

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

PRINTED: 11/29/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185409	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/10/2011
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NAME OF PROVIDER OR SUPPLIER CRESTVIEW CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065
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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)	(X6) COMPLETION DATE
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F 000 F 253 SS=E	<p>INITIAL COMMENTS</p> <p>A standard Health survey was initiated on 11/07/11 and concluded on 11/10/11 and a Life Safety Code survey was conducted on 11/07/11 through 11/08/11 with the highest scope and severity of an "F". The facility had the opportunity to correct deficiencies before remedies would be imposed.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure resident wheelchairs were maintained and in good condition for six (6) of the thirty-five (35) facility residents utilizing wheelchairs for mobility (Resident #9 and unsampled resident's A, B, C, D, and E).</p> <p>The findings include:</p> <p>Interview with the Administrator, on 11/10/11 at 3:15 PM, revealed the facility did not have a policy on maintenance or care of resident equipment or assistive devices.</p> <p>Observation of the meal service in the dining room, on 11/09/11 at 11:55 AM, revealed unsampled resident B sitting in a wheelchair with</p>	F 000 F 253	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Crestview Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>F 253</p> <p>1. The cracked or torn wheelchair arms belonging to resident #9, and unsampled residents A, B, C, and D were replaced on 11/09/2011 & 11/10/2011 by the Maintenance Director.</p> <p>2. Inspection of all wheel chairs in the facility was completed on 11/10/2011 by the Maintenance Director. Any repairs that were needed were completed on 11/10/2011 by the Maintenance Director.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X8) DATE 12-9-11

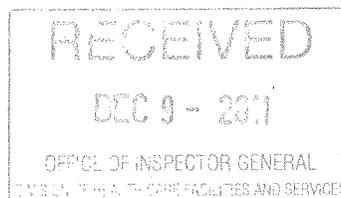
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 253	<p>Continued From page 1</p> <p>bilateral wheelchair arms cracked, peeled vinyl covering and exposed netting. Unsampled resident A was sitting in a wheelchair with the right arm surface cracked and rough to touch. Unsampled resident E was sitting in a wheelchair with the right arm surface cracked, vinyl peeled away exposing the netting.</p> <p>Observation of unsampled resident D, on 11/09/11 at 2:00 PM, revealed the surface of the right arm of the wheelchair cracked and rough to touch.</p> <p>Observation of Resident #9, on 11/09/11 at 3:00 PM, revealed the Resident sitting in the hallway in a wheelchair talking to another resident. The right arm of the wheelchair was cracked.</p> <p>Observation of the living room during an activity, on 11/10/11 at 9:00 AM, revealed unsampled resident C sitting in a wheelchair with the right arm surface cracked.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 11/10/11 at 10:45 AM, revealed she did not notice the condition of the wheelchair arms. The CNA revealed maintenance concerns are documented in the log book located at the nursing station. The CNA further revealed the third shift is responsible to clean the wheelchairs. The CNA revealed wheelchairs are monitored during cleaning and while transferring residents to the wheelchairs. The CNA stated a potential for skin tears with wheelchair arms cracked and peeling.</p> <p>Interview with Registered Nurse (RN) #2, on 11/10/11 at 11:00 AM, revealed wheelchairs are</p>	F 253	<p>3. Staff to include Department heads, maintenance and nursing have been re-educated as of 12/06/2011, by the Administrator and Director of Nursing, to monitor the condition of wheelchair arms for signs of wear and to report any concerns to maintenance by documenting in the Maintenance Log. The Maintenance Director will review the log 5 days per week and make repairs as needed. Wheelchair inspections have been added to the computerized audit tool to be completed monthly by the Maintenance Director.</p>	



