but stated they would now create one since he/she had swallowed part of a napkin. RN #2 did report that Resident #10 was known to place items in his/her mouth, but to her knowledge he/she had never swallowed any of them.</p> <p>Interview with the MDS Coordinator in the dining area, on 10/26/12 at 2:30 PM, revealed she was aware Resident #10 had behaviors that included grabbing items and placing them in his/her</p>	F 279		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/26/2012
NAME OF PROVIDER OR SUPPLIER  PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
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F 279	Continued From page 11 mouth. However, she reported the behavior sections of the MDS had been completed by the Social Services Director, and that she was unaware as to why the Resident had not triggered for these known behaviors.  Interview with Director of Social Services, on 10/26/12 at 2:50 PM, revealed she had conducted the behavior sections of Resident #10's MDS dated 09/13/12. She stated that she was aware Resident #10 placed items in his/her mouth, and it should have been coded on the MDS, so that it would have triggered the CAAS and a care plan would have been initiated to address these known behaviors. She stated she was responsible for completing the behavior Care Plans.  Interview on 10/26/12 at 3:15 PM with the Director of Nursing (DON), revealed she was new to the facility and did not know the residents that well; however, stated if the resident had a habit of placing objects in his/her mouth, there should have been a care plan in place to address this behavior prior to this incident. She further stated the care plan should have specified there was to be no paper products on the meal trays and no small objects in reach that the resident could place in his/her mouth.	F 279			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  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.	F 323	Providence Pavilion will ensure that the resident environment remains free of accident hazards as is possible.	12-10-12	

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F 323	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by:                  Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure the environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance to prevent accidents for one (1) of fifteen (15) sampled residents (Resident #10). Resident #10 was observed to swallow a piece of a napkin during dinner on 10/25/12, and staff was unaware until surveyor intervention. There was no documented evidence prior to this occurring, that the facility identified potential hazards and implemented interventions/supervision to keep Resident #10 safe from accidents related to the resident placing items in his/her mouth although interviews with staff revealed they were aware the resident consistently placed items in his/her mouth.</p> <p>In addition, the facility failed to ensure an environment free of accident hazards as evidenced by observation on initial tour revealed used razors on a shelf in the resident bathrooms, and scissors on the back of the toilet in a resident bathroom. Also a sharps container in the Providence shower room was overflowing with used razors.</p> <p>Observation of the crash cart on the Purpose Hall, on 10/26/12 at 11:10 AM, revealed the cart was at the end of the hall away from the nurses station, unlocked, and contained five three</p>	F 323	<p>Resident #10 was assessed and no adverse effect was noted. All razors and scissors were properly stored on 10/23/12. The sharps container was removed and replaced with a new container on 10/23/12. The crash carts contents were updated and the carts were locked on 10/26/12.</p> <p>To ensure no other residents were affected, the administrator and/or designee conducted environmental rounds to verify the environment was free of hazards such as razors, sharps, and scissors.</p> <p>Staff will be re-educated on or before December 7, 2012 by the Administrator and/or designee regarding keeping the environment safe to potential negative outcomes specifically related to proper storage of sharps/razors and proper control of the crash carts.</p>	

