

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

PRINTED: 02/09/2012
FORM APPROVED
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 01/26/2012
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NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2582 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 An annual survey was conducted on 01/24/12 through 01/26/12 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal requirements with deficiencies cited at the highest scope/severity of "D."	F 000	Plan of Correction Disclaimer for Shady Lawn Nursing Home 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. F157 NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 1. Resident #6's MD and guardian were notified of development of pressure ulcers on 1/25/12 by RN #1. Resident #9's family was notified of the lab results and treatment on 11/28/11 by LPN #2. The physician for resident # 9 was made aware of the lab results on 11/17/11 by LPN #3 and treatment on 11/28/11 by LPN #2. 2. All current residents' medical records for the past (30) thirty days will be reviewed by the Director of Nursing and Assistant Director of Nursing by 2-28-2012 to identify any change in condition to assure the physician and family were notified. Any identified as not having been notified will have immediate notification.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jammy Workman</i>	TITLE <i>Administrator</i>	(X6) DATE <i>2-17-12</i>
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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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NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2592 CERULEAN RD. CADIZ, KY 42211		
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F 157	<p>Continued From page 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to ensure immediate notification of the physician and/or family for two residents (#8 and #9), in the selected sample of eleven residents, when the resident experienced a change in condition. Resident #8 developed two Stage II Pressure Sores, necessitating a new order for treatment. Resident #9 experienced abnormal urinalysis lab results, necessitating a new order for treatment.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Notification of Resident Change in Condition," dated October 1999, revised February 2011 and July 2011, revealed "nursing staff were to immediately inform the resident, consult with the resident's physician, the resident's legal representative or an interested family member, when there was a significant change in the resident's physical, mental or psychosocial status (i.e., a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications.) If the change is not crucial or significant (does not meet AMDA criteria,) the resident's physician and family or legal representative will be notified at the earliest convenient time during regular business hours."</p>	F 157	<p>3. All Licensed staff will be re-educated by 2-28-2012 related to the requirement to notify the physician and family of any change in condition. This training will be completed by the Director of Nursing and Assistant Director of Nursing. No licensed staff will work past 2-28-2012 without having receiving this education.</p> <p>4. The Director of Nursing or the Assistant Director of Nursing will audit five (5) resident's medical records per week for twelve (12) weeks to assure that any change of condition has had physician and family notification. 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>	2/29/12	

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F 157	<p>Continued From page 2</p> <p>1. A record review revealed Resident #6 was admitted to the facility on 04/26/11 with diagnoses to include Paraplegia, Dementia with Behavioral Disturbances, Chronic Obstructive Pulmonary Disease (COPD) and Failure to Thrive.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 01/03/12, revealed the facility identified Resident #6 to be moderately cognitively impaired, short tempered, easily annoyed, resistive to care and had verbal behaviors directed at others. Further review revealed the resident required extensive assistance of two staff members with all activities of daily living. The resident was incontinent of bowel and bladder.</p> <p>A review of the care plan "At Risk for Skin Breakdown" revealed staff members were to inspect the skin for signs and symptoms of breakdown and to provide treatment according to the physician's orders.</p> <p>An observation of a skin assessment completed by Registered Nurse (RN) #1, on 01/24/12 at 2:45 PM, revealed the resident to have two new open areas to the sacrum. On the right side of the sacrum, there was an area which measured 0.5 centimeters (cm) by 0.75 cm. On the left side of the sacrum, there was an open area which measured 0.5 cm by 0.5 cm. The RN revealed there was an order in place for a DuoDerm to protect the sacral area, but stated the resident refused the application of the dressing.</p> <p>A review of the Treatment Records and the nursing notes revealed there was no documented</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>evidence of the two Stage II pressure sores. Additionally, there was no evidence the physician or the guardian was made aware.</p> <p>An interview with the guardian, on 01/25/12 at 2:18 PM, revealed he was not made aware of the development of the resident's pressure sores.</p> <p>An interview with RN #1, on 01/25/12 at 2:55 PM, revealed she did not notify the physician about the pressure sores or about the resident's refusal of the DuoDerm. Additionally, she could not provide any documentation from the resident's clinical record about the pressure sores. She stated she "had gotten side-tracked and forgot."</p> <p>An interview with the Director of Nursing (DON), on 01/25/12 at 3:00 PM, revealed the resident was a "constant case of trials and refusals" and she expected the staff members not to give up.</p> <p>2. A record review revealed Resident #9 was admitted to the facility on 05/03/02 with diagnoses to include Senile Dementia, Diabetes Mellitus Type II, Obesity and Psychosis.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 11/21/11, revealed the facility identified Resident #9 to be cognitively intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15). Further review revealed the resident required extensive to total assistance of two staff members with all activities of daily living and was non-ambulatory. The resident was occasionally incontinent of bladder and continent of bowel.</p> <p>A review of the nurses' notes revealed, on</p>	F 157			

