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

PRINTED: 10/03/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185358		09/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF TRIMBLE COUNTY	50 SHEPHERD LANE BEDFORD, KY 40006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on 09/18/12 through 09/20/12 and a Life Safety Code Survey was conducted on 09/18/12. Deficiencies were cited with the highest scope and severity of an "F".	F 000	Signature Healthcare of Trimble County does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policy Dialysis-Monitoring the ESRD Resident, the Outpatient Dialysis Services Agreement between the facility and the dialysis center and Tabers Cyclopedic Medical Dictionary, it was determined the facility failed to notify the physician of a critical lab value and coordinate care between the dialysis center and the facility for one (1) of the fifteen (15) sampled residents (Resident #3). The findings include: Review of the facility's policy Dialysis-Monitoring the End Stage Renal Disease (ESRD) Resident, dated 12/2010, revealed the resident's laboratory values ordered by the physician/ESRD center will	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

X Mark Witt — X Administrator — X 10/25/12

Administrator

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 309	Continued From page 1 be provided by the dialysis center, will be monitored by the clinical staff of the facility. The physician/designee will be notified regarding the laboratory results. Review of the facility's Outpatient Dialysis Services Agreement, effective 09/01/11, revealed both parties shall ensure that there is documented evidence of collaboration of care and communication between the nursing facility and the dialysis unit. Review of Resident #3's clinical record revealed the resident had a medical history that included Hypertension, Atrial Fibrillation (a type of irregular heart beat), two (2) Heart Attacks and ESRD requiring hemodialysis. The clinical record revealed the resident went to an outpatient dialysis center for treatment three times a week. Review of the Minimum Data Set (MDS), dated 06/13/12, revealed the resident was cognitively intact and had a Brief Interview of Mental Status (BIMS) score of 15, which was the highest maximum score. Review of the dialysis center transfer summary, dated 07/04/12, revealed the resident had a critical potassium level of 7.1 (normal range being 3.5 to 5) and to monitor high potassium foods as the resident reported drinking 3 to 5 glasses of orange juice and tomato juice every day. Further review of the dialysis transfer summaries revealed, on 07/20/12, the transfer summary communicated to watch fluids, and underlined the comment three (3) times. Review of the monthly physician orders dated 07/01/12 and 08/01/12 revealed the resident was on a regular diet with no restriction of food or fluid noted. Review of the	F 309	**F 309, 483.25 Provide Care/Services for Highest Well Being** **Address what corrective action will be accomplished for those residents found to be affected by the deficient practice.** 1.) The physician was notified on 9/19/12 by the Unit Manager of labs from July 4, 2012 and the transfer summary on July 20, 2012 that stated, "Watch fluids". No new orders were received at that time. 2.) On 9-20-2012 the dietary manager met with resident #3 to discuss the renal diet. Resident #3 reported that he will now follow the diet restrictions. 3.) All nursing and dietary staff were re-educated on 9/20/12 by the unit manager on the current renal diet for resident #3. 4.) A care plan meeting was held on 10-11-12 with resident #3 and the DON, unit manager, mds nurse, dietary manager and SSD to discuss current diet orders, any refusals to follow diet, labs for the last few months and any communication from the dialysis center. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** 1.) All resident diets will be reviewed by 10-26-12, by the unit manager,	11/3/12 F 309

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F 309	Continued From page 2 quarterly dietician assessment, dated 08/02/12, did not address the elevated potassium level. Review of the physician and the nurses notes did not address the elevated potassium level, or that the physician was notified. Review of Tabers Cyclopedic Medical Dictionary, 20th Ed. 2001, revealed elevated potassium levels cause weakness and paralysis, impaired electrical conduction in the heart, and eventually ventricular fibrillation (an irregular heart beat) and death. Review of Resident #3's comprehensive plan of care revealed the following nutrition approaches: to monitor lab/diagnostics and report results to physician; discuss with the resident/responsible party concerns about nutritional impairment; provide nutrition updates and education; and a therapeutic diet (type not listed). Review of the Dialysis/Renal Failure care plan approaches included: communicate with the dialysis center regarding medication, diet, and lab results; provide/monitor intake of diet/fluids; however, the fluid restriction was left blank. Review of the nursing assistant care plan revealed no diet restriction or precautions were listed or addressed. Observation of the meal service, on 09/18/12 at 12:30 PM, revealed the resident was sitting on the side of the bed eating a hamburger with a slice of tomato, and a half a glass of tomato juice was sitting on the tray. Observation of the refreshment cart, on 09/18/12 at 10:30 AM and 09/19/12 at 10:45 AM, revealed a certified nursing assistant (CNA) pushing the cart down the hall filled with coffee, orange juice, orange	F 309	dietary manager, MDS nurse and DON to ensure that all current diet orders reflect what is on the care plan and c.n.a. care plan. 2.) All resident charts will be reviewed for the last month by 10-26-12 by the unit manager, MDS nurse and DON to ensure that all communication from appointments, dialysis or hospital visits have communication in the chart and that the communication has been relayed to the physician, resident and/or poa. 3.) As of 9-20-12, during all care plan meetings, lab values and communication from appointments or hospital visits will be discussed with the resident and/or poa and documented on the care plan communication record by the MDS nurse and DON or unit manager. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** 1.) By 10-12-12, all charts of residents that go out to appointments or are re-admitted from the hospital will be brought to the morning clinical meeting daily Monday – Friday by the unit manager and don for review to ensure that communication was received from the appointment/dialysis center or from hospital re-admission to ensure that	11/3/12 F 309