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F 323	<p>Continued From page 13</p> <p>millimeter syringes with 5/8 inch needles, one (1) IV start Kit, approximately thirty (30) glucometer safety lancets, a vial of Bacteriostatic 0.9% Sodium Chloride (expiration date 05/01/12). Review of The Crash Carts Contents sheet revealed the date of inspection was 10/17/12 and the next inspection date listed was 11/14/12.</p> <p>The findings include:</p> <p>1. Review of Resident #10's medical record revealed diagnoses including Encephalopathy, Convulsions, and Aphasia. Review of the Minimal Data Set (MDS) Assessment, dated 09/13/12, revealed the facility assessed the resident as having severe cognitive impairment. Review of Section E (Behavior), revealed the facility assessed the resident as exhibiting no behavior symptoms. Review of Section G (Functional Status), revealed the facility assessed Resident #10 as totally dependent on staff to complete Activities of Daily Living (ADLs), including one person assist when eating. Further review of the MDS Section K (Swallowing/Nutritional Status) revealed the facility assessed the resident as requiring a mechanically altered diet.</p> <p>Review of Resident #10's Care Area Assessment Summary (CAAS), revealed Resident #10 did not trigger as having behavior symptoms, nor was the Resident triggered as requiring a care plan with interventions to address behaviors.</p> <p>Review of Resident #10's Comprehensive Plan of Care, dated 09/14/12, revealed a problem related to the resident's potential alteration in mood and/or behavior to prevent Resident #10 from self-harm or harming others due to scratching</p>	F 323	<p>Nursing staff will be re-educated on providing proper supervision of residents who may exhibit behaviors that could be a safety risk especially during meal times on or before December 7, 2012 by the Director of Nurses and/or designee.</p> <p>In order to ensure compliance, the administrator and/or designee will conduct an audit to ensure the environment is free of hazards for two (2) times per week for three (3) weeks and then one (1) time a week for three (3) weeks. The Director of Nurses and/or Designee will audit the dining rooms during meal service to ensure adequate supervision for two (2) times per week for three (3) weeks and then one (1) time a week for three (3) weeks. The Director of Nurses and/or Designee will audit the crash carts to ensure safety and proper storing of supplies for two (2) times per week for three (3) weeks and then one (1) time a week for three (3) weeks                      Results will be reviewed at the Quality Assurance Committee meeting for further</p>		

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F 323	<p>Continued From page 14</p> <p>others during care. Further review , revealed there was no documented evidence of the facility had identified and placed interventions to prevent accidents related to the resident placing items in his/her mouth.</p> <p>Review of the Physicians orders, dated 10/15/12, revealed Resident #10 was ordered a pureed diet.</p> <p>Observation of Resident #10 while dining in Providence Unit, on 10/25/12 at 5:26 PM, revealed Resident #10 lifted up a bowl of apple sauce from his/her tray while being fed by State Registered Nursing Assistant (SRNA) # 5 and threw the substance in the floor. Continued observation revealed he/she continued to reach for items on the food tray while being fed by SRNA #5.</p> <p>Further observation of Resident #10 while dining in Providence Unit, on 10/25/12 at 5:45 PM, revealed SRNA #5 cleaned Resident #10's mouth with a napkin, and the resident proceeded to tear a large piece of the napkin off and place it in his/her mouth. SRNA #5 and other staff were unaware of the incident until surveyor intervention. After being informed of the incident by the surveyor, Licensed Practical Nurse (LPN) #2 placed a gloved hand in Resident #10's mouth, but was unable to locate the napkin. Resident #10 had swallowed part of the napkin.</p> <p>Interview with SRNA #5, on 10/25/12 at 5:50 PM, revealed she was not aware Resident #10 had taken the napkin from her hand until surveyor intervention, SRNA #5 stated Resident #10 required close supervision due to grabbing</p>	F 323	<p>recommendation and determination of frequency of future monitoring</p>	12-10-12
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F 323	<p>Continued From page 15</p> <p>objects from his/her tray and she also reported she usually used an actual towel type clothing protector to clean the resident's mouth, but had used a paper napkin today for unknown reasons.</p> <p>Interview with LPN #2, on 10/25/12 at 6:02 PM, revealed Resident #10 required close supervision related to unpredictable behaviors of grabbing random objects. LPN #2 also reported she believed SRNA #5 should have monitored Resident #10 more closely during dining to prevent the accident.</p> <p>Interview with SRNA #6, on 10/26/12 at 10:11 AM, revealed "Everything he/she gets goes to his/her mouth". SRNA #6 reported Resident #10 required very close supervision when being fed. She also added that his/her tray had to be out of reach when in the dining room due to grabbing behaviors.</p> <p>Interview with SRNA #7, on 10/26/12 at 10:20 AM, revealed Resident #10 was known to grab items and place them in his/her mouth, so the facility had purchased large items for the Resident to keep in his/her room to prevent him from choking. Furthermore, she reported Resident #10 required interventions such as holding one of his/her hands while dining to prevent him/her from knocking food off of the table.</p> <p>Interview with Registered Nurse (RN) #2, on 10/26/12 at 10:30 AM, revealed Resident #10 did require very close supervision, and that he/she normally wore a towel/clothing protector instead of using a paper napkin. However, she was unaware of why Resident #10 was not wearing a</p>	F 323		

