

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

PRINTED: 04/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

RECEIVED  
MAY 2013  
OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186262	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/11/2013
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NAME OF PROVIDER OR SUPPLIER  SHADY LAWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2682 CERULEAN RD. CADIZ, KY 42211
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS  A recertification survey was conducted on 04/09/13 through 04/11/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of a "F".	F 000	Plan of Correction Disclaimer for Shady Lawn Nursing and Rehab The Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because of State and Federal requirement.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.  The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.  The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	F 164 Privacy, confidentiality  1. An observation by the Director of Nursing on 4/15/13 noted that while care was being provided to resident # 1, the privacy curtain was pulled and the door was closed. 2. An observation by the Director of Nursing on 4/15/13 noted staff to be performing care to all residents with the privacy curtains pulled and doors closed with no concerns related to privacy and dignity noted. 3. All direct care staff will be re-educated on providing privacy during care. The re-education will be provided by the Director of Nursing or Assistant Director of Nursing by 5/9/13 with no direct staff working after 5/9/13 without having received training. 4. The Director of Nursing and Assistant Director of Nursing will observe direct staff providing care five (5) times weekly for two (2) weeks; then, once a week for four (4) weeks; then monthly for two (2) months to assure resident privacy and dignity are maintained including pulling of the privacy curtains and closing of doors. The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dorinda D</i>	TITLE Admin	(X6) DATE 5/3/13
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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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F 164	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy and procedure, it was determined the facility failed to ensure privacy and confidentiality for one (1) resident (#1), in the selected sample of twelve (12) residents.</p> <p>Findings include:</p> <p>A review of the facility's policy and procedure, titled "QUALITY OF LIFE-DIGNITY", dated October 2009, revealed "residents shall be treated with dignity and respect at all times and resident's privacy, space and property will be respected at all times."</p> <p>A record review revealed Resident #1 was admitted to the facility on 08/13/12 with diagnoses to include Hypothyroidism, Diabetes Mellitus II, Senile Dementia, Mood Disorder, Schizophrenia, Psychosis, Generalized Anxiety, Depression, Chronic Pain, Hypertension, Hypotension, Constipation, Arthropathy, Insomnia, and Degenerative Joint Disease.</p> <p>Observation on 04/11/13 at 10:00 AM of a dressing change to Resident #1 revealed during the dressing change procedure, the privacy curtain was not pulled and the door to the resident's room remained open. The roommate was in the room and sitting up on the side of the bed. Resident #1 was in full view of the roommate and in view of anyone on the hall.</p> <p>An interview on 04/11/13 at 10:40 AM, with Licensed Practical Nurse (LPN) #1, revealed she</p>	F 164	Administrator, the Assistant Director of Nursing and the Social Services Director, with the Medical Director attending at least quarterly.	05/10/13	

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F 164	Continued From page 2 did not pull the privacy curtain or close the door to the resident's room prior to beginning the dressing change and he/she knew it should have been done.	F 164			
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE  An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure one (1) resident (#7), in the selected sample twelve (12) residents, was appropriately assessed for self-administration of medication. Resident #7 had two (2) diskus inhalers at beside.  Findings include:  Interview with the Director of Nursing, on 04/11/13 at 12:24 PM, revealed there was no policy for self-administration of medications.  A record review revealed Resident #7 was admitted to the facility on 12/06/11 with diagnoses to include Peripheral Vascular Disease, Chronic Airway Obstruction, and Circulatory Disease. A review of the Admission Data Set assessment, dated 08/01/12 and completed by the Assistant Director of Nursing (ADON), revealed Resident #7 was not assessed to self-administer medication. A review of the quarterly Minimum	F 176	F 176 Self Administrating of Medication  1. The Director of Nursing discussed with Resident # 7 completion of the Assessment for Self administration of Medication and Resident # 7 declined to self administer medications. An observation by the Director of Nursing on 4-15-2013 noted that there were no medications at bedside for resident # 7 and resident # 7's inhalers were located in the medication cart. 2. An audit of all residents will be completed by the Director of Nursing by 5-9-2013 to identify any resident who wished to self administer medication. Any identified as wishing to self administer medications will have a self administration assessment completed to determine if the resident is safe to self administer medications. 3. All Licensed staff will be re-educated on completion of the self administration of medication assessment if a resident wishes to self administer medications to include obtaining a physician order. This re-education will be completed by the Director of Nursing or Assistant Director of Nursing by 5-9-2013 with no staff working after 5-9-2013 without having received this re-education.		