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 NAME OF PROVIDER OR SUPPLIER
 SHADY LAWN NURSING HOME

 STREET ADDRESS, CITY, STATE, ZIP CODE
 2592 CERULEAN RD.
 CADIZ, KY 42211

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F 157	<p>Continued From page 4</p> <p>11/16/11 at 3:30 PM, "Resident complaining of burning with urination at times. Will collect urine specimen."</p> <p>A review of the lab report, dated 11/18/11, revealed urine was collected at 9:00 PM. The urinalysis report was sent to the facility on 11/17/11. A review of the final microbiology report, dated 11/19/11, revealed the presence of Escherichia coli in the urine with a notation at the bottom of the report, "11/25/11 Medical Doctor (MD) aware."</p> <p>A review of the physician's orders, dated 11/28/11 at 3:00 PM, revealed "Tetracycline 250 mg po qid (four times a day) times ten days for a Urinary Tract Infection (UTI)."</p> <p>An interview with Licensed Practical Nurse (LPN) #2, on 01/26/12 at 1:05 PM, revealed she obtained the order for Tetracycline on 11/28/11. After reviewing the lab results, dated 11/19/11, she stated, "According to the lab results, the physician was not notified until 11/25/11." She further stated it was not normal for that much time to lapse between receiving lab results and notifying the physician, or between notifying the physician and initiating antibiotic therapy. She stated, "I do not know why there was a lapse between receiving the lab results and starting the antibiotic."</p> <p>An interview with the DON and the Assistant Director of Nursing (ADON), on 01/26/12 at 1:20 PM, revealed they would not expect that much time to lapse between lab results, notifying the physician and initiation of antibiotic therapy. The ADON further stated, "I have no explanation why</p>	F 157		

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F 157 F 314 SS=D	<p>Continued From page 5 this happened."</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policy and procedure, and review of the manufacturer's guidelines, it was determined that the facility failed to ensure residents with pressure sores received necessary treatment and services to promote healing for one resident (#1), in the selected sample of eleven residents.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Pressure Ulcer Prevention/Treatment," revised 04/09, revealed that all applicable interventions are to be entered on the "Skin Integrity Assessment: Prevention and Treatment Plan of Care."</p> <p>A review of the facility's policy/procedure, "Skin Integrity Assessment: Prevention and Treatment Plan of Care," dated 12/11, revealed "bathe with</p>	F 157 F 314	<p>F314 TREATMENT/SVC TO PREVENT/HEAL PRESSURE SORES</p> <p>1. An observation by the Director of Nursing on 1/27/12 noted that the wound to resident #1's coccyx was washed with soap and water as prescribed by the physician. On 1/24/12 a skin grid (form to measure and monitor a wound) was implemented, the physician and family were notified of the scab to resident # 1's right second toe. The abraded area on resident # 1's coccyx peri wound was noted to be healed on 2/13/12.</p> <p>2. An observation by the Director of Nursing and the Assistant Director of Nursing on 1/27/12 noted that wound care was being performed in accordance with the physician orders to include cleansing of the wound if ordered. Skin assessments will be completed on all current residents by 2/22/12 by the Director of Nursing and the Assistant Director of Nursing to assure any skin impairments have been identified, have monitoring in place, physician notification with treatment orders as needed, as well as family notification. Any identified as not having been identified, have monitoring in place, physician notification with treatment orders as needed, as well as family notification will have immediate correction.</p> <p>3. All License staff will be re-educated by the Director of Nursing or Assistant Director of Nursing by 2-28-2012 related to following physician orders for treatment of skin impairments to include cleansing of the wounds</p>		