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F 309	Continued From page 3 punch, water, and assorted fruit, including oranges. The CNA was walking room to room offering each resident their choice of a snack or refreshment. Interview with CNA #1, on 09/20/12 at 9:22 AM revealed she did not know what type of diet Resident #3 was on, or if there were any diet restrictions in place. The CNA revealed Resident #3 goes to eat at restaurants all the time and keeps a supply of tomato juice and candy at the bed side. Interview with Licensed Practical Nurse (LPN) #4, on 09/20/12 at 9:25 AM, revealed Resident #3 was not placed on a renal diet until the resident returned from the hospital on 08/06/12. The LPN revealed the resident did not have any specific dietary restrictions. The LPN revealed dialysis communication sheets were to be initialed when addressed, then placed in the chart. The LPN revealed any notes from the Dialysis Center must be called to the physician. After reviewing the Dialysis transfer sheets dated 07/04/12, 07/20/12, and the resident's clinical record, the LPN revealed the communication regarding the potassium lab value of 7.1 and fluid volume was not addressed. The LPN revealed the lab value should have been called to the physician and care plans should have been updated to reflect the monitoring of the potassium foods and fluids. The LPN revealed a high potassium level could cause cardiac issues and fluid overload. Interview with LPN #5, on 09/20/12 at 10:00 AM, revealed she did not remember being the resident's nurse on 07/04/12. However, the LPN revealed the physician should have been notified	F 309	the physician, resident and/or poa have been notified of any recommendations or new orders. 2.) The dietary manager will print a list of all resident diet orders three times daily with each snack pass beginning on 10-26-12. The diet orders will be placed on the snack cart in a binder and will be initialed by the c.n.a. that is passing snacks to ensure each resident received the appropriate snack. These forms will be collected daily by the unit manager. 3.) The MDS nurse, Unit manager and DON were re-educated on the care plan meeting process on 9-20-12 by the Regional Nurse Consultant to include all labs from the previous quarter and all communication from appointments, doctor's visits or hospital visits into the discussion and documentation of the care plan meeting. 4.) The DON and Unit manager were re-educated on 9-20-12 by the regional nurse consultant, to bring the charts of all residents that have been out to an appointment, dialysis, or hospital to the morning clinical meeting Monday – Friday for review to ensure all communication from the outside visits has been communicated to the physician, resident and/or poa. 5.) All nursing staff will be educated by the staff development coordinator by 11/2/12 on the snack pass process to include review of current diet order	11/3/12 F 309