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F 176	<p>Continued From page 3</p> <p>Data Set (MDS) assessment, dated 01/21/13, revealed the facility assessed Resident #7 as cognitively intact. A review of the Comprehensive Care Plan, dated 02/18/13, revealed there were no interventions for Resident #7 to administer his/her medications or to keep medications at bedside.</p> <p>A review of the Physician's Orders, dated April 2013, revealed Resident #7 should receive one (1) puff of Advair 250-20 Diskus, by mouth daily at 8:00 AM and 8:00 PM, and two (2) times per capsule of Spiriva 16 mcg CP-Inhaler every day.</p> <p>Observation on 04/09/13 at 6:44 PM revealed two diskus inhalers, (an Advair diskus and a Spiriva handihaler) lying in Resident #7's wheelchair in the resident's shared room. Further observation at 6:52 PM with Certified Nursing Assistant (CNA) #3 revealed the two diskus inhalers still lying in Resident #7's wheelchair. CNA #3 picked up the inhalers out of the wheelchair, gave them to Resident #7 and stated "Resident #7 keeps them in the room". Resident #7 placed the respiratory medications on the over the bed table at bedside.</p> <p>Interview with Registered Nurse (RN) #2, on 04/09/13 at 7:08 PM, revealed Resident #7 liked to have the respiratory medication after he/she ate but the RN removes the medication after the resident was through with it. RN #2 proceeded to go to Resident #7's room and remove the respiratory medications from Resident #7's room.</p> <p>Further observation and interview with RN #2, on 04/09/13 at 8:05 PM, revealed RN #2 reviewed the Admission Data Set, dated 08/01/12 and stated "It was not marked for Resident #7 to</p>	F 176	<p>4. The Director of Nursing will audit five (5) records per week for four (4) weeks, followed by three (3) records per week for eight (8) weeks to determine if the resident wishes to self administer their medications and if the resident wishes to self administer medications that an assessment for self administration of medication is completed. The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, the Administrator, The Assistant Director of Nursing and the Social Services Director, with the Medical Director attending at least quarterly</p>	5/10/13
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F 176	Continued From page 4 administer his/her own medication, so I'm going to mark it yes because the resident keeps the medicine at bedside, and it should have been marked on the assessment when the assessment was completed. RN #2 asked for a pen from the Director of Nursing (DON) and proceeded to mark yes on the Admission Data Set.  An interview with the ADON, on 04/9/13 at 8:55 PM, revealed the Admission Data Set was filled out correctly and the marking of "yes" by RN #2 was going to be errored out.  An interview with the DON, on 04/11/13 at 10:35 AM, revealed the medicine was not expected to be left at the bedside of a resident.	F 176		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure appropriate care and services in accordance with the resident's written plan of care for one resident (#8), in the selected sample of twelve (12) residents. Resident #8 was observed transferred by one staff but the resident was care planned for the assistance of two staff	F 282	F 282 Services by Qualified person/per care plan  1. An observation by the Director of Nursing on 4/11/13 of transfer of resident #8 revealed use of the sit to stand lift and two (2) person assist. 2. An observation by the Director of Nursing on 4/11/13 of resident transfers noted that transfers were occurring as care planned with the appropriate number of staff and equipment. No concerns were identified. 3. All direct care staff will be re-educated on following the care plan to include transfers and use of lift equipment. This re-education will be provided by the Director of Nursing or Assistant Director of Nursing by 5/9/13 with no direct staff working after 5/9/13 without receiving training.	