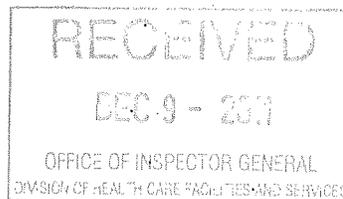
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F 253	<p>Continued From page 2</p> <p>monitored during resident transfer and during cleaning by the night shift. Concerns are reported to maintenance or written in the log book at the desk. Wheelchairs are cleaned according to grouping and rotated daily. A potential for skin tears, to the resident's arms, if not maintained.</p> <p>Interview with RN #3, on 11/10/11 at 1:10 PM, revealed a potential for skin tears or skin breakdown if the wheelchair arms are not maintained. Everyone is responsible to monitor the condition of the wheelchairs.</p> <p>Interview with the Unit Coordinator, on 11/10/11 at 1:25 PM, revealed wheelchairs are monitored by looking at each wheelchair everyday and immediately report any concerns to maintenance. The Unit Coordinator revealed wheelchairs are on a cleaning schedule, each wheelchair is cleaned and inspected at least once a week. The Unit Coordinator revealed she was not aware of the wheelchair conditions and stated a potential for skin tears to the resident if not well maintained. She further revealed everyone was responsible to monitor the wheelchairs.</p> <p>Interview with the Maintenance Director, on 11/10/11 at 2:00 PM, revealed he is notified by the staff when there is a problem with the wheelchairs or concerns are documented in the log book which is checked daily. The Maintenance Director revealed he also does a monthly walk through using a computerized audit, however he was not sure if assistive devices were included in the audit. Further interview, on 11/10/11 at 3:00 PM, revealed assistive devices were not included in the auditing tool.</p>	F 253	<p>4. The Maintenance Director will complete an audit once a week for (4) weeks and then once a month for two (2) months, to identify any wheelchairs in need of repairs. A summary of these findings will be submitted to the Performance Improvement Committee by the Maintenance Director monthly for three (3) months for review and further recommendations.....</p>	



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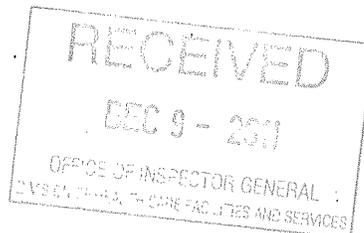
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F 253	Continued From page 3 Interview with the Director of Nursing (DON), on 11/10/11 at 1:40 PM, revealed wheelchairs are monitored during a walk through and during weekly washing. The DON revealed there is no auditing tool utilized during the walk through nor is there an inspection tool utilized during weekly cleaning and inspection.	F 253	5. Date of compliance: 12/09/2011.	
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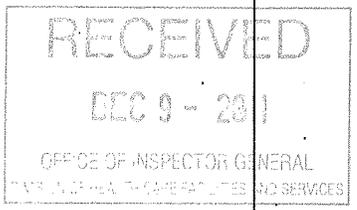
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105409	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 -MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2011
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1964, 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V Unprotected</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system</p> <p>GENERATOR: Type II generator, fuel source is diesel.</p> <p>A standard Life Safety Code survey was initiated on 11-07-11, and concluded on 11-08-11. Crestview Care and Rehab was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for fifty eight (58) beds and the census was fifty two (52) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Crestview Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	



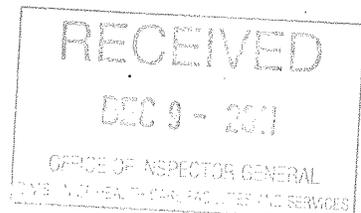
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Christina Seaman</i>	TITLE <i>Administrator</i>	(X8) DATE <i>12-9-11</i>
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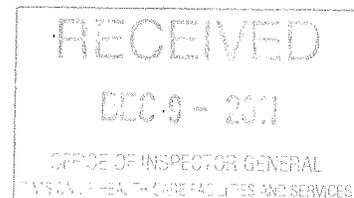
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K 000	Continued From page 1	K 000		
K 027 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for fifty eight (58) beds, with a census of fifty two (52) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 11/07/11 at 3:35 PM, with the Maintenance Director revealed the smoke doors located in the 100 Hall, would not close completely.</p> <p>Interview, on 11/07/11 at 3:35 PM, with the</p>	K 027	<p>K 027</p> <ol style="list-style-type: none"> 1. Smoke Doors located in the 100 hall were sanded and planed by the Maintenance Director, on 11/08/2011, and now close completely. 2. The Maintenance Director completed an audit on 11/11/2011 to determine that all smoke doors in the facility closed completely. No other issues were identified. 3. Maintenance Director was re-educated on 12/06/2011 by the Administrator regarding the standard that all cross corridor doors located in a smoke barrier would close and resist the passage of smoke and to complete a weekly inspection of all fire doors in the facility. 4. The Maintenance Director will complete an audit once a week for (4) weeks and then once a month for two (2) months ensure the doors in smoke barriers close and resist the passage of smoke. A summary of these findings will be submitted to the Performance Improvement Committee by the Maintenance Director, monthly times three (3) months for review and further recommendations. 	



