

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

PRINTED: 12/05/2011
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2011
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NAME OF PROVIDER OR SUPPLIER COVINGTON'S CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 115 CAYCE ST HOPKINSVILLE, KY 42240
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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 and an abbreviated survey (KY #16825) was conducted on 11/15/11 through 11/17/11, and a Life Safety Code survey was conducted on 11/16/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S of an "F." KY #16825 was substantiated with no deficiencies cited.	F 000	COVINGTON'S CONVALESCENT CENTER, INC. acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary and findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of the resident. COVINGTON'S CONVALESCENT CENTER, INC.'S response to the statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is totally accurate.	
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	F 157	F 157 483.10(b) (11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) Corrective action: The facility must immediately inform the resident; as is practicable, consult with the resident's physician, and if known, notify the resident's legal representative or interested family member when there is an accident involving the resident that results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; and need to alter treatment significantly (discontinue a treatment or commence with a new treatment) ; or a decision to transfer or discharge from the facility. On 11/17/11, the director of nurses, contacted the attending physician for	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Adm.	(X6) DATE 12-30-11
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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 157	<p>Continued From page 1 this section.</p> <p>The facility must record and periodically update 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 record review, review of the facility's policy/procedure and interview, it was determined the facility failed to notify the physician, for one resident (#16), in the expanded sample, when a decision was made to transfer or discharge the resident from the facility. Resident #16 was transferred from a Nursing Facility (NF) bed to a Personal Care (PC) bed, on 08/19/11, without consulting with the resident's physician or obtaining an order to transfer the resident.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure "Physician Notification," dated 12/01/09, revealed "the physician should be contacted for a resident's illness, lab reporting and non-emergent questions. Many physicians want fax sheet information instead of phone calls. If a resident is ill, notify the physician or Medical Director as indicated. If emergency treatment is needed, call 911 as indicated." Further review of the policy/procedure revealed there was no guidance to direct the staff on how to transfer a resident from the different levels of care.</p> <p>A record review revealed Resident #16 was admitted to the facility on 12/06/10 with diagnoses to include Congestive Heart Failure, Hypertension</p>	F 157	<p style="text-align: right;">Page 2 of 12</p> <p>resident #16 and discussed the resident's discharge from SNF level of care. The facility received an order for the need of personal care services and immediately documented the order, made the necessary documentation in the medical record, and mailed the phone order transcription form to the attending physician for his signature. The MDS assessments were completed relative to discharge from SNF care. Concurrently, the director of nurses documented the conversation and receipt of order for resident #16 within the resident's medical record. On 12/14/11 orders were received to admit resident #16 to PC level of care clarifying orders received on 11/17/11 regarding the 8/18/11 admission.</p> <p>In-services were performed by the director of nurses, on 12/14/11 and 12/15/11, regarding the facility protocol for obtaining proper orders for discharge or transfer of residents and appropriate documentation within the medical record.</p> <p>Identifying others: All residents residing in the facility have the potential to be affected by the same practice if not discharged from one level of care and admitted to another, if the resident, and the resident's family, and/or his/her legal guardian or representative, and the resident's physician are not properly notified and the appropriate orders received. This notification could be in face-to-face conferences, or by telephone, by facsimile.</p>		

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F 157	<p>Continued From page 2</p> <p>and Hypokalemia. Further review revealed he/she was transferred to a PC level bed, on 01/04/11, due to no longer qualifying for a NF level bed. Resident #16 was hospitalized, on 03/23/11, and returned to the Skilled Nursing Facility (SNF) level bed on 03/28/11. On 08/19/11, the resident was moved back to the PC level bed after a discussion between the Director of Nursing (DON) and the Assistant Administrator.</p> <p>A review of the nurses' notes revealed there was no documented evidence related to the discharge from the NF level of care or the admission to the PC level of care.</p> <p>An interview with the DON, on 11/16/11 at 10:15 AM, revealed she was responsible for Resident #16's move from the NF level of care to the PC level of care. The DON stated the resident became ill and was transferred to the hospital on 03/23/11. Upon the resident's return on 03/28/11, he/she required skilled nursing care. Resident #16 was monitored and he/she continued to improve in his/her activities of daily living. She stated she discussed moving the resident back to the PC bed, with the Assistant Administrator, and he was in agreement. She revealed she informed the resident's family and the physician about the move; however, upon review of the resident's record, there was no written order to discharge the resident from the NF level of care and admit him/her to the PC level of care. The DON revealed she had not documented the resident's transfer in the record. Additionally, she revealed there should be an order to move the resident from one level of care to another, as well as documentation in the nurses' notes. She revealed she did not obtain an order nor</p>	F 157	<p style="text-align: right;">Page 3 of 12</p> <p>An audit of the resident's charts within the facility was performed by the, Adm. Asst, on 12/12/11 to ensure that the physician's orders reflected the appropriate level of care for each resident and documented the same on the physician's orders.</p> <p>Systemic changes:</p> <p>The facility's policy/procedure for "Physician Notification" has been revised on 12/ 14/11 to include the following:</p> <ol style="list-style-type: none"> 1. The attending physician shall be notified for resident with an illness, when a resident falls, with acute pain and/or injury, exhibits signs and symptoms of illnesses or injury that are beyond the scope the routine nursing practice and intervention required, and/or when a resident is discharged and/or admitted to another level of nursing care. 2. If the attending physician has not returned the facility's call within one hour, or a timeframe relegated by the illness or injury, when there is acute pain, injury, or illness, or admission or discharge that presents imminent danger the charge nurse is to call the medical director for orders and treatment. 3. Orders for admission and discharge within the facility from one level of care to another, and/or discharge from the facility shall be documented in the 	