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F 323	<p>Continued From page 16</p> <p>towel/bib on 10/25/12. RN #2 was unaware if there was a care plan with interventions addressing this behavior, but stated they would now create one since he/she had swallowed part of a napkin. RN #2 did report that Resident #10 was known to place items in his/her mouth.</p> <p>Interview with MDS Coordinator, on 10/26/12 at 2:30 PM, revealed she was aware Resident #10 had behaviors that included reaching for objects and placing them in his/her mouth. However, she reported the behavior sections of the MDS had been completed by Social Services and that she was unaware as to why the Resident had not triggered for these known behaviors.</p> <p>Interview with Director of Social Services, on 10/26/12 at 2:50 PM, revealed she had conducted the behavior sections of Resident #10's MDS dated 08/13/12. She stated that she was aware Resident #10 placed items in his/her mouth, and it should have been on the MDS. Thus, the CAAS would have triggered the need for a care plan with interventions to prevent accidents/harm related to Resident #10's known behaviors.</p> <p>Interview, on 10/26/12 at 3:15 PM, with the Director of Nursing (DON) revealed she had only been at the facility for four (4) weeks and was still getting to know the residents. However, she stated if Resident #10 had a habit of placing objects in his/her mouth, there should have been a care plan in place to address this behavior prior to this incident. Further interview revealed the care plan should have specified there was to be no paper products on the meal trays and no small objects in reach that the resident could place in his/her mouth.</p>	F 323		

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F 323	<p>Continued From page 17</p> <p>2. Review of the facility's policy, "Infectious Wastes - Disposal of Contaminated Sharps" revealed the facility shall discard contaminated sharps into designated containers. Under Procedure: #1. Contaminated sharps shall be discarded immediately or as soon as feasible into designated containers. #2. Contaminated sharps will be discarded into containers that are closable, and #3. During use, containers for contaminated sharps were to be sealed and replaced when full.</p> <p>Observation on initial tour, on 10/23/12 at 8:30 PM, revealed resident room #434 contained four (4) used razors on a shelf in the bathroom, resident room #436 contained five (5) used razors on the back of the toilet in the bathroom; and resident room #443 contained two (2) used razors and one (1) pair of scissors on the back of the toilet in the bathroom. Observation on initial tour, on 10/23/12 at 8:45 PM, revealed a sharps container in the Providence shower room to be overflowing with used razors. Further observation of Initial tour, on 10/23/12 at 9:10 PM, revealed two used shaving razors in the bathroom of room #423.</p> <p>Interview, on 10/23/12 at 8:45 PM, with Nurse Manager (NM) #3 revealed the sharps container should have been emptied when it became full per the facility's policy. Further interview, on 10/26/12 at 12:05 PM, revealed the facility did not have a policy for residents having razors in their rooms; however, the used razors should be placed in a sharps container after use.</p> <p>Interview, on 10/23/12 at 9:10 PM, with tour staff person, Medical Records #1, revealed razors were not supposed to be in the residents' room</p>	F 323		