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F 282.	<p>Continued From page 5 for transfers.</p> <p>Findings include:</p> <p>A review of the facility's policy and procedure, titled "Resident Comprehensive Care Plan," dated 09/08, revealed "The residents comprehensive care plan should be viewed as an interdisciplinary approach to managing the acute and chronic needs of the resident living in the facility".</p> <p>A record review revealed Resident #8 was admitted to the facility on 01/16/04 with diagnoses to include Senile Dementia, Depressive Disorder, Cerebral Vascular Accident, Late effects Cerebral Vascular Disease, and Colostomy Status. A review of the annual Minimum Data Set (MDS) assessment, dated 01/21/13, revealed the facility assessed Resident #8 cognition as severely impaired.</p> <p>A review of the Comprehensive Care Plan, dated 01/21/13, revealed an intervention to use a Sit-to-Stand lift for transfers with two assist.</p> <p>Observation, on 04/09/13 at 6:30 PM, revealed Certified Nursing Assistant (CNA) #3 transferred Resident #8 out of his/her wheelchair with a sit to stand lift and placed the resident in the bed without another staff to assist and without the sit to stand lift.</p> <p>Interview with CNA #3, on 04/09/13 at 8:15 PM, revealed the CNA she transferred Resident #8 by herself when there should be two staff. CNA #3 stated two CNAs were on break and the other CNA was busy helping another resident, and Registered Nurse (RN) #2 was wanting the</p>	F 282.	<p>4. The Director of Nursing and Assistant Director of Nursing will monitor record reviews and observation of transfer of residents per plan of care five (5) times a week for two (2) weeks; then weekly for four (4) weeks; then monthly for two (2) months. The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, the Administrator, the Assistant Director of Nursing and the Social Services Director, with the Medical Director attending at least quarterly.</p>	5/10/13	

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F 282	Continued From page 6 resident in bed". The CNA revealed she usually transferred the resident to bed without the assistance of another staff.  Interview with RN #2, on 04/10/13 at 4:00 PM, revealed the CNAs should have another CNA assist them or call the nurse when a resident is a two assist. She stated the CNA should not try to transfer the resident by themselves. RN #2 further stated if the CNA cannot find another CNA to help, then they should get the charge nurse.  Interview with the Director of Nursing, on 04/11/13 at 10:35 AM, revealed she expected the staff follow the care plan.	F 282			
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, interview, record review, and facility policy review, it was determined the facility failed to ensure adequate supervision to prevent accidents for one resident (#8), in the selected sample of twelve (12) residents. Observation revealed CNA #3 transferred Resident #8 by herself from the resident's wheelchair to the bed even though the resident	F 323	F 323 Free of Accident Hazards/Supervision/Devices  1. An observation by the Director of Nursing on 4/11/13 of transfer of resident #8 revealed use of sit to stand lift and 2 person assist. 2. An observation by the Director of Nursing on 4/11/13 of resident transfers noted that transfers were occurring as care planned with the appropriate number of staff and equipment. No concerns were identified. 3. All direct care staff will be re-educated on following the care plan while performing resident care. The education will be provided by the Director of Nursing or Assistant Director of Nursing by 5/9/13 with no direct staff working after 5/9/13 without receiving re-education. 4. The Director of Nursing and/or Assistant Director of Nursing will monitor record reviews and observation of transfer of residents per plan of care five (5) time a		

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F 323	<p>Continued From page 7</p> <p>was assessed as needing two staff for transfers.</p> <p>Findings include:</p> <p>Review of facility's "Safety Summary" revealed the stand up lift may be operated by one (1) healthcare professional for ALL lifting preparation, transferring from and transferring to procedures with a cooperative, weight-bearing individual able to support the majority of his/her own weight. However, since medical conditions vary, the company recommended the healthcare/professional evaluate the need for assistance and determine whether more than one (1) assistant is appropriate in each case to safely perform the transfer.</p> <p>A record review revealed Resident #8 was admitted to the facility on 01/16/04 with diagnoses to include Senile Dementia, Depressive Disorder, Cerebral Vascular Accident, Late effects Cerebral Vascular Disease, and Colostomy Status. A review of the annual Minimum Data Set (MDS) assessment, dated 01/21/13, revealed the facility assessed Resident #8 cognition as severely impaired.</p> <p>A review of the Comprehensive Care Plan, dated 01/21/13, revealed an intervention to use a Sit-to-Stand lift for transfers with two assist. A review of a Multi-Disciplinary Therapy Screening tool, dated 03/19/12, revealed the facility assessed Resident #8 need a Sit-to Stand lift for transfers.</p> <p>Observation, on 04/09/13 at 6:30 PM, revealed Certified Nursing Assistant (CNA) #3 transferred Resident #8 out of his/her wheelchair and placed</p>	F 323	<p>week for two (2) weeks; then weekly for four (4) weeks; then monthly for two (2) months. The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, the Administrator, the Assistant Director of Nursing and the Social Services Director, with the Medical Director attending at least quarterly.</p>	05/10/13