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F 157	Continued From page 3 document this information in the record. An interview with the Assistant Administrator, on 11/17/11 at 1:40 PM, revealed the resident was moved from the NF level of care to the PC level of care. He stated the resident's daughter had inquired about his/her move back to the PC level. He informed the family that the staff were still monitoring the resident, due to some increased confusion. The resident continued to improve and he/she was transferred back to the PC level of care. He revealed the facility's protocol was to contact the physician and obtain an order to transfer the resident to another level of care; however, the staff did not follow the protocol for this resident.	F 157	Page 4 of 12 medical record and in the resident's nurse's notes. 4. The residents nursing notes shall contain documentation relative to the time, date, and circumstances of the admission and/or discharge. In-services were conducted by the director of nurses on 12/13/11, 12/14/11, and scheduled for 12/15/11 discussing physician notification related to admission and discharge from levels of care. Monitoring: Regular and routine monthly audits of the resident's medical record, specifically, the level of care orders shall be performed by the DON, or her designee, to ensure that discharge and/or admission documentation is maintained per protocol. Monthly reports are generated and printed documenting the level of care of each resident that resides in the facility; thereby corresponding to resident room and level of care placement within the facility. The Continuous Quality Improvement CQI policy and protocol have been updated and edited to emphasize monthly and routine auditing of the medical records to ensure the admission and discharge orders are documented appropriately and that physician orders have been obtained. The CQI manual and monthly reports are maintained by the assistant administrator.	
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, record review, review of the Material Safety Data Sheet (MSDS) and interview, it was determined the facility failed to ensure the resident's environment remained as free of accident hazards as is possible for one resident (#18), in the expanded sample, related to a bottle of 50% Isopropyl Alcohol (rubbing	F 323	Completion Date: 12/16/11	

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F 323	<p>Continued From page 4 alcohol) left unsupervised in a resident's room.</p> <p>Findings include:</p> <p>The facility was unable to provide a policy/procedure specific to accident hazards.</p> <p>A review of the facility's "MSDS for Isopropyl Alcohol 50%", dated 01/08/08, revealed, "If ingested, call a physician, pharmacist, or a Poison Control Center immediately."</p> <p>A record review revealed Resident #18 was admitted to the facility on 08/23/11 with diagnoses to include Vascular Dementia, Congestive Heart Failure, Hypertension and Osteoarthritis.</p> <p>A review of the admission Minimum Data Set (MDS), dated 09/03/11, revealed the resident was assessed to be cognitively independent.</p> <p>Observations, on 11/15/11 at 6:23 AM and 12:21 PM, and on 11/16/11 at 7:25 AM, revealed there was a 3/4 of a full bottle of rubbing alcohol located on the floor by the resident's bed.</p> <p>An interview with Certified Nurse Aides (CNAs) #1, #2, #3, and #4, on 11/17/11 at 1:15 PM, 1:44 PM, 1:55 PM, and 2:19 PM, respectively, revealed they periodically checked for chemicals in each resident's room during provision of care. They each stated that rubbing alcohol should not be stored in a resident's room.</p> <p>An interview with Certified Medical Technician (CMT) #1, on 11/16/11 at 7:30 AM, revealed she was responsible for periodically checking for hazardous chemicals in the residents' rooms.</p>	F 323	<p style="text-align: right;">Page 5 of 12</p> <p>F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>Corrective action:</p> <p>The facility must ensure that the resident's environment remains as free of accident hazards as is possible. The facility nurses and nursing assistants routinely check resident rooms for and remove unauthorized substances of any kind from those rooms. Immediately, on the day of our most recent survey process, the rubbing alcohol, that was hidden down on the floor beside the bed of resident #18, in the resident's room was removed from that room and returned to the locked storage area.</p> <p>In-services were performed on 12/13/11 and scheduled for 12/15/11 to reinforce monitoring of resident rooms for unauthorized chemicals or other harmful substances. These in services stressed the importance of a safe environment for all residents.</p> <p>Identify others:</p> <p>All residents residing in the facility have the potential to be affected of the same practice if families are not continuously counseled regarding the facility policy that no unauthorized substances (chemicals, medications, or other harmful substances or items) are to be delivered to the facility at any time. Medications and/or chemicals or any harmful substance brought into the facility by a family member are to be used</p>		