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F 323	<p>Continued From page 18</p> <p>and it was a safety concern. She stated, the razors should be disposed of in the sharps container because a resident could wander into the bathroom and cut themselves.</p> <p>Interview, on 10/26/12 at 3:15 PM, with Registered Nurse (RN) #3 revealed residents should not have razors in their rooms. She stated it was a sharp and should be disposed of after use. She further stated there was cognitively impaired residents who wandered and may try to use the razors. Continued interview revealed, having razors in resident rooms would be considered both a safety risk and infection control issue because the resident could cut themselves and the razor could be contaminated.</p> <p>Interview with the Director of Nursing (DON)/Infection Control Nurse (ICN), on 10/23/12 at 4:05 PM, revealed used razors would be considered a contaminated sharps item and were to be disposed of in sharps containers.</p> <p>Continued interview with the DON/ICN, on 10/26/12 at 4:05 PM, revealed used razors should not be kept in resident rooms. She stated, they were to be disposed of in sharps containers. She further stated, razors should be kept in locked drawers if the resident was allowed to have them. Further interview revealed the facility had residents at the facility who wandered and who were cognitively impaired. She stated, if a new razor was left out it was a safety issue because the resident could cut themselves, and if it was a used razor it would also be an infection control issue because of the possible transmission and infection from organisms on the razor. She further stated, when staff shaved a resident they</p>	F 323		

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F 323	<p>Continued From page 19</p> <p>were expected to put the razor in a sharps container. Further interview with the DON/ICN regarding the findings of a sharps container overfilled with razors, revealed staff should replace sharps containers when full. She stated there was a safety concern about overfilled sharps containers because residents could have access to a dirty razor and get cut.</p> <p>3. Review of the facility's policy and procedure "Crash Cart Supplies and Maintenance Schedule", updated 01/01/11, revealed the purpose was to ensure crash cart (s) were properly stocked and positioned at each nurses' station. Under the "Procedure" section, it revealed, each crash cart would be stocked with the following items and checked every Friday by the central supply clerk or designee; syringes and IV (intravenous) starter kits.</p> <p>Observation of the crash cart on the Purpose Hall, on 10/26/12 at 11:10 AM, revealed the cart was at the end of the hall away from the nurses station, unlocked, and contained five three millimeter syringes with 5/8 inch needles, one (1) IV start Kit, approximately thirty (30) glucometer safety lancets, a vial of Bacteriostatic 0.9% Sodium Chloride (expiration date 05/01/12). Review of The Crash Carts Contents sheet revealed date inspection was 10/17/12 and the next inspection date listed was 11/14/12.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 10/26/12 at 11:10 AM, revealed she thought the crash cart was checked by Central Supply monthly. If they used any supplies they were supposed to tell Central Supply. She further verified the crash cart was not locked and stated</p>	F 323		

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F 323	<p>Continued From page 20</p> <p>the nurses did not check the carts to ensure they were locked.</p> <p>Continued interview with LPN #3, upon review of the items in the crash cart, revealed the expired medication (0.9% Sodium Chloride vial) should not have been in the crash cart. She stated, it was a patient safety issue to have syringes and lancets in the unlocked cart because residents could injure themselves with those items. She further stated, the facility had cognitively impaired residents who wandered and had access to the unlocked cart.</p> <p>Observation of the crash cart on the Honor Hall, at 10/26/12 at 11:55 AM, revealed the cart was unlocked, and the oxygen tank did not have an oxygen regulator to administer oxygen. The crash cart contents included alcohol prep pads, IV needle filter, scissors, a Biohazard Spill kit with an absorbant packet, and a vial of Bacteriostatic 0.9% Sodium Chloride (expired 03/2012). The inspection sheet showed the cart was last inspected on 10/17/12 and the next inspection date was 11/14/12.</p> <p>Interview with LPN #1, on 10/26/12 at 11:55 AM, revealed the oxygen tank did not have a regulator to admtnister the oxygen if needed. She stated, the crash cart was not locked but should have been and the nurses did not check to see if the crash cart was locked. She further stated, the vial was not supposed to be in the cart and should have been thrown out because it was expired. Continued interview revealed the biohazard spill kit had a packet of absorbant chemical which would be potentially dangerous if a cognitively impalred resident were to find it.</p>	F 323		