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F 323	Continued From page 8 the resident in the bed without another staff to assist and without the lift to stand lift.  Interview with CNA #3, on 04/09/13 at 8:15 PM, revealed she transferred Resident #8 by herself when there should be two staff. CNA #3 stated two CNAs were on break and the other CNA was busy helping another resident, and Registered Nurse (RN) #2 was wanting the resident in bed. The CNA revealed she usually transferred the resident to bed without the assistance of another staff.  Interview with RN #2, on 04/10/13 at 4:00 PM, revealed the CNAs should have another CNA assist them or call the nurse when a resident is a two assist. She stated the CNA should not try to transfer the resident by themselves. RN #2 further stated if the CNA cannot find another CNA to help, then they should get the charge nurse.  Interview with the Director of Nursing, on 04/11/13 at 10:35 AM, revealed she expected the staff to transfer a resident with two staff if the resident was care plan for two assist with transfers.	F 323			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	F 441 Infection Control, Prevent Spread, Linens  1. An observation by the Director of Nursing on 4/15/13 noted perineal care to be provided appropriately and the hand hygiene policy being followed to include washing hands and changing gloves, on residents #5, #7 and #8 as well as colostomy care for resident # 8.  2. An observation by the Director of Nursing on 4/15/13 noted perineal care to be provided appropriately with direct care following the hand hygiene policy.		

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F 441	<p>Continued From page 9 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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</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 observation, interview, record review and facility policy review, it was determined the facility failed to provide a safe and sanitary environment for three (3) residents (#5, #7, and #8), in the selected sample of twelve (12) residents. The staff failed to wash hands before applying gloves and after removing gloves for Residents #5, #7 and #8 and during colostomy and stoma care for Resident #8.</p>	F 441	<p>3. All direct care staff will be re-educated on proper hand hygiene. The education will be provided by the Director of Nursing or Assistant Director of Nursing by 5/9/13 with no direct staff working after 5/9/13 without having received this re-education.</p> <p>4. The Director of Nursing and/or Assistant Director of Nursing will observe perineal and colostomy care five (5) times a week for two (2) weeks; then once a week for four (4) weeks; then monthly for two (2) months. The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, the Administrator, The Assistant Director of Nursing and the Social Services Director, with the Medical Director attending at least quarterly.</p>	05/10/13

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

PRINTED: 04/25/2013  
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/11/2013
NAME OF PROVIDER OR SUPPLIER  SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2682 CERULEAN RD. CADIZ, KY 42211		
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F 441	Continued From page 10  Findings include:  A review of the facility policy titled, "Hand Hygiene" revealed under the two-tier Transmission Based Precautions, Standard Precautions: the center will use standard precautions as approved by the CDC. Standard Precautions will be utilized on all residents which will include: 1. Hand washing- use hand hygiene after touching the following whether or not gloves are worn: Blood Body fluids, secretions, excretions, or contaminated items, after gloves are removed, between resident contact, between tasks and procedures on the same resident to prevent cross contamination of different body sites. 2. Gloves- put on clean gloves just before touching mucous membranes, and non-intact skin, change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Remove gloves before to another resident.  A review of the facility policy titled, "Recommendations" revealed indications for hand-washing and hand antisepsis states decontaminate hands after contact with a patient's intact skin (when taking a pulse or blood pressure, and lifting a patient), after contact with body fluids or excretions (mucous membranes, non-intact skin, and wound dressings) and if hands are not visibly soiled, if moving from a contaminated-body site to a clean-body site during patient care, after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient and after removing gloves.	F 441			

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 441	Continued From page 11  1. A review of facility policy on "Colostomy/Ileostomy Care Level III" revealed under STEPS IN THE PROCEDURE, 1. Place the clean equipment on the bedside table or over-bed table. Arrange the supplies so they can be easily reached. 2. Wash and dry your hands thoroughly. 3. Put on gown if soiling of clothing with feces is likely. 4. Put on gloves. 5. Remove drainage bag. 6. Remove gloves, wash hands, put on clean gloves. 13. Remove and discard gloves into designated container. Wash and dry your hands thoroughly. 14. Reposition the bed covers. Make the resident comfortable. 15. Place the call light within easy reach of the resident. 16. Clean the over-bed table and return it to its proper position. 17. Wash and dry your hands thoroughly.  A record review revealed Resident #8 was admitted to the facility on 01/16/04 with diagnoses that include Senile Dementia, Depressive Disorder, Cerebral Vascular Accident, Late effects Cerebral Vascular Disease, and Colostomy Status. A review of the annual Minimum Data Set (MDS) assessment, dated 01/21/13 revealed the facility assessed Resident #8 as cognitively intact.  Observation on 04/09/13 at 6:30 PM revealed Resident #8 was receiving peri-care and colostomy care from Certified Nurse Aide (CNA) #3. CNA #3 place a pair of gloves on her hands without washing her hands, pulled the colostomy supplies out of the closet, looked for supplies in a bedside table, pushed hair off of her face, and looked for supplies in the roommate's bedside table. The CNA proceeded to change the resident's brief. After completing incontinent	F 441			