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F 309	Continued From page 4 of the lab value and notations made in the clinical record. The LPN revealed a high potassium value could affect the heart. Interview with the Dietary Manager, on 09/20/12 at 10:07 AM, revealed she was not aware of Resident #3 having elevated potassium levels or a need to monitor potassium rich foods and fluids. The Dietary Manager revealed she was aware that the resident was noncompliant with the diet and frequently drank tomato juice. Interview with the Unit Manager, on 09/20/12 at 10:10 AM, revealed she had just started in July, 2012. The Unit manager revealed nurses receive the transfer information from the dialysis center and it should then go through the physician. The Unit Manager revealed she monitors communication by auditing the charts and ensuring the forms are in the chart. The Unit Manager revealed she monitors to ensure the concerns are addressed. The Unit Manager revealed she further reviews the chart during care plan meetings to ensure communication was added to the care plan. Review of the Care Plan Conference Summary, dated 08/15/12, revealed lab values were not addressed nor were the dietary needs which were communicated from the dialysis center. Continued interview with the Unit Manager revealed the abnormal lab, the lack of notation, and the dietary needs should have been caught during the care plan meeting. The Unit Manager revealed the resident could go into fluid overload and develop further cardiac problems if the concern was not addressed.	F 309	before passing snacks and initialing beside the diet as the snack is passed. **Indicate how the facility plans to monitor its performance to ensure that solutions are sustained** 1.) The unit manager, don and or dietary manager will audit 5 snack passes per week for 3 months, then monthly, to ensure that the diets are in a binder on the snack cart and are freshly printed with each snack pass, and that the residents are receiving snacks that are appropriate for their diets. Findings of the audits will be forwarded to the Administrator weekly to ensure completion and appropriate follow up. 2.) The don and unit manager will audit 5 charts weekly for 3 months , then monthly to ensure that communication has been received and is in the chart from all outside appointments, dialysis visits or hospital visits and that there is documentation reflecting that the physician, resident and/or poa have been notified with any new recommendations or orders. Findings of the audits will be forwarded to the Administrator weekly to ensure completion and appropriate follow up. 3.) The DON will audit all care plan meeting notes for 3 months to ensure	11/3/12 F309

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F 309	Continued From page 5 Interview with Resident #3, on 09/20/12 at 12:05 PM, revealed he/she was aware of the potassium level being elevated. The resident reveled drinking six (6) cans of tomato juice at a time. The resident stated the communication sheets were given to the nurse immediately upon return to the facility, but nothing was ever said about modifying the diet. The resident revealed the facility continued to give the juice on each tray and offered it from the refreshment cart. Interview with the Director of Nursing (DON), on 09/20/12 at 3:20 PM, revealed she started three (3) weeks prior to the start of the survey. The DON revealed she was not aware of concerns with how communication was being handled between the dialysis center and facility. The DON revealed the nurses should have called the dialysis center to clarify needs and the problem, then the physician should have been notified for orders. The DON revealed nurses need to be held accountable for ensuring continuity of care.	F 309	that all labs from the quarter and outside communications are being discussed with the resident and/or poa. Findings of the audits will be forwarded to the Administrator weekly to ensure completion and appropriate follow up. 4.) A dialysis center representative will be invited to attend quarterly care plan conferences for residents who require dialysis, and copies of facility care plans will be sent to the dialysis center to ensure continuity of care. The ADON will review the communication form following each dialysis center visit to ensure Physician and family notification of any changes that occurred that will require a change to the resident's care plan. The ADON will bring the dialysis communication form to the morning clinical meeting and changes will be discussed with the interdisciplinary team to ensure care plans are updated appropriately. 5.) Findings of all above audits will be reviewed by the DON during the QA committee monthly for follow up and recommendations. The QA Committee will determine the need to continue audits of the identified concerns after the stated time frames. QA meetings to be lead by Admin on a regular monthly basis.	11/3/12 F 309

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	185358	A. BUILDING 01 - MAIN BUILDING B. WING _____	09/18/2012

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1977 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: one (1) story, Type V (111) SMOKE COMPARTMENTS: Four (4) smoke compartments FIRE ALARM: Complete fire alarm system with heat and smoke detectors SPRINKLER SYSTEM: Complete automatic dry sprinkler system. GENERATOR: Type II generator. Fuel source is natural gas. A standard Life Safety Code survey was conducted on 09/18/12. Signature Healthcare of Trimble County was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility has sixty (60) certified beds with a census of fifty six (56) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator — 10/25/12

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		
	Deficiencies were cited with the highest deficiency identified at F level.		**Address what corrective action will be accomplished for those residents found to be affected by the deficient practice.**	0/6/12
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		025
	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		1. All penetrations located in dry-wall barrier walls were sealed with fire-retardant caulk and all penetrations located in concrete block barrier walls were sealed with concrete material. Completed on 10/5/12 by the Plant Ops Director.	
	This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, residents, staff and visitors. The facility has sixty (60) certified beds with a census of fifty six (56) on the day of the survey.		**Address how the facility will identify other residents having the potential to be affected by the same deficient practice.**	
	The findings include:		1. An inspection was completed on 10/5/12 by the Plant Ops Director of ALL attic barrier walls, which was a total of (6) in the facility. No further issues were identified.	
	Observation, on 09/18/12 between 11:00 AM and 12:00 PM, with the Regional Plant Operations Director revealed the smoke partition, extending above the ceiling located in the East and West Hall were not properly sealed. The facility used			

