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

PRINTED: 03/31/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185067		03/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CHARLES CARE CENTER	500 FARRELL DRIVE COVINGTON, KY 41011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The annual standard survey for recertification was conducted on 03/14/11 through 03/17/11. The facility was found to not meet the minimum regulatory requirements and a statement of deficiencies was issued with the highest S/S at a "F" level. The LSC Survey was conducted on 03/15/11. This was a NHI survey with entrance on 03/14/11 at 7:30pm.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to implement their policies and procedures related to abuse following an allegation of verbal abuse for one (1) of sixteen (16) sampled residents. Resident #1 stated a staff member told the resident they were "mean and rude". The resident perceived this to be verbally abusive. The facility failed to investigate this as a potential incident of abuse. The findings include: Review of the facility's abuse policy titled "Abuse Investigation" dated October 2000, revealed when a report of abuse are investigated according to state and federal requirements. When an incident or suspected incident of abuse is reported, the	F 226	St. Charles recognizes that the facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	4/15/11

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sr. Mary Luann Bender	Administrator	April 7, 2011

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

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F 226	Continued From page 1 Director of Nursing (DON), will investigate the incident. The investigation will consist of the following: b. an interview with the person (s) reporting the incident c. interviews with any witness (es) to the incident d. if possible, an interview with the resident e. a review of the resident's medical record f. if appropriate, an interview with staff members having contact with the resident during the period/shift of the alleged incident g. interview with the residen't roommate, family members, and visitors h. a review of all circumstances surrounding the incident The abuse policy revealed during the investigation, employee (s) will be barred from contact with residents of the facility. An interview with Resident #1 on 03/15/11 at 9:00am revealed when asked how he/she was treated by the staff, the resident stated they were called mean and rude by a staff member. Continued interview with Resident #1 on 03/15/11 at 1:15pm revealed when Resident #1 made a certain comment to a certain nurse in the past, the nurse "lashed out against me", calling Resident #1 mean and rude. Resident #1 stated he/she perceived it to be verbal abuse. Interview with the Director of Nursing (DON) on 03/16/11 at 2:15pm revealed she was aware of the incident Resident #1 was referring to and presented documentation (Resident concern process form) dated 09/13/10 where the incident was considered only a concern. The DON stated she did not view being told you are mean and	F 226	Upon notification of an allegation of verbal abuse by resident #1 an abuse investigation was initiated according to procedure by the DON (see attached).Employee involved was suspended until completion of the investigation. Interviews and statements from employees, residents, families and visitors were obtained. Interview with resident #1 was held along with review of his/her chart. Adult Protective and Cabinet were notified and within 5 days all required documents were faxed to the Cabinet for Health Services.	

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F 226	Continued From page 2 rude as abusive. Review of the concern process form dated 09/13/10 revealed Resident #1 had requested to see the Assistant Administrator to discuss the incident because it upset the resident. In addition, the written report revealed Resident #1 stated the same nurse had referred to the resident as "mean" on more than one occasion. The concern form further revealed Resident #1 stated he/she would like the treatment and attitude toward the resident by this employee to be addressed. Interview with the Assistant Administrator on 03/17/11 at 9:35am revealed she had not considered the incident to be an allegation of verbal abuse. She stated Resident #1 did request to speak with her regarding the incident and alleged the nurse told the resident he/she was being rude and mean. She acknowledged she had not interviewed any other residents or staff that had worked the day of the alleged incident. Interview on 03/17/11 at 9:35 with the DON revealed she had talked with Resident #1 on 09/14/10 and the resident told her the nurse had called the resident "rude and mean". However, she did not ask the resident how those statements made him/her feel and did not consider it to be verbal abuse. The DON further stated she believed no harm or intent was there which would constitute abuse. She indicated an investigation was not completed and the nurse was allowed to work. In addition, since the incident was not considered to be an allegation of abuse, the facility did not report the incident to the appropriate state agencies. The facility assessed Resident #1 to be	F 226	Policy and procedure on Abuse Investigation was revised and an Abuse Investigation Checklist was developed (see attached). The Assistant Administrator, DON and Social Service Director will be educated on abuse, reporting and investigation procedures by the Administrator. A mandatory scheduled in-service will be held for all employees by the Administrator, Social Service Director and DON (see attached in-service schedule). The DON will monitor the abuse investigation and adherence to abuse policy and procedure by utilizing the Abuse Investigation Checklist, which will be reviewed at the morning Administrative Meeting or as need makes evident. A report will be presented quarterly by the DON to the Quality Management Committee for twelve (12) months to ensure compliance.	