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

PRINTED: 04/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

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F 441	<p>Continued From page 12</p> <p>care, the CNA proceeded to change the resident's colostomy bag and place the bag in the trash can. The CNA then used toilet paper to clean around the stoma, inside the area of the stoma, and clipped on a new colostomy bag. CNA#3 then removed her gloves, did not wash her hands; placed pillows and cushions around the resident, placed Resident #8's gown on the over the bed table. The gown fell to the floor and the CNA picked the gown up off the floor and placed it on the table again.</p> <p>Interview with CNA #3, on 04/09/13 at 8:15 PM, revealed she wore one pair of gloves during all the care she provided for Resident #8, which included peri-care and colostomy care. She stated she did not change gloves between areas of care and did not wash her hands when she left the room. She revealed she washed her hands when she entered the next resident's room. She further stated she should have washed her hands before and after she provided care to the resident.</p> <p>2. A record review revealed Resident #7 was admitted to the facility on 12/08/11 with diagnoses to include Peripheral Vascular Disease, Chronic Airway Obstruction, and Circulatory Disease. A review of a quarterly MDS assessment, dated 01/21/13, revealed the facility assessed Resident #7 as cognitively intact.</p> <p>Observation on 04/10/13 at 11:53 PM revealed of CNA #4 was a bedpan for Resident #4. The CNA placed gloves on both hands and pulled the privacy curtain, removed newspaper and reading books from the resident's lap. The CNA walked into the bathroom, picked up an unlabeled</p>	F 441		

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

PRINTED: 04/25/2013  
FORM APPROVED  
OMB NO. 0938-0361

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NAME OF PROVIDER OR SUPPLIER  SHADY LAWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2882 CERULEAN RD. CADIZ, KY 42211
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F 441	<p>Continued From page 13</p> <p>bedpan, came back to the resident's bedside, pulled down the resident's pants and placed the bedpan under the resident. CNA #4 removed the bedpan from underneath Resident #7 after the resident finished voiding, wiped the resident with wet wipes and pulled up the resident's pants. The CNA proceeded to take off the gloves, wash her hands and gave the resident back the reading material.</p> <p>Interview with CNA #4, on 04/10/13 at 12:38 PM, revealed she did not gather the items she needed to provide the care before putting on her gloves.</p> <p>3. A record review revealed Resident #5 was admitted to the facility on 10/22/12 with diagnoses to include Congestive Heart Failure, Hypertension, A-Fib, Hyperlipidemia, Esophageal Reflux, Depressive Disorder, Generalized Anxiety, Heart Valve Replacement, Renal Failure, and Muscle Weakness. A review of the admission MDS assessment, dated 10/28/12, revealed the facility assessed Resident #5's cognition as severely impaired.</p> <p>Observation on 04/11/13 at 9:58 AM revealed CNA #4 and CNA #5 providing peri-care to Resident #5. CNA #4 and CNA #5 assembled their supplies and applied gloves to both hands. The CNAs proceeded to transfer the resident to the bed from the wheelchair, take off the resident's shoes, raised the bed, pulled resident #5's pants down, remove the resident's brief and cleaned the resident with wet wipes. After providing the peri-care, the CNAs removed their gloves. CNA #4 left the room to get the charge nurse to put ointment on a reddened area of buttocks. CNA #4 did not wash hands upon</p>	F 441		

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 441	<p>Continued From page 14</p> <p>leaving the resident's room. CNA #4 then came back into the resident's room with Licensed Practical Nurse ( LPN) #3 and they both applied gloves without washing hands.</p> <p>Interview with LPN #3, CNA #4, and CNA #5, on 04/11/13 at 10:15 AM and 10:45 AM respectively, revealed they did not wash their hands before they applied their gloves and they should have.</p> <p>Interview with the Director of Nursing, on 04/11/13 at 10:35 AM, revealed staff should wash hands before and after gloving up and should change gloves between peri-care and colostomy care, and cleaning the stoma. The DON further stated she expected the staff to wash their hands after removing gloves when leaving a room, before going to another resident's room, and before gloving and conducting a procedure.</p>	F 441			