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K 025	Continued From page 2 unrated material that was not equal to the wall. Further observation revealed unsealed penetrations by pipes in the same locations. Interview, on 09/18/12 between 11:00 AM and 12:00 PM, with the Regional Operations Director revealed he was not aware of the penetrations in the smoke barrier and unaware the penetrations that were sealed were sealed with a material not equal to the wall. 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	**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** 1. The Administrator educated the Plant Ops Director on 10/4/12 that all attic fire barrier walls must be free from penetrations. 2. The Plant Ops director will inspect All attic barrier walls in the facility two times a month for 3 months and then monthly. 3. The inspections will be given to the Administrator by the Plant Ops Director for review after each inspection is completed and any identified issues will be addressed immediately. **Indicate how the facility plans to monitor its performance to ensure that solutions are sustained** 1.) All inspection results will be brought to the QA meeting by the Plant Ops Director monthly for follow up review and recommendations. The QA committee will determine the need to continue audits of the identified concerns after the stated time frames. QA meetings to be lead by the Administrator on a monthly basis.	10/6/12 K 025

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K 025	Continued From page 3 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.	K 025		10/6/12 K 025
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility has sixty (60) certified beds with a census of fifty six (56) on the day of the survey. The findings include: Observation, on 09/18/12 between 1:00 PM and	K 029	K029 NFPA 101 Life Safety Code Standard **Address what corrective action wil be accomplished for those residents found to be affected by the deficient practice.** 1. On 10/8/12 self-closing door devices were installed on the doors of the MDS office and the dry storage room of kitchen by the Plant Operations Director. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** 1. All facility doors, per regulation, have been inspected for need of closer by the Plant Ops Director on 10/8/12.	10/9/12 K029

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	185358	A. BUILDING 01 - MAIN BUILDING B. WING _____	09/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF TRIMBLE COUNTY	50 SHEPHERD LANE BEDFORD, KY 40006

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K 029	Continued From page 4 4:30 PM, with the Regional Plant Operations Director revealed the door to the Kitchen dry storage room, and the MDS Office did not have a self-closing device to meet the requirement for protection from hazards. Interview, on 09/18/12 between 1:00 PM and 4:30 PM, with the Regional Plant Operations Director revealed they were not aware the dry storage room was required to have a door and be self-closing. Further interview revealed they were planning on relocating the MDS Office or the hazardous storage within the room. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms	K 029	**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** 1. The Administrator educated the Plant Ops Director on 10/4/12 on requirements for self-closing doors, per regulation NFPA 101 19.3.2 – Protection from Hazards. 2. An audit will be completed by the Plant Ops Director of all rooms monthly for 3 months and then at the discretion of the QA committee to ensure that any rooms that are used for hazardous materials storage have a self-closing door device. The Plant Ops Director will show documentation to the Administrator after each inspection. If any new self-closing devices are required, they will be added immediately by the Plant Ops Director.	10/9/12 K 029

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		K029	**Indicate how the facility plans to monitor its performance to ensure that solutions are sustained** 1. Door closures will be monitored by the Plant Ops. Director through use of regular monthly door check log tool to be continued on monthly basis as a permanent audit. Results to be reported during QA process. QA meetings to be lead by Admin on a regular monthly basis. The Administrator will review this audit tool during QA meeting each month.	10/9/12 K029

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K 029	Continued From page 5 (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029	**K 038 NFPA 101 Life Safety Code Standard** **Address what corrective action will be accomplished for those residents found to be affected by the deficient practice.** 1. On 10/11/12 all exit door exterior lights (qty. of 7) have been brought into requirement with UL-approved double-fixture exterior flood lights. Work performed by Plant Ops Director.	10/12/12 K038
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, residents, staff and visitors. The facility has sixty (60) certified beds with a census of fifty six (56) on the day of the survey. The findings include:	K 038	**Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** 1. All (100%) of facility exit doors were inspected by the Plant Ops Director on 10-11-12. No other issues were identified. **Address what measures will be put into place or systemic changes made**	