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F 323	Continued From page 21 She stated there was cognitively impaired patients at the facility who wander and they did not have a nurse at the nurses station at all times to watch over the crash cart.  Interview with the Director of Nursing (DON), on 10/26/12 at 4:15 PM, revealed crash carts were supposed to be set up as a basic crash cart. A previous DON had put IV starter kits and glucometers in the crash carts and those items should not be included because they required a Physician's Order. She stated, the 0.9% Sodium Chloride, syringes, IV starter kit, and glucometer were not on the crash cart check list. She further stated, staff was checking the crash carts, but not accurately. Further interview revealed the idea of the crash cart was to meet the basic needs of a residents during an emergency. She stated there were items on the crash cart such as the syringes and the blood spill kit that the general public and residents should not have access to because of safety. She further stated the crash carts should have been checked daily and if the lock was broken, the cart would need to be audited for supplies and relocked. Further interview revealed the oxygen tanks should have been functional in case of an emergency. She stated the crash cart on Purpose Hall would be covered to make sure it was not visible. The DON stated the policy was not appropriate and would be revised.	F 323			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371	Providence Pavilion will continue to store, prepare, distribute and serve food under sanitary conditions.	12-10-12	

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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	
F 371	Continued From page 22 under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions. Observation on initial tour of the kitchen on 10/23/12 revealed a meat slicer was observed with what appeared to be brownish/whitish particles on the piece of equipment near the slicer. Interview with Cook #1, who examined the meat slicer, revealed the piece of equipment was not clean and appeared to have meat particles on the equipment. Further interview revealed the slicer was used on 10/23/12 to slice turkey.  In addition, observation of the Purpose Unit diningroom during the lunch meal on 10/25/12, revealed the food server plated food using spoodles and ladels, and with the same gloved hands obtained rolls out of a plastic bag repeatedly.  The findings include:  Review of the facility's policy "Dietary Services", undated, revealed under Proper Food Handling: 14. All food choppers, mixers, slicers, processors, and blenders should be cleansed, sanitized, dried, and reassembled after each use. They should be kept covered when not in use.	F 371	Providence Pavilion believes that no residents were adversely affected by the observed events. The meat slicer was properly cleaned and sanitized at the time of discovery on 10/23/12. Staff was re-educated on the proper cleaning and sanitizing of the meat slicer on 10/24/12. The Food Service Director reviewed proper food handling with the Dietary Aide on 10/25/12. Food Service staff was educated on proper food handling with glove use and properly cleaning of dietary equipment on 11/19/12, 11/20/12, and 11/21/12 by the Food Service Director. In order to ensure compliance the Registered Dietitian and/or designee will conduct a food handling and equipment sanitation audit two (2) times per week for three (3) weeks and then one (1) time per week for three (3) weeks. All identified issues will be corrected immediately. Results will be reviewed at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring		

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F 371	<p>Continued From page 23</p> <p>1. Observation on initial kitchen tour, on 10/23/12 starting at 8:00 PM, with the cook revealed a meat slicer had what appeared to be some brownish - whiteish appearing particles on the piece of equipment near the slicer.</p> <p>Interview with Cook #1, on 10/23/12 at 8:10 PM, revealed the meat slicer is supposed to be clean, but appears to have meat particles on the equipment. Further interview revealed the meat slicer was used on 10/23/12 to slice up turkey.</p> <p>Interview with the Dietician/Food Service Owner, on 10/23/12 at 8:30 PM, revealed the meat slicer should have been cleaned properly. Further interview revealed if equipment was not cleaned it could be a food safety problem because of the possibility of bacterial growth.</p> <p>2. Review of the facility, "Dietary Services Proper Food Handling Policy", undated, revealed food should be prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable equipment.</p> <p>Observation of the Purpose Unit diningroom during the lunch meal on 10/25/12 at 12:10 PM, revealed the meal cart came to the unit with glasses, plates, and utensils uncovered on top of the cart. The food server (dietary aide #1) removed glasses, plates, spoodles and ladels from the top of the meal cart and placed the glasses on the counter and the spoodles/ladels on the steam table with gloved hands. The server did not wash or sanitize her hands after removing the items from the top of the meal cart. Further observation revealed the server began to</p>	F 371			