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

PRINTED: 04/25/2013  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  04/10/2013
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1964, 1982, 1993</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200)</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with twenty-two (22) smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type I generator. Fuel source is propane.</p> <p>A standard Life Safety Code survey was conducted on 04/10/2013. Shady Lawn Nursing Home was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for fifty (50) beds and the census was forty-five (45) 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><b>Plan of Correction Disclaimer for Shady Lawn Nursing Home</b></p> <p>The Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because of State and Federal requirement.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [Signature] TITLE: Admin (X5) DATE: 5/3/13

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

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

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  SHADY LAWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2582 CERULEAN RD. CADIZ, KY 42211
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K 000  K 027 SS=F	<p>Continued From page 1</p> <p>Deficiencies were cited with the highest deficiency identified at an "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-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 three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for fifty (50) beds and the census was forty-five (45) on the day of the survey. The facility failed to ensure two (2) doors in the smoke barriers had a gap less than 1/8 inch where the doors meet.</p> <p>The findings include:  Observation, on 04/10/13 PM with the Maintenance Supervisor, revealed the cross-corridor doors located at room #27 and</p>	K 000  K 027	<p><b>K027 Life Safety Code Standard</b></p> <p>1. The cross-corridor door located near room #27 was adjusted by the Maintenance Director on 04/10/2013 to ensure that it closes completely blocking the passage of smoke. The cross-corridor doors located near room #16 had the overlapping device adjusted outwards on 4/10/2013 to ensure to block the passage of smoke. The Administrator noted on 04/26/2013 that the cross-corridor doors near rooms # 27 and # 16 close appropriately to prevent the passage of smoke.</p> <p>2. All cross-corridor doors located at the facility smoke barriers will be inspected by the Maintenance Director, by 5/1/2013 to ensure they properly close blocking the passage of smoke. Any identified concerns will be corrected by 5/1/2013.</p> <p>3. The Maintenance Director was re-educated by the Administrator on 4/29/2013 related to cross-corridor doors located at facility smoke barriers must block the passage of smoke per NFPA guidelines.</p> <p>4. The Maintenance Director will audit all cross-corridor doors located at the smoke barriers of the facility, weekly for twelve (12) weeks to ensure those doors are closing properly and are blocking the passage of smoke. The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, the Administrator, the Assistant Director of Nursing and the Social Services Director, with the Medical Director attending at least quarterly.</p>	5/10/13
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  SHADY LAWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2582 CERULEAN RD. CADIZ, KY 42211
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K 027	<p>Continued From page 2</p> <p>room #18 would not close completely when tested, leaving a gap of approximately one-quarter of an inch or greater between the pair of doors and would not resist the passage of smoke.</p> <p>Interview, on 04/10/13 PM with the Maintenance Supervisor, revealed he was unaware the doors would not close all the way leaving a gap between the doors in the closed position.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>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.</p> <p>Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.</p>	K 027		
K 028 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are</p>	K 028		

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K 029	Continued From page 3 permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, twenty-six (26) residents, staff and visitors. The facility is certified for fifty (50) beds and the census was forty-five (45) on the day of the survey. The facility failed to ensure the dry storage room in the kitchen was properly separated.  The findings include:  Observation, on 04/10/13 at 11:45 AM with the Maintenance Supervisor, revealed the dry storage room in the kitchen did not have a closer added to either door of the room. This requirement is due to the storage of combustible items inside the area.  Interview, on 04/10/13 at 11:45 AM with the Maintenance Supervisor, revealed he was unaware the storage in a room determined whether the room was a hazardous storage area or not.  Reference: NFPA 101 (2000 Edition).  19.3.2 Protection from Hazards.	K 029	K029 Life Safety Code Standard  1. The Maintenance Director applied self closing devices to the two (2) doors located in the dry stock room of the kitchen area on 04/16/2013 to ensure the dry stock area will remain closed at all times.  2. The Maintenance Director inspected the entire facility on 04/16/2013 to ensure that any identified areas requiring self closures have self closures. None were identified.  3. Re-education for the Maintenance Director was completed by the Administrator on 04/29/2013 related to NFPA 19.2.3.1.  4. The Maintenance Director will audit self closing devices on the dry storage area of the kitchen weekly for twelve (12) weeks to ensure they are allowing the door to close properly. The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, The Administrator, The Assistant Director of Nursing and the Social Services Director, with the Medical Director attending at least quarterly	5/10/13	