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K 038	Continued From page 6 Observation, on 09/18/12 between 1:00 PM and 4:30 PM, with the Regional Plant Operations Director revealed the exterior exits at the ends of the North, West and East Halls had lights outside with only one bulb to light the egress pathes at each exit. Interview, on 09/18/12 between 1:00 PM and 4:30 PM, with the Regional Plant Operations Director revealed he was not aware the lighting outside the exterior exits was required to have more than one bulb. Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 038	**to ensure that the deficient practice will not recur.** 1. The Administrator educated the Plant Ops Director on 10/4/12 that all (100%) of facility exit doors are required to be illuminated by double-bulb fixtures, per regulation NFPA 101 19.2.1 – Exit access. 2. Any new lighting outside that is going to be installed must be approved by the Administrator before installation to ensure that regulation NFPA 101 19.2.1 is met.	10/12/12 K038
K 056 SS=F	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	K 056	**Indicate how the facility plans to monitor its performance to ensure that solutions are sustained** K 038 1. The Plant Ops Director will inspect all (100%) of facility exit doors monthly during emergency lighting testing. Any identified concerns will be addressed immediately. 2. Documentation of all inspections will be given to the administrator for review	

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K 056	Continued From page 7	K 056	and will be reported during QA process. QA meetings to be lead by Admin on a regular monthly basis. The Administrator will review this audit tool during QA meeting each month.	12/15/12 K056
	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 four (4) of four (4) smoke compartments, residents, staff and visitors. The facility has sixty (60) certified beds with a census of fifty six (56) on the day of the survey. The findings include: Observation, on 09/18/12 between 1:00 PM and 4:30 PM, with the Regional Plant Operations Director revealed a standard response sprinkler head and a quick response sprinkler head in the same compartment located in the dish room. Interview, on 09/18/12 between 1:00 PM and 4:30 PM, with the Regional Plant Operations Director revealed they were not aware that the sprinklers had to have the same response time if the sprinkler heads are located in the same compartment. Observation, on 09/18/12 between 1:00 PM and 4:30 PM, with the Regional Plant Operations Director revealed STAR ME1 sprinkler heads were located throughout the corridors, resident rooms, and offices. The STAR ME1 sprinkler heads were part of a sprinkler head recall and the		K 056 NFPA 101 Life Safety Code **Address what corrective action will be accomplished for those residents found to be affected by the deficient practice.** 1. On 10/4/12 Century Fire Protection Company replaced the deficient standard sprinkler head with a quick-response sprinkler head to match in the identified dish room area. 2. On 10/4/12 Century Fire Protection Company removed ten (10) of the STAR ME-1 sprinkler heads and sent off for testing and documentation. Awaiting results of testing. Will notify Life Safety Office/OIG when results are obtained and documented.	

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K 056	Continued From page 8 facility failed to provide documentation that the sprinkler heads in the facility had been tested and approved for continued use. Interview, on 09/18/12 between 1:00 PM and 4:30 PM, with the Regional Plant Operations Director revealed he was aware of the recall and thought the sprinkler heads had been tested but was not aware the facility did not have documentation on the sprinkler heads being tested. Reference: NFPA 13 (1999 Edition) 7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type.	K 056	3. On 10-4-12 the Administrator began the process of seeking quotes for replacement of sprinkler heads throughout facility. 4. On 10/24/12, Facility contracted Century Fire Protection Company to perform complete replacement of all facility sprinkler heads with quick-response heads. This work is scheduled to begin 11/12/12 and is scheduled to be completed 12/15/12. Attached to this document is job specification letter from Century Co. and Approval-PO from Signature Healthcare Home Office. The fire protection system is currently fully-functional. During process of sprinkler head replacement work, the alarm system will still be fully functional at all times. At any time during the replacement work when the sprinkler system will be non-functional, Plant Ops Director will perform proper Fire Watch procedures and will notify local fire dept. of timeframes that the sprinkler system will be non-	12/15/12 K056

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		K056	functional. Century Fire Co. is to ensure that the system is fully functional at conclusion of work each evening, until work is resumed the following morning. Plant Ops Director to monitor the process of Century Fire Company, and he will report daily to the Administrator the status of the replacement process. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** K 056 1. All (100%) of facility areas containing multiple sprinkler heads have been inspected and checked for mixed sprinkler heads by Century Fire Protection Company on 10-4-12. 2. On 10-4-12 Century Fire Company selected sprinkler heads for testing from mixture of	12/15/12 K056