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F 323	<p>Continued From page 5</p> <p>After discovery of the bottle of rubbing alcohol, the CMT removed the rubbing alcohol from Resident #18's room and stated it should be stored in a secure location and not in a resident's room.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 11/17/11 at 1:23 PM, revealed she checked residents' rooms during provision of care to identify items in the room that were not appropriate. She stated rubbing alcohol was not supposed to be stored in a resident's room.</p> <p>An interview with Registered Nurse (RN) #1, on 11/16/11 at 7:35 AM, revealed he was not aware rubbing alcohol was being stored in Resident #18's room. He stated CNAs and housekeeping conducted periodic checks for chemicals in the residents' rooms. He stated rubbing alcohol should not be left at the bedside.</p> <p>An interview with the Director of Nursing (DON), on 11/17/11 at 10:35 AM, revealed she recognized the risks of having a chemical in a resident's room, but currently did not have any residents who exhibited behaviors, such as ingesting chemicals.</p>	F 323	<p style="text-align: right;">Page 6 of 12</p> <p>and left in the resident's room only under unusual circumstances. They must be ordered by the attending physician, contain the name, dosage, form, strength, route and or method of use. The director of nursing must approve their use and in room storage.</p> <p>Systemic changes:</p> <p>The facility developed policy and procedures for accident hazards, specific to storing unauthorized substances in resident rooms. The policy contains the following:</p> <ol style="list-style-type: none"> 1. A written order for bedside storage must be present in the medical record, 2. the manner of storage must prevent access by other residents, 3. the resident must be instructed as to proper use of these items, 4. charge nurses must routinely insure that these items are used properly, 5. all nurses and aides are required to report to the charge nurse, on duty, any items found at bedside that are not authorized, 6. Families or responsible parties are routinely counseled, during the admission process and periodically, thereafter, of this policy and procedure. <p>Monitoring:</p>		

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The Continuous Quality Improvement CQI policy and protocol has been updated and reinforced to emphasize daily and regular routine resident room and bedside table inspections to ensure that no unauthorized medications, chemicals, and/or harmful substances have been brought into the facility by families, visitors, friends, and responsible parties. The Continuous Quality Improvement manual is maintained on the Assistant Administrator

Completion date: 12/16/11

F156 483.10(b)(5)-(10), 483.10(b)(1)
NOTICE OF RIGHTS, RULES,
SERVICES, CHARGES

Corrective action:

On 12/13/11, the power of attorney for resident #17 was advised of the date error with respect to #17's SNF Determination Notification that was inadvertently dated 10/06/11 when her benefits ended on 10/05/11. The power of attorney signed the corrected SNF determination: form and made no request, changes, for demands for billing. Self determination notification dates were corrected during this conference. Resident #17's course of stay was not affected as a result of the dating error.

Identify others:

All residents admitted to the facility for a SNF Medicare service have the potential

Debra L. Adams

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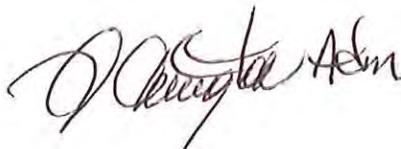
to be affected by the same practice, if the "SNF Determination on Continued Stay" is not completed in a timely fashion and dated to coincide with the exact date when his/her benefits are terminated. A review of the census days of all residents residing in the facility qualifying for an SNF Medicare stay must ensure that the end of service date coincides with the end of benefits.

Systemic changes:

Meetings were conducted on 12/13/11 with the administration, therapy coordinator, and nursing to discuss the importance of following the SNF determination notification protocol. The therapy department will notify the administration and nursing five to seven days in advance of Medicare/therapy discharges. The administration will coordinate, complete and date the SNF Determination Form to coincide with the end of benefits, as is practicable, and notify the powers of attorney regarding the determination. Notification will be reviewed by the responsible parties prior to discontinuation of coverage under a SNF Medicare course of treatment.

Monitoring:

The Continuous Quality Improvement CQI, protocol and policy has been upgraded to include weekly meetings with the administration, nursing, and therapy departments to ensure identification,



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documentation, and completion of the necessary records of all residents whose services are approaching completion. The assistant administrator, will coordinate the meetings and ensure that they facility protocol is followed regarding proper documentation and notification of responsible parties.

Completion date: 12/16/11

F202 483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES

Corrective action:

On 11/09/11 the RN charge nurse contacted the attending physician for resident #08 and discussed the residents decline and need for SNF care due to a significant change. The facility received orders for 0.9% Saline NS, 80ml/hr x 3days, Cipro 250mg PO BID x 7 days for UTI; recheck BMP Friday. The orders were transcribed and documented in the nurse's notes, and mailed to the attending physician for his signature. The order was signed and returned to the facility on 11/16/11. The MDS admission assessments were conducted on the admission date. On 12/14/11 orders were received to discharge resident #8 from PC level of care and an order to admit to SNF level of care correcting an entry of 11/09/11. Concurrently, the RN charge nurse documented the conversation and receipt of orders for resident #08 within the residents medical record nurses notes.



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On 11/17/11, the director of nurses, contacted the attending physician for resident #16 and discussed the resident's discharge from SNF level of care. The facility received an order for the need of personal care services and immediately documented the order, made the necessary documentation in the medical record, and mailed the phone order transcription form to the attending physician for his signature. The MDS assessments were completed relative to discharge from SNF care. Concurrently, the director of nurses documented the conversation and receipt of order for resident #16 within the resident's medical record. On 12/14/11 orders were received to admit resident #16 to PC level of care clarifying orders received on 11/17/11 regarding the 8/18/11 admission.