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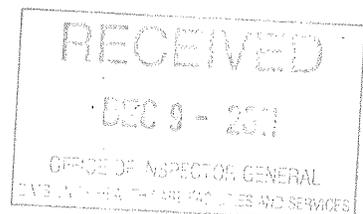
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K 027	Continued From page 2 Maintenance Director revealed the doors were just painted the previous week and they were not aware they would not close properly.	K 027	5. Date of compliance: 12/09/2011.	
K 050 SS=F	Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and fire drill review it was determined the facility failed to ensure fire drills were conducted at unexpected times under varied conditions in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for fifty eight (58) beds with a census of fifty two (52) on the day of the survey. The findings include:	K 050 K 050	1. A fire drill was held by the maintenance director on 12/08/2011 at 12:45pm. 2. The administrator reviewed the previous logs by 12/09/11 of drills, dates, and times to validate other drills were conducted at various shifts and times. No residents were found to be affected. 3. Maintenance Director was re-educated 12/06/2011 by the Administrator regarding conducting fire drills at random times on each shift. A schedule of shifts and times for fire drills has been developed by the Maintenance Director and Administrator to conduct fire drills at different times on all shifts.	



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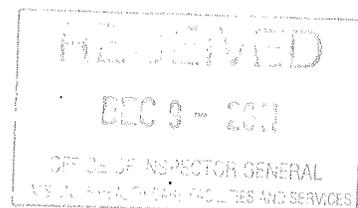
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K 050	Continued From page 3 Fire Drill review, on 11/08/11 at 9:00 AM, with the Maintenance Director revealed the fire drills were not being conducted at unexpected times under varied conditions. First shift fire drills were being conducted predictably between 9:30 AM to 10:00 AM and Second shift fire drills were conducted predictably at 3:30 PM. Interview, on 11/08/11 at 9:00 AM, with the Maintenance Director revealed he was not aware the fire drills were not being conducted as required. Reference: NFPA Standard NFPA 101 19.7.1.2, Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050	4. The Maintenance Director will complete an audit once a week for (4) weeks and then once a month for two (2) months to determine that fire drills are conducted at random times on each shift. A summary of these findings will be submitted to the Performance Improvement Committee by the Maintenance Director, monthly times three (3) months for review and further recommendations. 5. Date of compliance: 12/09/2011.	
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 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for fifty eight (58) beds with a census of	K 062	1. Items stored within 18 inches of sprinkler head in the closet of the Admissions/Social Services Office were immediately removed by the Maintenance Director on 11/09/2011. 2. Residents residing in the facility have the potential to be affected. The Maintenance Director completed an audit of the facility on 11/09/2011 to determine that no other items were being stored within 18 inches of sprinkler head. No other concerns were identified.	



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K 062	Continued From page 4 fifty two (52) on the day of the survey. The Findings Include: Observation, on 11/07/11 at 2:10 PM, with the Maintenance Director revealed Items being stored within 18 inches of a sprinkler head located in the Admissions/Social Services Office. Interview, on 11/07/11 at 2:10 PM, with the Maintenance Director revealed they were aware items could not be stored within 18 inches of a sprinkler head, but not aware who placed the items so close to the sprinkler head. Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous 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.	K 062	3. Staff have been re-educated as of 12/06/2011 by the Administrator and Director of Nursing regarding storage of items stored within 18 inches of a sprinkler head. The Maintenance Director will make rounds at least monthly ongoing to ensure items are not stored within 18 inches of a sprinkler head. 4. The Maintenance Director will complete an audit once a week for (4) weeks and then once a month for two (2) months to monitor there are no items stored within 18 inches of any sprinkler head in the facility. A summary of these findings will be submitted to the Performance Improvement Committee by the Maintenance Director, monthly times three (3) months for review and further recommendations. 5. Date of compliance: 12/09/2011.		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids,	K 066	K 066 1. The open ash tray in the designated smoking area was immediately removed on 11/08/2011 by the Maintenance Director and was replaced with an approved NFPA ash tray.		