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		K056	resident areas. All 100% of facility sprinkler heads have been contracted to be replaced by Century Fire Protection Co **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** 1. The Administrator educated Plant Ops Director on 10/4/12 on regulation requiring matching sprinkler head types, in regards to NFPA 13/25 – Sprinkler System. 2. The Administrator educated Plant Ops Director on 10/4/12 as to sprinkler head recall testing and requirements of compliance, per regulation NFPA 13/25 – Sprinkler System. 3. Century Fire Protection company will continue ongoing quarterly monitoring/testing of	12/15/12 K056

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		K056	sprinkler heads and will report their findings to the Plant Ops director and Administrator. Any identified issues will be corrected immediately. **Indicate how the facility plans to monitor its performance to ensure that solutions are sustained** 1. Century quarterly audits will be reported during QA process by the Plant Ops Director. The QA meetings will be lead by the Admin on a regular monthly basis. 2. Plant Ops Director and Administrator shall maintain documentation of tested sprinkler heads.	12/15/12 K056

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K 056	Continued From page 9 Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 056		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility has sixty (60) certified beds with a census of fifty six (56) on the day of the survey. The findings Include: Observation, on 09/18/12 between 1:00 PM and 4:30 PM, with the Regional Plant Operations Director revealed paint on the sprinkler head located in room #112. Interview, on 09/18/12 between 1:00 PM and 4:30 PM, with the Regional Plant Operations Director revealed he was not aware of the paint on the sprinkler head.	K 062	K 062 NFPA 101 Life Safety Code Standard **Address what corrective action will be accomplished for those residents found to be affected by the deficient practice.** 1. On 10/3/12 sprinkler head in room #112 has been cleaned and is free of debris/paint by Plant Ops Director. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** 1. The Plant Ops Director completed and inspection of all (100%) of sprinkler heads in the facility. No other issues were identified.	10/19/12 K062

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K 062	Continued From page 10 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. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a	K 062	**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** 1. The Administrator educated the Plant Ops Director on 10/4/12 on the regulation requiring sprinkler heads be free of debris, NFPA 13/5-5.5.2. & .1. 2. The Plant Operations Director will audit all sprinkler heads two times a month for three months during the water temperature inspection log process. Any issues identified will corrected immediately by the Plant Ops Director and, if needed, Century Fire Company and will be reported to the administrator immediately. 3. All inspections/audits will be reviewed by the Administrator monthly. **Indicate how the facility plans to monitor its performance to ensure that solutions are sustained**	10/19/12 K 062

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K 062	Continued From page 11 sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 062	1. The sprinkler head audits will be brought to the QA meeting monthly by the Plant Operations Director. After 3 months, if no further areas of concern are identified, inspections will be conducted monthly on a permanent basis by the Plant Ops Director at the discretion of the QA committee. QA meetings to be lead by Admin on a regular monthly basis.	10/19/12 K 062
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire extinguishers were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility has sixty (60) certified beds with a census of fifty six (56) on the day of the survey. The findings include: Observation, on 09/18/12 at 12:59 PM, with the Regional Plant Operations Director revealed there was no signage stating that the hood	K 064	K 064 NFPA Life Safety Code Standard **Address what corrective action will be accomplished for those residents found to be affected by the deficient practice.** 1. On 10/5/12 a proper notification sign was installed near the hood suppression system by the Plant Ops Director, in regards to range hood suppression system and the use of class K fire extinguisher.	10/6/12 K 064

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185358	A. BUILDING 01 - MAIN BUILDING B. WING _____	09/18/2012

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		K064	**Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** 1. On 10-5-12 the Plant Ops Director ensured that any equipment in kitchen requiring a hood suppression extinguishing system is located within visual range of proper notification sign. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** 1. The Administrator educated the Plant Ops Director and Food Service Director on 10/4/12 that any new equipment placement or maintenance relocation of relevant kitchen equipment must be identified by proper signage relating to extinguishing system, per regulation NFPA 10 19.3.5.6 – Fire Extinguishers.	10/6/12 K 064

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		K064	2. The kitchen will be monitored for sign placement on a permanent monthly basis during the monthly fire extinguisher check log procedures by Plant Ops Director. If signage is found to be missing, the Plant Ops Director will immediately replace with a temporary sign until another permanent sign can be obtained. The administrator will be notified immediately. **Indicate how the facility plans to monitor its performance to ensure that solutions are sustained** 1. The Plant Ops Director or Food Service Director will audit the kitchen weekly for 3 months to ensure that proper signage is intact. Any identified issues will be corrected immediately and reported to the administrator immediately. 2. Results of the weekly kitchen audits will be reported during QA process by the Plant Ops Director or Food Service Director. If	10/6/12 K 064