In-services were performed by the director of nurses, on 12/14/11 and 12/15/11 regarding the facility protocol for obtaining proper orders for discharge or transfer of residents and appropriate documentation within the medical record.

Identifying others:

All residents residing in the facility have the potential to be affected by the same practice if not discharged from one level of care and admitted to another, if the resident, and the resident's family, and/or his/her legal guardian or representative, and the resident's physician are not properly notified and the appropriate orders received. This notification could be

[Handwritten signature]
Admin.

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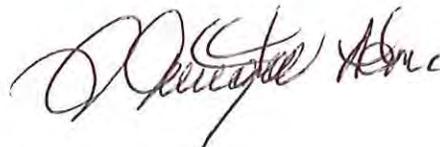
in face-to-face conferences, or by telephone, by facsimile.

An audit of the resident's charts within the facility, was performed on 12/12/11 by the Adm. Asst. to ensure that the physician's orders reflected the appropriate level of care for each resident and documented the same on the physician's orders.

Systemic changes:

The facility's policy/procedure for "Physician Notification" has been revised on 12/14/11 to include the following:

1. The attending physician shall be notified for resident with an illness, when a resident falls, with acute pain and/or injury, exhibits signs and symptoms of illnesses or injury that are beyond the scope the routine nursing practice and intervention required, and/or when a resident is discharged and/or admitted to another level of nursing care.
2. If the attending physician has not returned the facility's call within one hour, or a timeframe relegated by the illness or injury, when there is acute pain, injury, or illness, or admission or discharge that presents imminent danger the charge nurse is to call the medical director for orders and treatment.
3. Orders for admission and discharge within the facility from one level of care to another;



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and/or discharge from the facility shall be documented in the medical record and in the resident's nurses notes.

4. The residents nursing notes shall contain documentation relative to the time, date, and circumstances of the admission and/or discharge.

In-service was conducted by the director of nurses on 12/13/11 and 12/14/11 and scheduled for 12/15/11 discussing physician notification related to admission and discharge from levels of care.

Monitoring:

Regular and routine monthly audits of the resident's medical record, specifically the level of care orders shall be performed by the director of nurses, or her designee, to ensure that discharge and/or admission documentation is maintained per protocol. Monthly reports are generated and printed documenting the level of care of each resident that resides in the facility; thereby corresponding to resident room and level of care placement within the facility.

The Continuous Quality Improvement CQI policy and protocol have been updated and edited to emphasize monthly and routine auditing of the medical records to ensure the admission and discharge orders are documented appropriately and that physician orders have been obtained. The CQI manual and monthly reports are maintained by the assistant administrator

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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: 1962, 1981, 1984, 1989, 1999</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V Unprotected</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system</p> <p>GENERATOR: Type II generator, fuel source is propane.</p> <p>A standard Life Safety Code survey was conducted on 11/16/11. Covington's Convalescent Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for seventy two (72) beds and the census was sixty nine (69) 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>COVINGTON'S CONVALESCENT CENTER, INC. acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary and findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of the resident.</p> <p>COVINGTON'S CONVALESCENT CENTER, INC.'S response to the statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is totally accurate.</p> <p>K 018 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Corrective action: On the week of 11/21/11, a routine inspection was conducted of all resident rooms in the facility by the Maintenance Staff, Jerry Tucker and The Administrator, William Covington. The object of the inspection was to ascertain any blockage of resident room corridor doors whether it be privacy curtains, furniture, door stops, chocks, tie-backs, or other devices.. Privacy curtains for rooms #225, 227, 228, 230, and 232 were repositioned to their normal hanging status thereby allowing corridor doors to close properly and easily. Items were removed from resident's rooms and/or room furniture was rearranged to ensure proper corridor door closure. The facility will affix a laminated sign to the inside of the resident room door to instruct</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 COVINGTON'S CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 CAYCE ST HOPKINSVILLE, KY 42240	
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K 000	Continued From page 1	K 000	and alert employees not to block the door from closing with privacy curtains. <u>"DO NOT BLOCK DOOR from closing with PRIVACY CURTAINS"</u> and utilize Velcro tie-backs for curtain storage, attached to the room wall, to ensure proper positioning of privacy curtains when not in use.	
K 018 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, in accordance with NFPA standards. The deficiency had the potential to affect three (3) of six (6) smoke compartments, residents, staff, and visitors. The facility is licensed for seventy two (72) beds and</p>	K 018	<p style="text-align: right;">Page 2 of 17</p> <p>Identify others: All residents' rooms and corridor doors have a potential to be affected by the same practice if clearance is not insured to allow the door to close properly. On the week of 11/21/11, a routine inspection was conducted of all resident rooms in the facility by the Maintenance Staff, Jerry Tucker and The Administrator, William Covington to remove and or rearrange any item that could be identified as blocking resident room corridor doors from closing properly. In services were initiated by the administrator William Covington, the maintenance staff, Jerry Tucker, and the laundry and housekeeping supervisor, Jackie Byron during this inspection with one-on-one conferences with facility staff relative to maintaining proper closure of all resident room doors totally free from obstruction. Standup conferences were conducted on 11/21/11 with the facility license nursing staff by Cathlee Kington, DON during all shifts relative to routine and daily monitoring of a clear door opening.</p> <p>Systemic changes:</p>	