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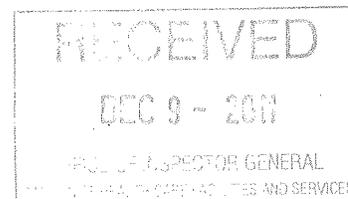
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NAME OF PROVIDER OR SUPPLIER CRESTVIEW CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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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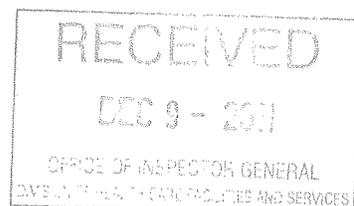
K 066	<p>Continued From page 5</p> <p>combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect residents, staff and visitors. The facility is licensed for fifty eight (58) beds with a census of fifty two (52) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 11/07/11 at 4:05 PM, with the Maintenance Director revealed an ashtray on a table in the designated smoking area of an</p>	K 066	<p>2. The Maintenance Director completed an audit of the facility on 11/08/2011 to determine that only NFPA ash trays were present in designated smoking areas.</p> <p>3. Maintenance Director and staff have been re-educated as of 12/06/2011 by the Administrator and Director of Nursing regarding the use of NFPA approved ash trays in all designated smoking areas. The Maintenance Director will make rounds at least monthly to determine that only approved ashtrays are in use within the facility.</p> <p>4. The Maintenance Director will complete an audit once a week for (4) weeks and then once a month for two (2) months to monitor the use of approved NFPA ash tray in all designated smoking areas. A summary of these findings will be submitted to the Performance Improvement Committee by the Maintenance Director, monthly times three (3) months for review and further recommendations.</p>	
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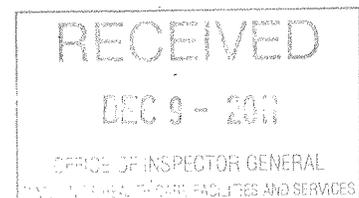
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185409	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2011
NAME OF PROVIDER OR SUPPLIER CRESTVIEW CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065	
(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 066	Continued From page 6 unapproved type. Interview on 11/07/11 at 4:06 PM, with the Maintenance Director revealed the ashtray would be removed and an ashtray of the approved type would be provided. Reference: NFPA Standard 101 (2000 Edition). 19.7.4 Smoking (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066	5. Date of compliance: 12/09/2011.	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for fifty eight (58) beds with a census of fifty two (52) on the day of the survey. The findings include:	K 072	K 072 1. All linen carts, ice carts and medication carts removed from the corridors on 11/8/11 by the Maintenance Director. 2. The Maintenance Director completed an audit of the facility 11/08/2011 to determine that each corridor was free of all obstructions or impediments to ensure full instant use in the case of fire or other emergency. No further issues were identified. 3. Staff have been re-educated as of 12/06/2011 by the Administrator and Director of Nursing regarding the storage of linen carts, ice carts, and med carts in the corridors and the need to maintain the means of an egress continuously.	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185400	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2011
NAME OF PROVIDER OR SUPPLIER CRESTVIEW CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065	
(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 072	Continued From page 7 Observation, on 11/07/11 at 1:55 PM, with the Maintenance Director revealed linen carts, ice carts, and med carts, were being stored in the 100, and 300 corridors. Interview, on 11/07/11 at 11:55 PM, with the Maintenance Director revealed the facility routinely stored linen carts, ice carts, and med 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	4. The Maintenance Director will complete an audit once a week for (4) weeks and then once a month for two (2) months to determine no furnishings or other objects are stored in the corridors. A summary of these findings will be submitted to the Performance Improvement Committee by the Maintenance Director monthly times three (3) months for review and further recommendations. 5. Date of compliance: 12/09/2011.	
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and Interview, it was determined the facility failed to maintain doors within a required means of egress in accordance with NFPA standards. This deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for fifty eight (58) beds, with a census of fifty two (52) on the day of the survey. The findings include: Observation, on 11/07/11 between 1:30 PM and 4:00 PM, with the Maintenance Director revealed	K 130	K 130 1. Slide bolt type lock identified on the public restroom door located in 100 Hall near the nurses station removed 11/09/2011 by the Maintenance Director. The flip down hold open devices on the exit door at the end of the 100 Hall, the 300 Hall, and the Front exit door were removed on 11/09/2011 by the Maintenance Director. 2. The Maintenance Director completed an audit of the facility doors on 11/10/2011 to inspect for other unapproved locks or hold open devices. No other concerns were identified.	