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K 064	Continued From page 12 suppression system must be used before the class K fire extinguisher. This type of extinguisher is used as a secondary measure to the range hood extinguishing system. Interview, on 09/18/12 at 12:59 PM, with the Regional Plant Operations Director revealed he was unaware of the signage requirement. Reference: NFPA 10 (1998 Edition). 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.	K 064	no further issues are identified, the audits will change to monthly and be continued on a monthly basis by the Plant Operations Director at the discretion of the QA committee. QA meetings to be lead by Admin on a regular monthly basis.	10/20/12 K068
K 068 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure combustion air and ventilation for boilers, incinerators, and heater rooms were installed in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty six (56) on the day of the survey. The facility failed to ensure the laundry room did not vent into the attic.	K 068	K 068 NFPA 101 Life Safety Code Standard **Address what corrective action will be accomplished for those residents found to be affected by the deficient practice.** 1. On 10/9/12 the dislodged ceiling supply vent was repaired by re-attaching the supply vent to the duct. Work performed by Plant Ops Director. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** 1. By 10-19-12 the Plant Ops Director had inspected all (100%) of vent/duct work in attic are of facility, correcting any dislodged vents.	

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K 068	Continued From page 13 The findings include: Observation, on 09/18/12 between 11:00 AM and 4:30 PM, with the Regional Plant Operations Director revealed a vent in the ceiling of the laundry room that was open to the attic above. Interview, on 09/18/12 between 11:00 AM and 4:30 PM with the Regional Plant Operations Director, revealed he was unaware the vent was open to the attic. Reference: NFPA 101 Life Safety Code (2000 edition) Section 19.5 Building Services 19.5.2.2 Any heating device other than a central heating plant shall be designed and installed so that combustible material will not be ignited by the device or its appurtenances. If fuel-fired, such heating devices shall be chimney connected or vent connected, shall take air for combustion directly from the outside, and shall be designed and installed to provide for complete separation of the combustible system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure.	K 068	**Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** 1. The Administrator educated the Plant Ops Director on 10/4/12 that all vents in the attic must be properly attached to duct work, per regulation NFPA 101 19.5.2.2 – Combustion and Ventilation. 2. All (100%) of vent attachments will be inspected monthly during the monthly fire wall inspection process on a permanent basis by Plant Ops Director. Any disconnected duct/vent work is to be corrected immediately by Plant Ops Director and reported to the Administrator. **Indicate how the facility plans to monitor its performance to ensure that solutions are sustained** 1. The monthly vent audits will be reported during QA process monthly by the Plant operations Director. QA meetings to be lead by Admin on a regular monthly basis.	10/20/12 K 068
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96	K 069		

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K 069	Continued From page 14 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the cooking appliances were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility has sixty (60) certified beds with a census of fifty six (56) on the day of the survey. The findings include: Observation, on 09/18/12 at 12:54 PM, with the Regional Plant Operations Director revealed the manual pull for the activation of the hood suppression system was blocked by an ice maker. Interview, on 09/18/12 at 12:54 PM, with the Regional Plant Operations Director revealed the ice maker was moved to that location just two (2) weeks prior, and he was not aware it was placed in front of the manual pull, blocking it from use. Observation, on 09/18/12 at 12:56 PM, with the Regional Plant Operations Director revealed the deep fryer located in the kitchen was not completely under the hood system. Interview, on 09/18/12 at 12:56 PM, with the Regional Plant Operations Director revealed he was unaware the deep fryer had been pushed over and was no longer completely under the hood system. Reference: NFPA 96 (1998 edition)	K 069	K 069 NFPA 101 Life Safety Code Standard **Address what corrective action will be accomplished for those residents found to be affected by the deficient practice.** 1. On 10/11/12, contractor Superior Fire Company re-located the manual pull station to an accessible wall near the exit of kitchen. 2. On 10/4/12 the deep fryer was relocated to be completely under the hood coverage area by Plant Ops Director. 3. On 10/4/12 a splash/barrier guard has also been installed onto side of deep fryer by the Plant Ops Director. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** 1.) On 10/12/12, the Plant Ops Director completed an inspection of all (100%) of manual pull Stations in the facility, ensuring that they are completely accessible.	10/13/12 K 069