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K 018	<p>Continued From page 2</p> <p>the census was sixty nine (69) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 11/16/11 between 1:30 PM and 5:00 PM, with the Maintenance Staff revealed the corridor doors to rooms 225, 227, 228, 230, and 232 were blocked from closing by privacy curtains, and tables.</p> <p>Interviews, on 11/16/11 between 1:30 PM and 5:00 PM, with the Maintenance Staff confirmed the observation of the doors not closing due to the curtains and tables in the path of the door swing.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar</p>	K 018	<p>The facility revised and updated its hazardous materials and resident safety policy and procedure to include but not be limited to the following:</p> <ol style="list-style-type: none"> regular quarterly staff meetings to discuss the concerns of using and storage of hazardous materials and practices that could create hazardous situations, maintaining clear and unobstructed thresholds or passageways to corridor room doors, maintaining proper placement of resident room furniture to maintain clear passageways and door closure, Doors should not be blocked open by furniture, door stops, chocks, tie backs, drop-down and/or plunger type devices, or other devices that necessitate manual un-latching or releasing action to close. <p>Monitoring:</p> <p>The Continuous Quality Improvement CQI policy and protocol has been updated and reinforced to emphasize quarterly and routine monitoring of obstructions to resident room corridor doors. The CQI at committee composed of members of every discipline from administration, nursing, CNA's, maintenance departments shall inspect and document that the facility protocol relative to unobstructed doorways is followed.</p>		

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K 018	Continued From page 3 auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018	Completion date: 12/15/11 K 025 NFPA 101 LIFE SAFETY CODE STANDARD Corrective action: On the week of 11/21/11, a routine inspection was conducted of all smoke barriers within the facility by the Maintenance Staff, Jerry Tucker and The Administrator, William Covington. The object of the inspection was to ascertain any penetration by pipes or wires to the smoke barriers. All furnace room vents, mechanical room vents, water heater vents, and any penetration of the two-hour fire wall ceiling and penetrations of the smoke barrier were identified and repaired with a fire barrier sealant and/or 2 hour fire rated sheet rock. Identify others: When any maintenance work is contracted to vendors outside the facility and/or when any new equipment is installed or repaired in the facility that could, in any way, create a penetration to a fire wall or smoke barrier; an immediate inspection of the affected area will be conducted. If indeed, smoke barrier penetrations have occurred they will be repaired, by the maintenance department supervisor, Jerry Tucker, in coordination with completion of the maintenance work or equipment installation while the work is in progress. Systemic changes:		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 025			

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K 025	<p>Continued From page 4</p> <p>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 six (6) smoke compartments, residents, staff and visitors. The facility is licensed for seventy two (72) beds with a census of sixty nine (69) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 11/16/11 between 3:00 PM and 5:00 PM, with the Maintenance Staff revealed the smoke partitions extended above the ceiling and located at the breezeway to the Activity Center, and between the Dining room and the Chart Room next to room 232 to be penetrated by pipes and wires. Further observation revealed penetrations around the furnace vents, in the ceiling of the Mechanical Room in the Activity Center, and the Water Heater Room across from room 230. The spaces around the penetrations were not filled with a material rated equal to the partition and could not resist the passage of</p>	K 025	<p style="text-align: right;">Page 5 of 17</p> <p>The facility revised and updated its hazardous materials policy and procedure to include but not be limited to the following:</p> <ol style="list-style-type: none"> regular quarterly staff meetings to discuss the concerns of using and storage of hazardous materials and practices that could create hazardous situations, Smoke barrier penetrations that have occurred during scheduled maintenance, and/or installation or updating of equipment will be repaired in coordination with the maintenance work or equipment installation in progress. <p>Monitoring:</p> <p>Continuance Quality Improvement, CQI policy and protocol has been updated and revised to emphasize regular inspections during upgrading and/or installation of equipment. This could include, but not be limited to, electrical repair or upgrades, installation of telephone equipment, nurses call systems, fire alarm systems, plumbing repairs and/or any upgrade or new installation. The CQI committee is composed of members of every discipline from the administration, nursing, CNA's, maintenance, housekeeping, and laundry. The CQI committee is chaired by the assistant administrator, Richard Covington. Regularly scheduled quarterly meetings will document all recent repairs and/or upgrades, and additions of</p>	

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K 025	Continued From page 5 smoke. Interview, on 11/01/11 at 2:45 PM, with the Maintenance Director revealed he was not aware of the penetrations. Reference: NFPA 101 (2000 Edition). 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: (a) The space between the penetrating item and the smoke barrier shall 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. (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 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. (c) Where designs take transmission of vibration 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	Page 6 of 17 equipment and the necessary repairs to prevent penetration of the smoke barrier in the facility. Completion date: 12/31/11 K 050 NFPA 101 LIFE SAFETY CODE STANDARD Corrective action: The facility has corrected the fire drill protocol effective 11/21/11 and 11/22/11. Facility fire drills were conducted on specific individual shifts at varying times. Drills were conducted on the first shift at 10:20 a.m. on 11/21/11, second shift at 3:10 p.m. on 11/21/11, and on third shift at 6:30 a.m. on 11/22/11. At the conclusion of each shift fire drill, staff meetings were conducted to review the protocol of fire safety. The fire alarm panel notification system for an identified location of trouble was discussed, along with a review of the monitoring company (Vanguard systems) protocol. In-services have been conducted on 11/18/11 and 12/13/11 with the administrative staff relative to conducting fire drills on all shifts at unexpected times under varying conditions. In-services were presented by Richard Covington, assistant administrator, and included members from administration, maintenance, and nursing staff.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.	K 050	Identify others:	