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F 314	<p>Continued From page 6 mild soap, rinse, and dry thoroughly."</p> <p>A review of the manufacturers' guidelines, provided by the facility, revealed dressings should be changed every 48 to 72 hours and no less than three times a week (for non-infected wounds). Further review of the guidelines revealed thorough wound and periwound area cleansing according to the physician's order, and according to the Institution's protocol prior to each dressing application.</p> <p>A record review revealed Resident #1 was admitted to the facility on 04/08/11 with diagnoses to include Pressure Sore to the Coccyx. A review of the admission Minimum Data Set (MDS), dated 04/14/11, revealed the facility assessed the resident to require assistance with bed mobility and transfers, and assistance of one with ambulation.</p> <p>A review of the physician's orders from the wound care center, dated 1/05/12, revealed the pressure area was to be washed with soap and water with each dressing change, and change the dressing every two to three days.</p> <p>An observation of wound care, on 01/24/12 at 3:44 PM, revealed LPN #3 completed a wound vacuum assisted closure (VAC) dressing change to a stage IV pressure ulcer on Resident #1's coccyx. The LPN placed the resident in a right side-lying position in the bed with the suction tubing underneath him/her. Further observation revealed she removed the old dressing and made contact with the bed while trying to reposition the resident and the resident's tubing. Further observation revealed a nickel-sized skin tear on</p>	F 314	<p>as ordered. All Licensed staff will be re-educated on completing weekly skin assessments as scheduled and procedure to document skin impairments, notification of physician and family as well as obtaining appropriate treatment orders. This education will be provided by the Director of Nursing and the Assistant Director of Nursing. No license staff will work past 2-28-2012 without having received this education.</p> <p>4. The Director of Nursing or the Assistant Director of Nursing will observe three (3) dressing changes to wounds per week for twelve (12) weeks to assure the physician orders are followed and wounds are cleansed per physician orders. The Director of Nursing or the Assistant Director of Nursing will complete five (5) skin assessments per week for twelve (12) weeks to assure all skin impairment have been identified, documented and have had physician and family notification. 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>	2/29/12	

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F 314	<p>Continued From page 7</p> <p>the resident's right buttock. LPN #3 stated it was a skin tear caused by the removal of the adhesive dressing.</p> <p>She repacked the pressure sore and placed the adhesive VAC dressing over the area around the wound, to include the skin tear. Additionally, during the observation of wound care, a 0.5 centimeter (cm) by 0.5 cm scab on the top of the resident's right second toe was noted. LPN #3 stated she was aware of the scab, and was watching it; however, there was no documented evidence of the scab found in the chart.</p> <p>A review of the Treatment Administration Record (TAR), dated 01/12, revealed LPN #3 completed the resident's weekly skin assessments from 01/06/12 to 01/20/12. Further review of the TAR revealed that LPN #3 completed most of the ordered dressing changes since the first VAC dressing was placed on 01/06/12.</p> <p>An interview with the Director of Nursing (DON), on 1/25/12 at 1255 PM, and on 01/26/12 at 3:25 PM, revealed that soap and water wash, or a shower was intended to be part of the prescribed treatment of the resident's pressure ulcer. She revealed when the staff found any new skin conditions, she expected them to measure the site and make the appropriate documentation in the chart, related to size and location. Staff would then be expected to notify the attending physician, the family, and the DON of a change in condition, obtain orders from the attending physician and transcribe the information onto the Medication Administration Record (MAR) or TAR. She further revealed she was not aware of the scab on the resident's right second toe until now.</p>	F 314			

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F 314	Continued From page 8 An interview with Resident #1, on 01/26/12 at 8:25 AM, revealed he/she did not recall if his/her wound or the area around the wound was washed with soap and water.	F 314			
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 review of the facility's policy/procedure, it was determined the facility failed to ensure the resident's environment remained as free from accident hazards as is possible, for two residents (#12 and #13), not in the selected sample. Observations during the survey revealed Resident #12's safety alarm was not activated, and unsecured medication was observed in Resident #13's room. The findings include: 1. A record review revealed Resident #12 was admitted to the facility on 04/03/09 with diagnoses to include Alzheimer's Disease and Senile Dementia. A review of the quarterly Minimum Data Set (MDS) assessment, dated 12/09/11, revealed the facility assessed the resident to be	F 323	F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 1. An observation of resident # 12 by the Director of Nursing on 1/25/12 noted the resident's alarm to be in place and functioning. The identified medication in resident # 13's room was removed on 1/25/12 by LPN for resident #13. An observation of resident # 13's room by the Director of Nursing on 1/25/12 noted that there were no unsecured medications in the room. 2. An audit of all resident rooms was completed on 1/25/12 by the Director of Nursing and the Assistant Director of Nursing to assure that there were no unsecured medications. None were noted. An audit of all current resident's care planned alarms was completed by the Director of Nursing and the Assistant Director of Nursing on 1/25/12 to assure that all alarms were in place and functioning. No concerns were identified.		