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F 226	Continued From page 3 interviewable with no cognition or memory recall impairment. Review of the most current Minimum Data Set (MDS) completed on 01/16/11 revealed the resident scored a 15 out of 15 on the Basis Interview for Mental Status.	F 226		
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. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the residents' environment remained as free from accident hazards as possible. Observation during the medication pass revealed the facility failed to ensure scissors were secured and not accessible to residents. The findings include: Interview on 03/16/11 at 2:50pm with the Director of Nursing revealed there is not a policy on the storage or securing of scissors. The facility follows no standard of practice related to scissors. Observation on 03/15/11at 8:30am revealed a pair of scissors was left unsecured on top of the	F 323	St. Charles recognizes that 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. Potential for 27 residents to be effected. On 3/16/11 scissors were removed from the top of 1st floor medication cart and placed in secured medication cart drawer. Medication carts on all units were inspected by DON and ADON. On 3/16/11 scissors were removed from the other two medication carts used in the facility and placed in secured medication cart drawer. Policy and Procedure was written to address resident safety regarding storing and securing of potentially hazardous objects (see attached). Each nurse and KMA will be educated on the policy and procedure on hazardous objects by the DON and ADON.	4/27/11

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F 323	Continued From page 4 medication cart on the first floor long hall and accessible to residents. Interview on 03/15/11at 10:13am with LPN #1 revealed she did leave scissors on top of the medication cart while passing the morning medications. It was further revealed when she enters a room while passing medications, the scissors are not secured and remain in a cup holder placed on top of the medication cart, accessible to residents. It was revealed there are residents present with known aggression. LPN#1 stated scissors could be of potential harm to residents. Interview on 03/16/11 at 2:10pm with CNA #1 revealed scissors could be harmful. It was stated residents could hurt themselves or others. Per CNA #1, "You have got to put everything up."	F 323	During each shift, the supervisor or his/her designee will inspect medication carts for sharp objects using form NSAF67aF (see attached). This form will be reviewed daily with appropriate follow-up by the DON, ADON & Supervisor in the daily nurses' meeting. Currently this will allow for monitoring of an average of 3 staff per shift for a total of 9 staff in a 24 hour period. All new RN,LPN and KMA hires will be educated by the DON,ADON or Supervisor on the policy and procedure on storing and securing potentially hazardous objects. A report will be presented quarterly by the DON to the Quality Management Committee for twelve (12) months to ensure compliance.	
F 371 SS=E	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 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined the facility failed to store food under sanitary conditions. Observation revealed multiple food containers opened with no	F 371	St. Charles recognizes that it must procure food from sources approved or considered satisfactory by Federal, State or local authorities: and store, prepare, distribute and serve food under sanitary conditions. Food items opened in the main freezer, including the mixed vegetables, corn, carrots, breaded chicken patties, garlic bread sticks, and individual packaged servings of pureed chili were discarded.	4/15/11

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F 371	Continued From page 5 date in the main freezer. The findings include: Review of the facility's policy "Food Storage" (Number FP3a) dated 05/2008, revealed when any food is opened it must be clearly marked with the date on which it was opened. Observation on 03/14/11 at 7:40pm revealed several opened items in the main freezer that were not dated. The food items included: mixed vegetables, corn, carrots, breaded chicken patties, garlic bread sticks, and individual packaged servings of pureed chili. Interview with the Dietary Manager on 03/16/11 at 2:45pm revealed she was aware of the frozen, opened items in the main freezer that were not labeled for date opened. The Dietary Manager stated she did not realize that the opened frozen items needed to be dated and was unaware of what the facility's policy stated.	F 371	Dietary Manager was educated on the food storage policy and procedure by the Assistant Administrator. The Dietary staff will be in- serviced by the Dietary Manager on the food storage policy and revised procedure on dating and labeling items when opened (see attached). Dietary staff will be in-serviced by 4/15/11. The Dietary Supervisor will monitor daily the dating and labeling of any opened food items utilizing the food storage log (see attached). The Dietary Manager will review weekly,the completed food storage log, as well as inspect food items for dates and labels. A report will be presented quarterly by the Dietary Manager to the Quality Management Committee for twelve(12) months to ensure compliance.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425	St. Charles recognizes the facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in 483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate	4/22/11