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K 029	Continued From page 4 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029			
K 048 SS=F	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1	K 048			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186262	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  04/10/2013
NAME OF PROVIDER OR SUPPLIER  SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2692 CERULEAN RD. CADIZ, KY 42211	
(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 048	Continued From page 5  This STANDARD is not met as evidenced by: Based on interview and policy review, it was determined the facility failed to implement a proper Fire Safety Plan and Procedure Policy in the event of an emergency in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for fifty (50) beds and the census was forty-five (45) on the day of the survey. The facility failed to ensure smoke compartments were correctly identified on the evacuation plan.  The findings include:  Policy review, on 04/10/13 at 10:28 AM with the Maintenance Supervisor, revealed the facility's Fire Safety Plan and Procedure Policy did not have the internal evacuation floor plan labeled correctly. The plan showed a smoke compartment next to the DON office but there is no wall above the cross-corridor doors to make the area next to the kitchen a smoke compartment.  Interview, on 04/10/13 at 10:28 AM with the Maintenance Director, revealed he was unaware the smoke compartments were not correctly identified.  Actual NFPA Standard: 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every healthcare occupancy	K 048	K048 Life Safety Code Standard  1. The Maintenance Director removed all evacuation plans located throughout the facility and immediately re-constructed the plan showing proper smoke barrier labeling and evacuation plans on 04/16/2013.  2. The Evacuation plans located throughout the facility have been inspected by the Administrator on 04/18/2013 and determined to be labeled correctly showing the three (3) smoke compartments and the proper evacuation routes from any point in the facility.  3. The Maintenance Director was re-educated by the Administrator on 04/29/2013 of accurate labeling and evacuation procedures.  4. The Maintenance Director will monitor all floor plans displayed throughout the facility to ensure accuracy and proper labeling monthly for three (3) months. The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, the Administrator, the Assistant Director of Nursing and the Social Services Director, with the Medical Director attending at least quarterly.	5/10/13

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K 048	Continued From page 6 shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator's position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. 19.7.2 Procedure in Case of Fire. 19.7.2.1* For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the	K 048		

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NAME OF PROVIDER OR SUPPLIER  SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2882 CERULEAN RD. CADIZ, KY 42211		
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K 048	Continued From page 7 fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy's fire safety plan. 19.7.2.2 A written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire 19.7.2.3 All health care occupancy personnel shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions: (1) When the individual who discovers a fire must immediately go to the aid of an endangered person (2) During a malfunction of the building fire alarm system Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and	K 048			
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the	K 056			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2582 CERULEAN RD. CADIZ, KY 42211	
(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 056	<p>Continued From page 8</p> <p>building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, two (2) residents, staff and visitors. The facility is certified for fifty (50) beds and the census was forty-five (45) on the day of the survey. The facility failed to ensure all sprinkler heads in the same compartment would engage at the same heat level in room #26.</p> <p>The findings include:</p> <p>Observations, on 04/10/13 at 11:00 AM with the Maintenance Supervisor, revealed a standard response sprinkler head and quick response sprinkler head in the same compartment located in room #26.</p> <p>Interview, on 04/10/13 at 11:00 AM with the Maintenance Supervisor, revealed he was not aware that the sprinklers had to have the same engagement heat if the sprinkler heads are</p>	K 056	<p>K056 Life Safety Code Standard</p> <ol style="list-style-type: none"> <li>1. The Maintenance Director called Tri-State Fire Inspections on 04/12/2013 to come to facility and replace the standard response sprinkler located in room #26. Tri-State Fire Inspections came to facility on 4/23/2013 to measure the sprinkler head to be replaced. The sprinkler head located in room #26 will be replaced by 5/10/2013.</li> <li>2. The Maintenance Director and Tri-State Fire Inspection conducted an audit of all sprinkler heads, on 04/23/2013, to ensure that all current sprinkler heads had the same response time for the entire compartment. No other concerns were identified.</li> <li>3. The Maintenance Director was re-educated by the Administrator, on 04/29/2013, that all sprinkler heads have to have the same response time for the entire compartment.</li> <li>4. The Maintenance Director will conduct monthly audits of all sprinkler heads for three (3) months to assure sprinkler heads in the facility have the same response time in each compartment. The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, the Administrator, the Assistant Director of Nursing and the Social Services Director, with the Medical Director attending at least quarterly.</li> </ol>	5/10/13