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NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2682 CERULEAN RD. CADIZ, KY 42211		
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F 323	<p>Continued From page 9</p> <p>cognitively impaired, required extensive assistance with transfers, and was incontinent of bowel and bladder.</p> <p>Further record review revealed the resident was found on the floor by his/her bed on 12/14/11 at 4:20 PM, on 12/26/11 at 9:15 PM, on 01/07/12 at 7:30 PM, and on 01/09/12 at 1:45 AM. A review of the resident's care plan, dated 12/21/10, revealed there was to be a sensor alarm on the bed to alert the staff of the resident's attempts to self-transfer. A review of the Certified Nurse Aide (CNA) assignment sheet revealed the resident's bed was to be in the low position and a sensor alarm utilized.</p> <p>Observations, on 01/25/12 at 7:50 AM, 8:30 AM, 9:30 AM and 10:30 AM, revealed Resident #12 was in his/her bed. The bed was observed to be at normal height and the bed sensor alarm mat was not connected to the alarm box. Further observation revealed the connector was hanging loose and laying on the floor.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 01/25/12 at 10:35 AM, revealed the alarm was not activated if it was not connected properly. The floor nurse was ultimately responsible to ensure alarms were activated and in proper working order, and the CNAs were expected to monitor also. The floor nurse was to document on the Treatment Administration Record (TAR) every shift if safety alarms were in place and in working order. Additionally, the ADON stated there was no facility policy/procedure which addressed safety alarms.</p> <p>An interview with CNA #3, on 01/25/12 at 2:30</p>	F 323	<p>3. All direct care staff will be re-educated by the Director of Nursing and Assistant Director of Nursing related to assuring all care planned alarms are in place and functioning as indicated on the nursing assistant worksheet (a tool to identify residents with alarms and type of alarm). This re-education will be completed by 2-28-2012 with no staff working past 2-28-12 without having received this re-education. All licensed staff will be re-educated on not leaving unsecured medications at bedside as well as the policy for self medication assessment. This education will be conducted by the Director of Nursing and Assistant Director of Nursing by 2-28-2012 with no licensed staff working after 2-28-2012 without having first receiving this re-education.</p> <p>4. The Director of Nursing or the Assistant Director of Nursing will audit all alarms five (5) times per week for two (2) weeks followed by three (3) times per week for ten (10) weeks to assure all are in place and functioning. Room rounds will be completed by the Director of Nursing or the Assistant Director of Nursing five (5) times per week for two (2) weeks followed by three (3) times per week for ten (10) weeks to assure no medications are left unsecured.</p>		

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PRINTED: 02/08/2012
FORM APPROVED
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 01/26/2012
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING HOME			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	
F 323	<p>Continued from page 10</p> <p>PM, revealed she was responsible for Resident #12's care and provided assistance for toileting, but had not noticed the safety alarm was not connected or not working. Additionally, she stated the resident's bed was supposed to be in the low position.</p> <p>An interview with the Director of Nursing (DON), on 12/25/12 at 11:00 AM, revealed she expected the CNAs to monitor residents' alarms to ensure they were in place and in working order. She stated the nurse was ultimately responsible to ensure safety alarms were being utilized appropriately.</p> <p>2. A review of the facility's policy/procedure, "Self-Medication Assessment and Management," dated 08/09, revealed "Determine location to store medications. Ensure that the location is secure and clean (i.e., in resident room and in locked cupboard/drawer)."</p> <p>A record review revealed Resident #13 was admitted to the facility on 10/26/11 with diagnoses to include Congestive Heart Failure, Cancer, Diabetes Mellitus and Depression. A review of a quarterly MDS assessment revealed the facility assessed the resident to be cognitively impaired, independent with transfers and required assistance with hygiene/bathing.</p> <p>A review of an "Interdisciplinary Resident Teaching Record," dated 11/17/11, revealed "Resident is able to self-administer inhaler. Demonstrated proper use of inhaler. Educated to keep inhaler in pocket or in a locked box." There was no evidence of a signature on the document.</p>	F 323	<p>The results of the audits will be reviewed with the Quality Assurance Committee monthly for three 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>	2/29/12	