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F 425	Continued From page 6 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure a recommendation for a change in drug therapy from the pharmacist was followed up for one (1) resident out of a sample of sixteen (16). Resident #2 had a recommendation from the pharmacist dated 01/31/11 to discontinue Vistaril 25 mg and it was not acted upon by the physician until 03/16/11. The findings include: The facility was unable to produce a policy related to recommendations from pharmacists and how to process them. Review of the clinical record revealed Resident #2 was admitted to the facility on 06/09/10 with the following diagnoses: gastro-intestinal bleed, depression, debility, dementia, history of falls and psychosis. Record review of a physician order dated 12/29/10 revealed an order for Vistaril 25 mg, one capsule, by mouth, daily at 9:00 am. Review of the pharmacy recommendation sheets revealed the pharmacist made a recommendation on 01/31/11 concerning the Vistaril order. The pharmacist requested the physician discontinue	F 425	acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. The attending physician was called and the order for Vistaril 25mg was discontinued for resident #2. The charts of all residents were checked for pharmacy recommendations by the ADON and DON with appropriate follow-up. A Pharmacy Recommendations policy and procedure was developed addressing timely follow-up(see attached).License nursing staff will attend a mandatory in-service on the policy and procedure by the DON and ADON. Compliance with policy and procedure on Pharmacy Recommendations will be monitored by DON and ADON to assure that recommendations are addressed in a timely manner. Monitoring will occur utilizing the Pharmacy Recommendation Log (see attached).	

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F 425	Continued From page 7 the Vistaril because the drug use was not recommended in patients greater than 65 years old due to increased sedation and anticholinergic effects in the elderly. The pharmacist requested the physician to consider discontinuing the Vistaril and using Ativan. It was also noted that if the physician wished to continue the current therapy, it should be documented that the risk versus benefit had been considered. The pharmacist communication form dated 01/31/11, was first noted to be faxed on 02/14/11, and faxed again on 03/02/11. There was no response from the physician noted in resident's record. Observations of Resident #2 on 3/15/11 at 8:45am, 12:10pm, and 2:45pm revealed the resident with eyes closed. Further observation of Resident on 3/16/11 at 9:15am and 9:51am revealed resident with eyes closed. Interview with the Assistant Director of Nursing (ADON) on 03/16/11 at 1:30pm revealed she is the one who initially faxes the pharmacist communication form to the physicians for residents residing on 2 South. She did not have an explanation as to why it had been two weeks from the time of receiving the recommendation to the time she faxed the physician. She stated the form had been refaxed to the physician on 03/04/11 and to date, the facility still had not heard back from the physician. She stated if the Vistaril was causing increased sedation, this could effect a resident's quality of life. She indicated the physician should have been called when he did not respond. Interview with the Director of Nursing (DON) on	F 425	A report will be presented quarterly by the ADON to the Quality Management Committee for twelve (12) months to ensure compliance.	

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F 425	Continued From page 8 03/17/11 at 11:45am revealed the pharmacy e-mails the pharmacist recommendations to her, she then faxes the recommendations to each resident's physician on the first floor and gives the recommendations for residents on the second floor to the ADON. The DON stated the expectation is for the pharmacy recommendation forms to be faxed within 24 hours of receipt. She stated the form should have been faxed earlier than two weeks from receipt and the physician should have been contacted when there was no response. The DON stated that while she did not consider this a critical error, it could effect a resident's quality of life.	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	St. Charles recognizes that 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.	4/26/11