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F 371	Continued From page 24 plate food using spoodles/ladels and with the same gloved hands obtained rolls out of a plastic bag repeatedly.  Interview on 10/24/12 at 12:40 PM with the server (dietary aid #1) revealed she did not usually use tongs to pick up bread during tray line.  Interview on 10/24/12 at 12:45 PM with the Dietician/Food Service Owner, revealed the server could use the same gloved hands to plate food and pick up bread; however, would need to sanitize or wash hands prior to handling the ladels/spoodles.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents Infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	Providence Pavilion continues to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment. Resident #1 had a PPD given on 10/25/12 and read on 10/27/12. The PPD 2 <sup>nd</sup> Step was given on 11/5/12 and read on 11/7/12. Results were negative for both the 1 <sup>st</sup> step and 2 <sup>nd</sup> step PPD. All new residents charts were audited on 10/26/12 and all PPDs were given according to policy and doctors orders.	12-10-12

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F 441	<p>Continued From page 25</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development of disease and infection.</p> <p>Resident #1 was administered the Tuberculin Skin (TB) Test on admission; however, the facility failed to follow up with administering a second step TB Skin Test.</p> <p>The findings include:</p> <p>1. Review of the facility policy entitled "Tuberculosis Screening", undated, revealed the purpose of the policy was to screen residents for communicable diseases. Further review revealed all residents shall have a two (2) step Mantoux test no more than three months prior to</p>	F 441	<p>Nurses will be re-educated on proper PPD protocol on or before December 7, 2012 by the Director of Nurses and/or designee.</p> <p>In order to ensure compliance, the Director of Nursing and/or designee will audit all new admission charts within 72 hours of admission to verify that the PPD 2 step orders were written and 1<sup>st</sup> step given on admission. The Director of Nursing and/or designee will review the charts by day 14 of stay to assure the 2<sup>nd</sup> step was given and results recorded. These audits will be conducted for a period of six (6) weeks. Any identified issues will be corrected immediately. Results will be reviewed at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring</p>	

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F 441	Continued From page 26 admission and annually thereafter.  Review of the Centers for Disease Control (CDC) "Prevention and Control of Tuberculosis in Facilities providing Long Term Care to the Elderly Recommendations of the Advisory Committee for Elimination of Tuberculosis", dated 07/13/90, revealed TB Skin Tests should be administered to all new residents as soon as their residency begin unless they have documentation of a previous positive reaction. Further review revealed a two step procedure was advisable for the initial testing of residents in order to establish a reliable baseline.  Review of Resident #1's medical record revealed the facility admitted the resident on 03/28/12. Review of the Medication Administration Record (MAR), dated 03/12, revealed the resident received the Tuberculin (TB) Skin Test on 03/28/12 and the test was read on 03/31/12. Review of the Immunization Record revealed the TB Skin Test was read as negative on 3/31/12. Review of the 04/12 MAR, revealed there was no documented evidence a second step TB Skin Test was administered.  Interview, on 10/25/12 at 12:00 PM, with the Nurse Manager where Resident #1 resided, revealed a two (2) step TB Skin Test had not been completed for Resident #1 in 04/12. She stated this was probably because the nurse who reviewed and completed the change over for the Physician's Orders and MAR's from 03/12 to 04/12 failed to carry over the TB Skin Test on the 04/12 MAR's.	F 441		

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F 441	Continued From page 27  Interview, on 10/26/12 at 3:30 PM, with the Infection Control Nurse (ICN), revealed residents were required to have a two (2) step TB Skin Test on admission and annually thereafter.	F 441			