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PRINTED: 02/09/2012
FORM APPROVED
OMB NO. 0938-0391

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F 323	Continued From page 11 Observations, on 01/24/12 at 11:00 AM and 5:00 PM, and on 01/26/12 at 7:30 AM and 3:00 PM, revealed a rescue Inhaler laying on an over the bed table across from Resident #13's bed. An interview with Resident #13, on 01/25/12 at 3:20 PM, revealed he/she only used the rescue Inhaler in the event of respiratory distress. The resident could not recall when he/she last used it and that he/she kept it on the table for emergency use. An interview with the DON, on 01/25/12 at 3:30 PM, revealed medications were to be secured in a locked drawer. She revealed Resident #13's Inhaler should not be laying out in open view, and was unaware that this occurred.	F 323			
F 371 SS=D	483.35(j) 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 observation and interview, it was determined the facility failed to ensure food was stored, distributed and served under sanitary conditions. Observation revealed a build-up of dust on the interior fan in the walk-in refrigerator.	F 371	F371 FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY 1. The fan in the walk in refrigerator was noted to be clean and free of dust on 1/25/12 by the Dietary Services manager. The hole in the ceiling of the refrigerator was repaired by the Maintenance Director on 1/25/12. An observation by the Dietary Services Manager on		

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F 371	<p>Continued From page 12</p> <p>There was a hole in the ceiling of the walk-in refrigerator which exposed the structure and electrical components of the refrigerator. A sanitizer bucket was determined to not contain sanitizer solution when tested. Additionally, a kitchen staff was observed to touch a contaminated trash container lid and return to serving food without washing her hands or replacing her gloves.</p> <p>The findings include:</p> <p>An observation during the initial tour of the kitchen, on 01/24/12 at 9:30 AM, revealed a fan located inside the walk-in refrigerator over the food had a heavy build-up of dust. A large circular hole was observed in the ceiling of the refrigerator which exposed the structure and electrical components of the refrigerator.</p> <p>An observation, on 01/24/12 at 11:20 AM, revealed Kitchen Staff #1 left the food tray preparation area and disposed of an item in the trash container. Kitchen Staff #1 raised the trash container lid with her hand, and then returned to the tray preparation area, where she continued to plate food from the steam table without washing her hands or replacing her gloves.</p> <p>An observation, on 01/24/12 at 11:30 AM, revealed a sanitizer bucket, which had gray colored water and a rag in it, was being used to wipe surface areas in the kitchen. The solution showed no sanitizer present when the kitchen staff tested it with a test strip. The test strip container label indicated the solution should test at 200 parts of sanitizer to be adequate for sanitizing surfaces.</p>	F 371	<p>1/25/12 revealed that dietary staff were changing gloves and washing hands appropriately including when leaving the tray line to a dirty area. An observation by the Dietary Services Manager on 1-25-2012 revealed sanitation solution to have proper sanitization solution mixture.</p> <p>2. A sanitation audit was completed by the Dietary Services Manager on 1/25/12 to assure that no other areas of repair or unsanitary conditions existed. None were identified. An observation by the Dietary Services Manager on 1/25/12 revealed that dietary staff were changing gloves and washing hands appropriately including when leaving the tray line to a dirty area. An observation by the Dietary Services Manager on 1/25/2012 revealed sanitation solution to have proper sanitization solution mixture.</p> <p>3. The cleaning of dietary fans will be added to the monthly cleaning schedule and documented on the Monthly Preventive Maintenance logs. All Dietary staff were re-educated to this change in the cleaning schedule in addition to re-education related to appropriate hand washing/changing of gloves in the kitchen, and re-educated to proper mixing of sanitation solution. This re-education will be provided by the Dietary Service Manager by 2/28/12; no Dietary staff will work past 2/28/12 without having received this training. Monthly inspection of the dietary department for maintenance concerns will be completed by maintenance and documented on the Preventive Maintenance log. The Maintenance Director was re-educated on this change by the Administrator on 1/26/12.</p>		