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K 050	<p>Continued From page 6</p> <p>The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and fire drill review it was determined the facility failed to ensure fire drills were conducted at unexpected times under varied conditions in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for seventy two (72) beds with a census of sixty nine (69) on the day of the survey.</p> <p>The findings include:</p> <p>Fire Drill review, on 11/16/11 at 5:10 PM, with the Maintenance Staff and the Assistant Administrator revealed the fire drills were not being conducted quarterly per shift, at unexpected times under varied conditions. The facility was conducting one fire drill at 3:00 PM, to cover first and second shift, when first shift was leaving and second shift was coming to work. The drills were documented 1st/2nd.</p> <p>Interview, on 11/16/11 at 5:10 PM, with the Maintenance Staff, and the Assistant Administrator revealed they were not aware the</p>	K 050	<p>All residents of the facility have the potential to be affected when fire drills are not conducted according to facility protocol and/or staff members are not well educated and in-serviced regarding proper response during a far alarm.</p> <p>Systemic changes: The policy and procedure for conducting fire alarm drills has been updated and revised to include but not be limited to the following:</p> <ol style="list-style-type: none"> 1. Fire drills are to be conducted at unexpected times and under varying conditions, at least, quarterly on each shift, 2. Each fire drill shall include meetings to review the protocol for proper action during an alarm. 3. Richard Covington, assistant administrator, will ensure that the fire drills are documented according to facility protocol. <p>Monitoring:</p> <p>The continuous quality improvement CQI policy and protocol has been updated and revised to include the following:</p> <ol style="list-style-type: none"> 1. Fire drills are to be conducted at unexpected times and under varying conditions, at least, quarterly on each shift, 2. Each fire drill shall include a meeting to review the protocol for proper action during an alarm. 3. Richard Covington, assistant administrator, will ensure that the 	

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K 050	Continued From page 7 fire drills were not being conducted as required. Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050	fire drills are documented according to facility protocol.	Page 8 of 17	
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 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 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 six (6) smoke compartments, residents, staff, and visitors. The facility is licensed for seventy two (72) beds with a census of sixty nine (69) on the day of the survey.	K 056	The CQI committee is composed of members of every discipline from administration, nursing, CNA's, maintenance, dietary, housekeeping, and or laundry. The quarterly meeting of the CQI committee will document that each element of the policy and procedure and facility protocol have been followed. Richard Covington, assistant administrator, will document as indicated. Completion date: 12/01/11 K 056 NFPA 101 LIFE SAFETY CODE STANDARD Corrective action: On 12/06/11 Pennyrile Fire Safety was contacted to inspect and provide the facility a quote for installation of the appropriate sprinkler devices within walk-in cooler/freezer. The quote was received by William Covington, administrator of the facility, signed, and returned to the company. They are to install 2 dry sprinkler heads in the cooler/freezer with head guards. Work is to be completed during normal business hours M-F 8 a.m. to 4:30 p.m.. In a follow-up conference with Kenneth Calvin at Pennyrile Fire Safety, the urgency of the prompt installation was discussed and they assured me that they would perform the installation, as quickly as possible, and		

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K 056	Continued From page 8 The findings include: Observation, on 11/16/11 at 4:01 PM, with the Maintenance Staff revealed a walk-in cooler, and freezer located in the Kitchen, were not sprinkler protected. Interview, on 11/16/11 at 4:00 PM, with the Maintenance Staff revealed he was not aware the walk-in cooler and freezer were required to be sprinkler protected. Reference: NFPA 13 (1999 Edition) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect one (1) of the six (6) smoke compartments, residents, staff and visitors. The facility is licensed for seventy two (72) beds and the census was sixty nine (69) on the day of the survey. The findings include:	K 056	Page 9 of 17 therefore, scheduled the project on that date. The company that is to install the sprinkler heads did say that there were widespread citations involving freezer/cooler throughout Kentucky and that there is a backlog of installations.; ; however, we received a fax from Ohio Valley Sprinklers' Service Technician, Joe Knott, that the sprinkler coverage in the cooler/freezer will be installed and completed on 12/21/11. Identify others: There are no other walk-in cooler/freezers in the facility. Systemic changes: Routine quarterly sprinkler inspections performed by Pennyrile Fire Safety Company will include inspections the newly installed sprinkler heads in the walk-in cooler/freezer. Monitoring: Pennyrile Fire Safety Company supplies routine documentation of the inspections performed of the facility sprinkler system. These reports will document that the freezer/cooler sprinkler heads have been observed and inspected at least quarterly each year. Completion date: 12/31/2011 K 062 FIRE SAFETY CODE STANDARD Corrective action:	
K 062 SS=D		K 062		