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F 441	Continued From page 9 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to consistently implement their infection control policy and procedure to assure a sanitary environment was maintained. Observation of the 2 South pink shower room revealed two bedside commode containers with yellow fluid and brown smears inside the containers. Those containers were observed to be on the shower stall floor during multiple observations. The findings include: Observations on 03/16/11 at 8:45am, 9:15am, 9:45am, 10:00am and 11:15am revealed two bedside commode containers stacked one inside the other sitting on the floor of the pink-tiled shower room on 2 South. The bottom container had yellow colored liquid and the top container contained yellow colored liquid and brown smears on the inside of the container. There was a odor	F 441	All 22 residents on 2 South had the potential to be effected. On 3/16/11 bedside commodes/shower bucket chairs were immediately cleaned by the CNA's on duty. All bedside commodes/shower chair buckets were checked house wide and none were found to be soiled. A mandatory in-service will be held by DON and ADON on 4/19/11 to educate all CNA's on the procedure for cleaning bedside commode/shower chair buckets (see attached). All new hires will be educated to cleaning procedure for bedside commode/shower chair buckets. At the beginning of each shift, a CNA will be appointed by the unit nurse to check bedside commode/shower chair buckets and clean as necessary.	

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F 441	Continued From page 10 present in the pink-tiled shower room. Interview with CNA (certified nursing assistant) #4 on 03/16/11 at 11:20am revealed the cleaning of the bedside commode containers falls to whoever is aware they are soiled. CNA #4 stated it is usually the CNA's responsibility and they do not leave them dirty. CNA #4 also stated that housekeeping sanitizes those containers once a week. Interview with RN #2 on 03/16/11 revealed all staff are responsible to ensure the bedside commode containers are kept clean. RN #2 stated she was unsure why the soiled containers were left in the shower room. She further stated it is an infection control issue to leave them sitting on the floor in the shower area.	F 441	The appointed CNA will report findings to nurse on duty or supervisor using form NES1cF (see attached). Weekly infection control rounds will be completed by ADON and DON using form INF1bF1 (see attached). The ADON will monitor the facility's plan to assure compliance achieved and sustained. Compliance will be monitored by using the End of Shift Report Form NEScIF completed by CNA's and weekly Infection Control Rounds Form INF1bF1 completed by ADON. An average of 21 CNA's will be monitored daily for procedure compliance. A report will be presented quarterly by the ADON to the Quality Management Committee for twelve (12) months to ensure compliance.	

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185067	A. BUILDING 01 - ST. CHSRLES CARE CEN B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CHARLES CARE CENTER	500 FARRELL DRIVE COVINGTON, KY 41011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 03/15/2011. The facility was found not to meet the minimal requirements with 42 Code of Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was at "F" level.	K 000		
K 021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors located in the corridors where held open only by approved devices, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) smoke compartments, 28 residents, staff and visitors.	K 021	St. Charles recognizes that the facility must meet the minimum requirements with 42 Code of Federal Regulations, Part 483.70.	3/18/11

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sr. Mary Joann Bender	Administrator	April 7, 2011

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 021	Continued From page 1 The findings include: Observation on 03/15/2011 at 10:20 AM, revealed wooden chocks holding the doors open to the copier room and front office located on one (1) West. During the survey wooden chocks were observed holding doors open for Medical records, Recreation Therapy, and the Activities room. The observations were confirmed with the Maintenance Director. Interview on 03/15/2011 at 10:20 AM, with the Maintenance Director, revealed the facility had been told not to use the wedges in the past. Reference: NFPA 101 (2000 edition) 19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility.	K 021	On March 15, 2011 wooden door chocks holding the doors open to the copier room, front office located on one West, Medical records, Recreation Therapy and the Activities room were removed by the Maintenance Director. The Maintenance Director went through the entire facility to check and remove all door chocks. All staff members were educated on the National Fire Protection Association (NFPA) standards ensuring that doors are not propped open. Beginning March 15, environmental rounds will be made and documented weekly by the Maintenance Director to monitor that wooden door chocks or any type of door props are not being used. These weekly rounds will be documented on the door holding device inspection log.(see attached) The door holding device inspection log will be reviewed quarterly by administration. A report will be presented quarterly by the Maintenance Director to the Quality management Committee for twelve (12) months to ensure compliance.	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	St. Charles recognizes that exit access must be arranged so that exits are readily accessible at all times in accordance with section 7.1.19.2.1.	4/8/11