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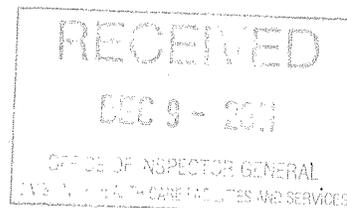
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185409	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2011
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NAME OF PROVIDER OR SUPPLIER CRESTVIEW CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065
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K 130	<p>Continued From page 8</p> <p>an unapproved lock (slide bolt type) was installed on the egress side of a public restroom door located in the 100 Hall, near the nurses' station. Further observation revealed the exit door at the end of the 100 Hall, the 300 Hall, and the Front exit door, had flip down hold open devices mounted on the bottom of the doors.</p> <p>Interview, on 11/07/11 between 1:30 PM and 4:00 PM, with the Maintenance Director revealed they were aware of the locks, and the flip down hold open devices, but not aware they could not be used.</p> <p>Reference: NFPA 101 (2000 Edition) 19.2.2.2.4</p> <p>Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.</p>	K 130	<p>3. Staff have been re-educated as of 12/06/2011 by the Administrator and Director of Nursing regarding the use of any slide locks or hold open devices on doors within the facility. The Maintenance Director will complete rounds of the facility at least monthly to monitor that no unapproved locking or hold open devices are in use.</p> <p>4. The Maintenance Director will complete an audit once a week for (4) weeks and then once a month for two (2) months to determine that no unapproved locking or hold open devices are in use in the facility. A summary of these findings will be submitted to the Performance Improvement Committee by the Maintenance Director, monthly times three (3) months for review and further recommendations.</p> <p>5. Date of compliance: 12/09/2011.</p>	
K 147 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for fifty eight (58) beds with a census of fifty two (52) on the day of the survey.</p>	K 147	<p>See Next Page.....</p>	



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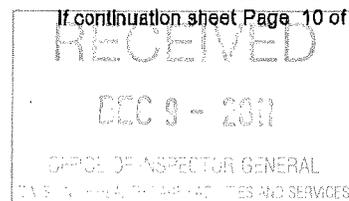
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185409	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2011
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NAME OF PROVIDER OR SUPPLIER CRESTVIEW CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1671 MIDLAND TRAIL SHELBYVILLE, KY 40065
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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 147	<p>Continued From page 9</p> <p>The findings include:</p> <p>Observation, on 11/07/11 between 1:00 PM and 4:30 PM, with the Maintenance Director revealed:</p> <ol style="list-style-type: none"> 1) A mattress pump and an oxygen concentrator plugged into a power strip located in room 113. 2) A resident bed and a nebulizer plugged into a power strip located in room 103. 3) Storage in front of electrical panels, and heat tape wrapped around sprinkler piping plugged into an extension cord that was plugged into a power strip, located in the Mechanical Room of the 100 Hall. 4) An oxygen concentrator and a mini nebulizer plugged into a power strip located in room 201. 5) A resident bed plugged into a multi plug extension cord located in room 302. 6) An extension cord plugged into a wall receptacle in the laundry room, penetrated the drywall behind the dryer to supply power for a wall receptacle in the resident corridor. <p>Interview, on 11/07/11 between 1:00 PM and 4:30 PM, with the Maintenance Director revealed they were not aware of the extension cords and power strips being misused, and storage in front of electrical panels was not permitted.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p>	K 147	<p>K 147</p> <ol style="list-style-type: none"> 1. Power strips identified in room 113, 103, 201, 302, in the Mechanical Room on 100 Hall were removed by the Maintenance Director by 11/08/2011. Stored items were immediately removed from in front of the electrical panels and the heat tape was removed by the Maintenance Director on 11-08-11. The extension cord in the laundry room was removed and the wall receptacle in the hall was removed and covered with a blank plate, by the Maintenance Director on 11/08/2011. 2. The Maintenance Director completed an audit of the facility 11/09/2011 and inspected every room for power strips/extension cords and inspected each electrical panel to determine nothing was being stored in front of the panels. No other issues were identified. 	
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NAME OF PROVIDER OR SUPPLIER CRESTVIEW CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40085	
(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)	(X6) COMPLETION DATE
K 147	Continued From page 10 Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. 110-26, Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K 147	3. Maintenance Director and staff have been re-educated as of 12/06/2011 by the Administrator and Director of Nursing regarding the use of power strips, extension cords and storing items in front of electrical panels. The Maintenance Director will make monthly rounds to determine that no power strips, extension cords, or items are stored in front of electrical panels ongoing. 4. The Maintenance Director will complete an audit once a week for (4) weeks and then once a month for two (2) months to monitor that no power strips, extension cords, or items are stored in front of electrical panels. A summary of these findings will be submitted to the Performance Improvement Committee by the Maintenance Director, monthly times three (3) months for review and further recommendations. 5. Date of compliance: 12/09/2011.	

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