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NAME OF PROVIDER OR SUPPLIER COVINGTON'S CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 116 CAYCE ST HOPKINSVILLE, KY 42240	
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K 062	Continued From page 9 Observation, on 11/16/11 at 3:27 PM, with the Maintenance Staff revealed a buildup of dust on the sprinkler heads located in the whirlpool room next to room 225. Interview, on 11/16/11 at 3:27 PM, with the Maintenance Staff confirmed the observation. Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2. NFPA 25 (1998 Edition) 1-11.1 Maintenance shall be performed to keep the system equipment operable or to make repairs. As-built system installation drawings, original acceptance test records, and device manufacturer ' s maintenance bulletins shall be retained to assist in the proper care of the system and its components.	K 062	<p style="text-align: right;">Page 10 of 17</p> <p>On 11/21/11 the facility housekeeping department physically cleaned every sprinkler head in the entire facility to remove dust, paint, or any debris from its surfaces. Jackie Byron, housekeeping and laundry supervisor, personally performed the cleaning. In particular, she cleaned build up of dust on the sprinkler heads located in the whirlpool room next to room 225.</p> <p>Identify others: A Survey of all the facility sprinkler heads within the facility was conducted on 12/14/11 to ensure proper cleaning. The facility floor plan diagram was utilized to ensure that every device had been properly cleaned and that it was in good repair.</p> <p>Systemic changes: Regular quarterly and periodic visual inspections will be made of all sprinkler heads within the facility for dust, lint, and/or erosion, free of corrosion, paint, and/or physical damage. These inspections will be performed by Jackie Byron, Housekeeper Supervisor, and Jerry Tucker, Maintenance Supervisor.</p> <p>Monitoring: The Continuous Quality Improvement CQI policy and protocol has been reviewed and reinforced to emphasize routine and periodic inspections of sprinkler heads to ensure they remain clean, free of dust, and erosion, free of corrosion,, and physical damage. The CQI is committee composed</p>	
K 070 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in	K 070		

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K 070	<p>Continued From page 10</p> <p>all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for seventy two (72) beds with a census of sixty nine (69) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 11/16/11 at 4:28 PM, with the Maintenance Staff revealed a portable space heater located in the sprinkler riser room located on the exterior of the building.</p> <p>Interview, on 11/16/11 at 4:28 PM, with the Maintenance Staff revealed the heater was kept in the sprinkler room as a back up to the permanent heat source.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall</p>	K 070	<p>Page 11 of 17</p> <p>of members of every discipline from administration, nursing, CNA'S, maintenance, dietary, housekeeping and laundry. Richard Covington will maintain records for the CQI meetings to document the results facility inspections that monitor the cleaning and maintenance of sprinkler heads.</p> <p>Completion date: 11/21/11</p> <p>K 070 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Corrective action: On 11/29/11, the portable space heater located in the sprinkler riser room on the exterior of the building was removed and a fan forced wall heater 120v, 1500 W, 5120 BTU, 12.5 amps was installed, using conduit, in the sprinkler riser room. This heater will be utilized in conjunction with another permanent heater source as an anti-freeze source.</p> <p>Identify others: There are no other sprinkler riser rooms on the exterior of the building.</p> <p>Systemic changes: The policy and protocol associated with routine maintenance as been reinforced and revised to continue to include regular inspections of the heating sources in the sprinkler riser room during the winter months and inclement weather seasons. Jerry Tucker, maintenance supervisor, will</p>	

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K 070	Continued From page 11 be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).	K 070	Page 12 of 17 be responsible for inspections and documentation of routine performance of the heating unit within the routine preventive maintenance manuals.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen cylinders were stored in accordance with NFPA standards. This deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff, and visitors. The facility is licensed for seventy two (72) beds with a census of sixty nine (69) on the day of the survey. The findings include: Observation, on 11/16/11 at 3:48 PM, with the Maintenance Staff revealed oxygen tanks were stored within five (5) feet of combustible materials located in the oxygen storage room accessible	K 076	Monitoring: The Continuous Quality Improvement CQI Policy and protocol has been updated and reinforced to emphasize routine and periodic inspections of the sprinkler riser room. The CQI committee composed of members of every discipline from administration, nursing, CNA's, maintenance, dietary, housekeeping, and laundry shall meet quarterly and document that the facility policy and procedures and protocol related to proper inspection of the sprinkler riser room are followed. Richard Covington, assistant administrator is responsible for conducting the CQI meetings and providing documentation : Completion date: 11/29/11 K 076 NFPA 101 LIFE SAFETY CODE STANDARD Corrective Action: On 12/14/11 all combustible materials (oxygen cylinders) were removed from the room where oxygen cylinders were stored. The oxygen cylinders can be stored in this room protected by an automatic sprinkler system if stored at a minimum distance of 5 feet combustible materials. The oxygen cylinders were relocated to a storage room	