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K 038	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access was maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) smoke compartment, twenty eight (28) residents, and visitors. The findings include: Observation on 03/15/2011 at 10:16 AM, revealed the exit door for 1 West was secured with a magnetic lock using a keypad combination. The combination was not posted, and the door was not equipped with a delayed egress device. The door was not near a nurse's station. The observation was confirmed with the Maintenance Director. Interview on 03/15/2011 at 10:16 AM, with the Maintenance Director, revealed the door would release with the combination lock or when the fire alarm activated. The Maintenance Director confirmed the door was not equipped with a delayed egress device and staff for the area left at 5:00 PM. Further interview, with the Maintenance Director, revealed the combination to the keypad was not posted due to wandering residents using the area. NFPA reference: NFPA 101 (2000 edition)	K 038	On March 15, the combination to the keypad was posted on the 1 West door. The Maintenance Director will post combinations by all keypad doors throughout the facility. The Maintenance Director will educate staff on the postings. Environmental rounds will be made and documented weekly by the Maintenance Director to monitor that combination postings are in place and visible. These weekly rounds will be documented on the keypad combination log. (see attached) The keypad combination log will be reviewed quarterly by administration. A report will be presented quarterly by the Maintenance Director to the Quality Management Committee for twelve (12) months to ensure compliance.	

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K 038	Continued From page 3 19.2.2.2.4 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. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2:* Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.	K 038		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. 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:	K 050	St. Charles recognizes that fire drills must be conducted according to National Fire Protection Association standards. The fire drill procedure was revised, to include, that drills are held at unexpected times under varying conditions (see attached). The fire drill schedule will be revised to include the tracking of unexpected times of drills. The next three drills have been scheduled according to NFPA standards, varying times and shifts (see attached).	4/8/11

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K 050	Continued From page 4 Based on record review and interview, it was determined the facility failed to ensure fire drills were conducted, according to National Fire Protection Association. The deficiency had the potential to affect nine (9) smoke compartments, seventy five (75) residents, staff and visitors. The findings include: Record review of fire drills conducted by the facility, on 03/15/2011 at 12:20 PM, revealed fire drills on 2nd shift were only conducted between 6:30 AM and 6:34 AM. Further record review revealed fire drills on 3rd shift were only conducted between 4:00 PM and 4:30 PM. The observations were confirmed with the Maintenance Director. Interview on 03/15/2011 at 12:20 PM, with the Maintenance Director, indicated the facility would change its current policy on when fire drills were conducted.	K 050	The fire drill schedule will be reviewed by the Maintenance Director monthly. The fire drill schedule will be reviewed quarterly by administration. A report will be presented quarterly by the Maintenance Director to the Quality Management Committee for twelve (12) months to ensure compliance.	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to use extension cords, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect four (4) smoke compartments, forty eight (48) residents, staff and visitors.	K 147	St. Charles recognizes that electrical wiring and equipment must be in accordance with NFPA 70, National Electrical Code.9.1.2. Extension cords being used for the entertainment center in the 1st floor Gathering Space, for the televisions in resident room 150, 151, and 215 have been removed. The coffee pot, located in Medical Records, has been removed. All extension cords have been removed throughout the facility. Staff will be educated by the Human Resource Coordinator through the employee newsletter that extension cords may not be used.	4/26/11

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K 147	Continued From page 5 The findings include: Observation on 03/15/2011 at 10:23 AM, with the Maintenance Director, revealed an extension cord being used to supply electrical power on a permanent basis to the entertainment center in the 1st floor Gathering Space. Further observation, with the Maintenance Director, revealed extension cords being used to supply electrical power on a permanent basis to televisions in resident rooms 150, 151, and 215 Observation on 03/15/2011 at 11:05 AM, with the Maintenance Director, revealed an extension cord being used to supply electrical power on a permanent basis to a coffee pot, located in the Medical Records Office. Interview on 03/15/2011 at 10:23 AM, with the Maintenance Director, revealed the facility does need to add electrical plugs to meet the needs of the facility and residents. Reference: NFPA 99, Chapter 3 Electrical Systems. 3-3.2.1.2 D 2. 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. 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: 1. As a substitute for the fixed wiring of a structure	K 147	Resident and visitors will be informed by the Social Service Department upon admission and through the Social Service Newsletter that extension cords may not be used. Environmental rounds will be made and documented weekly by the Maintenance Director to monitor that extension cords are not being used. These weekly rounds will be documented on the extension cord monitoring log (see attached). The extension cord monitoring log will be reviewed quarterly by administration. A report will be presented quarterly by the Maintenance Director to the Quality Management Committee for twelve (12) months to ensure compliance.	

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K 147	Continued From page 6 2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code.	K 147		

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