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PRINTED: 02/09/2012
FORM APPROVED
OMB NO. 0936-0391

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 13 An interview with Kitchen Staff #1, on 01/24/12 at 11:25 AM, revealed she should have washed her hands and replaced her gloves after she touched the contaminated garbage container lid, but she did not do this. Kitchen Staff #1 revealed no sanitizer was put in the bucket and only soap and water was being used. An interview with the Registered Dietician, on 01/24/12 at 11:30 AM, revealed he observed Kitchen Staff #1 contaminate her hands and return to preparing food trays. He revealed Kitchen Staff #1 should have washed her hands and replaced her gloves before returning to the tray line. Additionally, he stated the solution in the sanitizer bucket was not acceptable. An interview with the Nutritional Services Manager, on 01/25/12 at 8:00 AM, revealed maintenance was responsible to clean the fan inside the walk-in refrigerator; however, documentation to verify cleaning was not completed.	F 371	4. The Dietary Services Manager will complete a weekly sanitation audit to identify any concerns with sanitation to include dust on the walk in refrigerator fans. This audit will continue for twelve (12) weeks. The Administrator will complete a monthly audit for three (3) months of the Dietary department to assure all repair issues have been identified. The Dietary Services Manager will monitor sanitation solution and appropriate washing of hands/glove weekly for twelve (12) weeks and document on kitchen sanitation rounds sheet. 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.		
F 441 SS=D	483.85 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;	F 441		2/29/12	

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F 441	<p>Continued From page 14</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to Infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's Infection Control policy and procedure, it was determined the facility failed to ensure appropriate use of gloves and handwashing during incontinent care for one resident (#6), in the selected sample of eleven residents.</p> <p>The findings include:</p>	F 441	<p>F441 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>1. An observation by the Director of Nursing on 1/25/12 noted staff to be performing appropriate hand washing during peri-care as well as appropriate placement of soiled linens in a bag for resident # 6.</p> <p>2. An observation by the Director of Nursing on 1/25/12 noted staff to be performing appropriate hand washing during peri-care as well as appropriate placement of soiled linens in a bag.</p> <p>3. All direct care staff will be re-educated on appropriate hand washing to include hand washing during peri care and appropriate storage of soiled linens. This education will be provided by the Director of Nursing and Assistant Director of Nursing by 2-28-2012 with no direct care staff working after 2-28-2012 without having received this re-education.</p>		

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 PRINTED: 02/09/2012
 FORM APPROVED
 OMB NO. 0938-0391

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F 441		Continued From page 15 A review of the facility's policy/procedure, "Hand Hygiene," dated April 1999, and revised April 2010 and November 2011, revealed hands should be washed "after contact with body fluids or excretions, mucous membranes, non-intact skin and wound dressings and after removing gloves." An observation of incontinent care, on 01/24/12 at 2:45 PM, revealed Certified Nurse Aide (CNA) #1 donned gloves and wiped stool from Resident #8's lower torso with a peri-wash solution and wash cloths, and placed the unbagged, soiled linen on the floor. With visible stool on her glove, she repositioned the resident to the side-lying position and picked up the bottle of peri-wash with the same soiled gloves. She cleansed the resident's buttocks, repositioned the resident in bed, unfolded the resident's clean bed linen, tucked the pull sheet under the resident, and utilized the electric bed control device, all while wearing the soiled gloves. She placed the peri-wash on the resident's bedside table, picked up the soiled linen off the floor, placed it in a bag and took off the soiled gloves. She then picked up the peri-wash bottle and placed it in the top of the resident's wardrobe. CNA #1 then washed her hands. An interview with CNA #1, on 01/24/12 at 3:00 PM, revealed she should have removed her gloves and washed her hands and was "just nervous." An interview with the Director of Nursing (DON), on 01/26/12 at 2:00 PM, revealed the CNA should have washed her hands and changed her gloves	F 441	4. The District Education and Training Director, Director of Nursing or the Assistant Director of Nursing will observe peri-care ten (10) times per week for two (2) weeks followed by five (5) times per week for ten (10) weeks to assure staff are performing appropriate hand washing and storage of soiled linens. 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.	2/29/12

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PRINTED: 02/09/2012
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NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2582 CERULEAN RD. CADIZ, KY 42211		
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F 441	Continued From page 16 after they were visibly soiled and should not have placed dirty linen on the floor. The DON stated the staff were trained on the proper procedures.	F 441			