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K 076	<p>Continued From page 12 only from the Med Room due to storage blocking the door to the corridor. There was no signs indicated hazardous storage within the room.</p> <p>Interview, on 11/16/11 at 3:48 PM, with the Maintenance Staff revealed he was not aware combustible material could not be stored within five (5) feet of the oxygen tanks.</p> <p>Reference: NFPA 99 (1999 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.</p>	K 076	<p style="text-align: right;">Page 13 of 17</p> <p>protected by the sprinkler system with adequate floor space to allow for the 5 foot separation from combustible items.</p> <p>Identify others:</p> <p>There are no other oxygen cylinders stored within the facility.</p> <p>Systemic changes:</p> <p>A policy and procedure for storing hazardous materials has been updated and revised to include the following:</p> <ol style="list-style-type: none"> 1. Oxygen cylinders shall maintain a safe storage distance of 5 feet from any combustible material. 2. Signs will be posted on all doors used for storing oxygen cylinders identifying it as containing hazardous storage. The Sign shall include "Caution Oxidized Gases Stored within No Smoking." 3. Regular and routine monthly observations to ensure the 5 foot clearance from combustible material rule. 4. Have all excess storage oxygen cylinders, full and empty, returned to the supplier on a regular basis. <p>Monitoring:</p> <p>Continuous quality improvement, CQI, policy and protocol has been updated and revised to emphasize regular</p>		

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K 076	Continued From page 13	K 076		
K 147 SS=E	<p>8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING</p> <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 four (4) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for seventy two (72) beds with a census of sixty nine (69) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 11/16/11 between 1:00 PM and 5:00 PM, with the Maintenance Staff revealed:</p> <ol style="list-style-type: none"> 1) An extension cord to a radio located in the Activities Room. 2) An extension cord located in resident room 101. 3) A power strip with the supply wire spliced into an extension cord to extend the length of the 	K 147	<p>Page 14 of 17</p> <p>observations and inspections of the oxygen cylinder tank storage to ensure proper storage. The CQI committee is composed of members of every discipline from the facility including the administration, nursing, CNA's, maintenance, dietary, housekeeping, and laundry. The CQI committee is chaired and monitored by Richard Covington, assistant administrator. Regularly scheduled quarterly meetings will document that the policy and protocol for storage of oxygen cylinders is followed.</p> <p>: Completion date: 12/15/11</p> <p>K 147 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Corrective action:</p> <ol style="list-style-type: none"> 1. On 11/17/11, when identified during the annual survey, the extension cord to the radio located in the activity room was disconnected and removed 2. On 11/17/11 and extension cord located in resident room #101 was disconnected and removed 3. On 11/21/11 the power strip spliced into an extension cord located in room #200 was removed and replaced with a power strip of the appropriate length. 4. The air pump in room #210 was disconnected from a power strip and plugged into a wall outlet. 	

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K 147	<p>Continued From page 14 cord, located in room 200.</p> <p>4) An extension cord in use, and an air pump plugged into a power strip located in room 210.</p> <p>5) Electrical panels unlocked in resident corridors.</p> <p>6) An air pump plugged into a power strip located in room 217.</p> <p>7) An extension cord to a radio located in the Laundry Room.</p> <p>Interview, on 11/16/11 between 1:00 PM and 5:00 PM, with the Maintenance Staff revealed they were not aware of the extension cords and power strips being misused.</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D</p> <p>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.</p> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance</p>	K 147	<p>Page 15 of 17</p> <p>5. On 12/08/11, Glover's Lock Company re-keyed the locks on two (2) electrical breaker panels to allow for locking. On 12/13/11 the locking device was applied to the remaining breaker box panel next to the nurse's station from 200 wing of the building.</p> <p>6. On 12/02/11 the air pump plugged into a power strip in room #217 was disconnected and plugged into a wall outlet.</p> <p>7. On 11/17/11 the radio plugged into an extension cord located in the laundry room was disconnected and removed.</p> <p>Identify others:</p> <p>All residents residing in the facility have the potential to be affected by the same practice if extension cords and power strips are utilized inappropriately in the facility and if Electrical breaker panel boxes, in the corridor, are not locked for access by anyone other than designated employees.</p> <p>Systemic changes:</p> <p>The policy and procedure and protocol for resident safety and hazards in the facility has been revised and updated to include the following:</p> <p>1. Routine monthly inspections of all departments, and resident rooms will be conducted by the</p>	

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K 147	Continued From page 15 of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K 147	<p style="text-align: right;">Page 16 of 17</p> <p>maintenance department supervisor, Jerry Tucker to ensure the extension cords are not in use.</p> <ol style="list-style-type: none"> The power strips are not used inappropriately for medical equipment connection, and The electrical breaker panel boxes in the corridor remain locked. Family members are advised during the admission process that extension cords are not allowed in resident rooms, Routine and quarterly in-services, employee conferences and/or face-to-face meetings will be conducted concerning the appropriate use of power strips and the prohibition of the use of extension cords. <p>Monitoring:</p> <p>A continuous quality improvement CQI policy and protocol has been updated to include the following:</p> <ol style="list-style-type: none"> Routine monthly inspections of all departments, and resident rooms will be conducted by the maintenance department supervisor, Jerry Tucker to ensure the extension cords are not in use. That power strips are not used inappropriately for medical equipment, and 		

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3. The electrical breaker panel boxes in the corridor remain locked.

The CQI and maintenance manuals will reflect documentation of the inspection and all in-service meetings to ensure compliance. Richard Covington, assistant administrator, and the maintenance supervisor Jerry Tucker are responsible for documentation of these quarterly meetings and/or routine observations and inspections.

Completion date: 12/31/11

 12-19-11