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NAME OF PROVIDER OR SUPPLIER  PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  Building: 01 4th Floor  Plan Approval: 1992  Survey under: 2000 existing  Facility type: SNF  Type of structure: Five story Type I (Fire Resistive).  Smoke Compartment: Four smoke compartments  Fire Alarm: Manual initiating devices located at exits. Smoke detectors located in all corridors and resident rooms. Fire Alarm panel updated in 2010.  Sprinkler System: Complete automatic (wet) sprinkler system  Generator: Type II diesel, installation date unknown by facility.  A standard Life Safety Code survey was conducted on 10/25/12. Providence Pavillon was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census the day of the survey was seventy-two (72) and the facility is licensed for eighty-two (82). Deficiencies were cited with the highest deficiency identified at an " F".	K 000	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Providence Pavilion agrees with the allegations and citations listed on this statement of deficiencies. Providence Pavilion maintains that the alleged deficiencies do not, individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by the regulations. This plan of correction shall operate as Providence Pavilion's written credible allegation of compliance.  By submitting this plan of correction, Providence Pavilion does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Providence Pavilion reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action, or proceeding.	
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Marianne Allen</i>	TITLE <i>Administrator</i>	(X6) DATE 11-21-12
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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 038 SS=F	<p>Continued From page 1</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for eighty-two (82) beds and the census the day of the survey was seventy-two (72).</p> <p>The findings include:</p> <p>Observation, on 10/25/12 at 11:15 AM, with the Maintenance Director revealed that all seven (7) exit doors did not have signage stating that the doors was equipped with delayed egress and doors would release after 15 seconds per NFPA standards.</p> <p>Interview, on 10/24/12 at 11:15 AM, with the Maintenance Director revealed he was unaware the doors had to have signage and patients could possibly get out if signage was on the doors.</p>	K 038	<p>Providence Pavilion will continue to ensure delayed egress doors and exits are maintained in accordance with NFPA standards.</p> <p>No residents were found to be affected.</p> <p>Required signage was installed on all seven (7) exit doors on November 16, 2012.</p> <p>In order to ensure ongoing compliance the Maintenance Supervisor will ensure signs are in place during the monthly audits conducted on exit doors. Results will be reviewed at the Quality Assurance Committee meeting for further recommendation and determination of frequency of future monitoring</p>	12-10-12

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K 038	<p>Continued From page 2 Reference:  NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device</p>	K 038	

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K 038 Continued From page 3  
required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.  
Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.

(d) \*On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows:  
PUSH UNTIL ALARM SOUNDS  
DOOR CAN BE OPENED IN 15 SECONDS  
NFPA 101 LIFE SAFETY CODE STANDARD

K 072 SS=F  
Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10

This STANDARD is not met as evidenced by:  
Based on observation and interview, It was

K 038

K 072 Providence Pavilion will continue to ensure the means of egress are maintained free of obstructions in accordance with NFPA standards.  
No residents were found to be affected.  
The furniture identified during tour was removed from the hallways on 10/24/12

12-10-12

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K 072 Continued From page 4  
determined the facility failed to maintain exit access in accordance with National Fire Prevention Association (NFPA) standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, all residents, staff, and visitors. The facility is licensed for eighty-two (82) beds with a census of seventy-two (72) on the day of the survey.

The findings include:

Observation, on 10/24/12 between 9:30 AM and 1:30 PM, with the Maintenance Director revealed medication carts were stored and not in use in corridors at nurses stations near room # 442 and Honor nurses' station. Furniture was also observed in corridors at stairway exits #2 and #3. Means of egress must remain clear of all obstructions and impediments at all times in case of emergency or fire.

Interview, on 10/24/12 at 11:45 AM, with the Maintenance Director revealed he was aware the facility routinely stored the medication carts in the corridors.

Reference: NFPA 101 (2000 Edition)  
Means of Egress Reliability 7.1.10.1  
Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.

K 072 Nursing associates were re-educated by the Nurse Manager on 10/24/12 regarding the proper placement of medication carts when not in use at the time of survey  
In order to ensure ongoing compliance the Maintenance Supervisor will conduct a hallway audit three (3) times per week for four (4) weeks to insure hallways are free of obstructions. Results will be reviewed at the Quality Assurance Committee meeting for further recommendation and determination of frequency of future monitoring