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PRINTED: 04/11/2012
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 03/29/2012
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NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2582 CERULEAN RD. CADIZ, KY 42211
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{K 000}	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1964, 1982, 1993</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is propane.</p> <p>A revisit Life Safety Code survey was conducted on 03/29/12. Shady Lawn Nursing Home was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for fifty (50) beds and the census was forty (40) 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>Plan of Correction Disclaimer for Shady Lawn Nursing Home</p> <p>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>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Sammy Workman* TITLE *Administrator* (X6) DATE *4-20-12*

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 000}	Continued From page 1	{K 000}		
{K 025} SS=E	<p>Deficiencies were cited with the highest deficiency identified at " F " level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for fifty (50) beds with a census of forty (40) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 03/29/12 at 3:28 PM, with the Maintenance Director revealed the smoke partitions extending above the ceiling next to the electrical room to be penetrated by cable wires</p>	{K 025}	<p>K025 LIFE SAFETY CODE STANDARD</p> <ol style="list-style-type: none"> The gaps in the smoke partition extending above the ceiling next to electrical room were sealed with a fire retardant sealant on 3/30/12 by the Maintenance Director. The penetration in the fire wall next to the conference room was sealed with block and mortar 3-30-2012 by the maintenance department. The attic space has been inspected by maintenance on 3/30/12 to identify other smoke partitions penetrations. An inspection reveals no other areas of concern. The Maintenance Director will check smoke partitions for new areas of penetrations whenever contractors are brought in to run new wiring/plumbing or any other construction that could involve breaching smoke partitions. The Maintenance Director was re- educated on smoke barrier penetrations by the Administrator on 3/30/12. Environmental audits will be conducted by Maintenance monthly for three (3) months to ensure that contractors have not been in attic space leaving smoke partitions penetrated, with the results of audits added to the Monthly Preventive Maintenance log. The results of these 	

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NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2682 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 025}	<p>Continued From page 2</p> <p>and sprinkler pipes. Further observation revealed the fire wall next to the conference room had the use of flammable Kwik Foam to seal penetrations. When I arrived at the facility the work was being performed on the smoke barriers.</p> <p>Interview, on 03/29/12 at 3:28 PM, with the Maintenance Director revealed, they were not aware of the penetrations nor the use of Kwik Foam was not suitable for use in smoke partitions. Further interview revealed the smoke barrier next to the conference room was fixed but not properly.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration</p>	{K 025}	<p>audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time non-compliance is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations and QA reviews will continue until three (3) months of compliance has been established.</p> <p style="text-align: right;">3/31/12</p>	

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

PRINTED: 04/11/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 03/29/2012
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2682 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 027	<p>Continued From page 4 in the fire wall next to the Conference Room.</p> <p>Interview, on 03/29/12 at 3:28 PM, with the Maintenance Director revealed he was not aware the door in the attic must be rated for use.</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.</p> <p>Reference: NFPA 101 (2000 Edition) Continuity 8.3.2 Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.</p> <p>Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p>	K 027		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 03/29/2012
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING HOME			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 025}	Continued From page 3 into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	{K 025}			
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure access doors in smoke barriers were installed in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for fifty (50) beds with a census of forty (40) on the day of the survey. The findings include: Observation, on 03/29/12 at 3:28 PM, with the Maintenance Director revealed one (1) unrated homemade smoke barrier access doors located	K 027	K027 LIFE SAFETY CODE STANDARD 1. The homemade smoke barrier door was replaced with block and mortar patch on 3/30/12 2. The Maintenance Director completed a complete facility audit on 3-30-12 to identify other smoke barriers and the inspection revealed no other areas of concern. 3. The Maintenance Director will check smoke partitions for new areas of penetrations whenever contractors are brought in to run new wiring/plumbing or any other construction that could involve breaching smoke partitions. The Maintenance Director was re-educated on smoke barriers and penetrations by the Administrator on 3/30/12. 4. Environmental audits will be conducted by the Maintenance Director monthly to ensure no contractors have been in the attic leaving smoke barriers penetrated with results of audits documented on the Monthly Preventive Maintenance log. The results of these audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time non-compliance is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations and QA reviews will continue until three (3) months of compliance has been established. 3-31-2012		