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NAME OF PROVIDER OR SUPPLIER  SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2682 CERULEAN RD. GADIZ, KY 42211		
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K 058	Continued From page 9 located in the same compartment.  Reference: NFPA 13 (1999 Edition) 7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 058			
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Transferring of oxygen is:  (a) separated from any portion of a facility	K 143			

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K 143	<p>Continued From page 10</p> <p>wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to assure the room being used to transfer liquid oxygen was rated per NFPA requirements. The deficiency had the potential to affect two (2) of three (3) smoke compartments, twenty-six (26) residents, staff and visitors. The facility is certified for fifty (50) beds and the census was forty-five (45) on the day of the survey. The facility failed to ensure the oxygen transferring room had a fire rated door and frame that had a 1 hour fire resistive rating.</p> <p>The findings include:</p> <p>Observation, on 04/10/13 at 10:28 AM with the Maintenance Supervisor, revealed the oxygen trans-filling room did not have a fire rated door</p>	K 143	<p>K143 Life Safety Code Standard</p> <ol style="list-style-type: none"> <li>1. An observation by the Administrator was completed on 04/12/2013 and it was determined that the door frame had a ninety (90) minute rating, however it had been painted over. The paint was removed from the frame on 04/12/2013. A ninety (90) minute rated door was order for the facility oxygen room on 04/16/2013 and will be installed by 5/10/2013.</li> <li>2. An audit of all liquid Oxygen storage areas was completed by the Maintenance Director with no concerns identified.</li> <li>3. The Maintenance Director will be re-educated by facility the Administrator related to proper fire rating on doors and the visibility of the fire rating on the doors and frames for areas where liquid oxygen is stored and transferred.</li> <li>4. The Maintenance Director will conduct monthly inspections for three (3) months of doors and frames to ensure the rating is correct and visible. The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, the Administrator, the Assistant Director of Nursing and the Social Services Director, with the Medical Director attending at least quarterly.</li> </ol>	5/10/13

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K 143	<p>Continued From page 11</p> <p>and frame installed that had a 1 hour fire resistive rating. The door installed on the trans-filling room has a 20 minute rating.</p> <p>Interview, on 04/10/13 at 10:28 AM with the Maintenance Supervisor, revealed he was unaware of the proper rating for a door to the trans-filling oxygen room.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <ul style="list-style-type: none"> <li>a. Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and</li> <li>b. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and</li> <li>c. The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted.</li> </ul> <p>Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures.</p> <p>The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.</p>	K 143		

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K 147 SS=E	<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 two (2) of three (3) smoke compartments, twenty-four (24) residents, staff and visitors. The facility is certified for fifty (50) beds and the census was forty-five (45) on the day of the survey. The facility failed to ensure power strips and extension cords were being used properly.</p> <p>The findings include:</p> <p>Observations, on 04/10/13 between 10:50 AM and 2:00 PM with the Maintenance Supervisor, revealed:</p> <ol style="list-style-type: none"> <li>1) An extension cord was plugged into the microwave in the employee break room.</li> <li>2) A bed was plugged into a power strip located in room #24.</li> <li>3) An oxygen concentrator, mini nebulizer, and a bed were plugged into a power strip located in room #26.</li> </ol> <p>Interview, on 04/10/13 between 10:50 AM and 2:00 PM with the Maintenance Supervisor, revealed he was unaware of what could be plugged into a power strip and he was unaware of</p>	K 147	<p>K147 Life Safety Code Standard</p> <ol style="list-style-type: none"> <li>1. On 4/12/2013, the Maintenance Director removed the extension cord in the break room and also removed the power strips from room #24 and #26 to ensure there was no medical equipment plugged into the power strips.</li> <li>2. An audit was completed by the Maintenance Director on 04/15/2013 to remove all extension cords and to remove all power strips from the facility connected to medical equipment. None were identified.</li> <li>3. The Maintenance Director was re-educated by the Administrator, on 04/29/13, to ensure there are no extension cords in the facility, and what is able to be plugged into power strips.</li> <li>4. The Maintenance Director will conduct weekly for twelve (12) weeks inspections to ensure that there have been no extensions cords brought into the facility. Also, the Maintenance Director will ensure that there is no medical equipment plugged into power strip within the facility. The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, the Administrator, the Assistant Director of Nursing and the Social Services Director, with the Medical Director attending at least quarterly.</li> </ol>	5/10/13
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K 147	Continued From page 13 the extension cord in the break room.  Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D 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.	K 147			