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K 069	Continued From page 15 7-5.1 A readily accessible means for manual activation shall be located between 42 in. and 60 in. (1067 mm and 1524 mm) above the floor, located in a path of exit or egress, and clearly identify the hazard protected. The automatic and manual means of system activation external to the control head or releasing device shall be separate and independent of each other so that failure of one will not impair the operation of the other. Exception No. 1: The manual means of system activation shall be permitted to be common with the automatic means if the manual activation device is located between the control head or releasing device and the first fusible link. Exception No. 2: An automatic sprinkler system. NFPA 96 (1998 Edition) 9-1.2.3 All deep fat fryers shall be installed with at least 16-in. (406.4-mm) space between the fryer and surface flames from adjacent cooking equipment. Exception: Where a steel or tempered glass baffle plate is installed at a minimum 8 in. (203 mm) in height between the fryer and surface flames of the adjacent appliance.	K 069	2.) On 10-12-12 the Plant Ops Director and Food Service Director visually inspected all equipment in the kitchen requiring to be placed within confines of hood suppression system, ensuring all equipment is properly located. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** 1.) On 10/4/12 the Administrator educated the Plant Ops Director and Food Service Director that any relocation of equipment within facility must allow for free access to any manual fire pull stations, per regulation NFPA 96 19.3.2.6 (7-5.1) – Cooking facilities Protected. 2.) In future, if kitchen area gets rearranged for any reason, Plant Ops Director and/or Food Service Director will visually and physically ensure that deep fryer remains completely	10/13/12 K069
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by:	K 104		

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		K 069	under hood coverage area. 3.) Any changes to the kitchen will first be approved by the administrator. **Indicate how the facility plans to monitor its performance to ensure that solutions are sustained** 1.) The kitchen will be monitored every 6 months during hood suppression system inspection performed by the contracted Superior Fire Company. The Facility Plant Ops Director will monitor the Superior inspection and documentation process. The Plant Ops Director to report status to Admin during QA meeting process that follows the 6-month inspection. Any immediate corrective action required to be reported immediately to Admin. 2.) The Plant Ops Director will inspect the deep fryer placement and all other kitchen equipment requiring hood suppression confining monthly on a permanent monthly basis during Fire Extinguisher audit procedures. Findings to be documented on the Fire Extinguisher audit tool. Results will be reported during QA committee by the Plant Ops Director monthly. QA meetings to be lead by Admin on a regular monthly basis.	10/13/12 K 069

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K 104	Continued From page 16 Based on interview and record review of Fire Damper Testing records, it was determined the facility failed to ensure fire/smoke dampers were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility has sixty (60) certified beds with a census of fifty six (56) on the day of the survey. The findings include: Fire Damper Testing Record review, on 09/18/12 at 11:30 AM with the Regional Plant Operations Director revealed the facility did not have documentation for fire damper testing. Interview, on 09/18/12 at 11:30 AM, with the Regional Plant Operations Director revealed that the facility did not keep maintenance documentation on the fire/smoke dampers. Reference: NFPA 90A (1999 edition) 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 104	K104 NFPA Life Safety Code Standard **Address what corrective action will be accomplished for those residents found to be affected by the deficient practice.** 1. All (100%) dampers in facility will be inspected and tested by licensed contractor Butterfield HVAC Company. Initial testing visit performed on 10/12/12. Replacement of deficient dampers to be completed by 11/2/12. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** 1. All (100%) of facility damper devices to be included in testing procedures.	11/2/12 K 104
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

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		K104	**Address what measures will be put into place or systemic changes made To ensure that the deficient practice will not recur.** 1. The Administrator educated the Plant Ops Director on 10/4/12 on directive to utilize Butterfield HVAC Company for testing and monitoring of damper system, per regulation NFPA 90A 3-4.7. **Indicate how the facility plans to monitor its performance to ensure that solutions are sustained** K 104 1. Dampers will be monitored and inspected per regulation every 4 years by licensed contractor. Documentation to be maintained by Plant Ops Director. Plant Ops Director to call and schedule inspection per requirements. During every January QA meeting, Plant Ops Director will report to Admin if the upcoming year is an inspection year. QA meetings to be lead by Admin on a regular monthly basis.	11/2/12 K104

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K 147	Continued From page 17 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff, and visitors. The facility has sixty (60) certified beds with a census of fifty six (56) on the day of the survey. The findings include: Observations, on 09/18/12 between 11:00 AM and 4:30 PM, with the Regional Plant Operations Director revealed: 1) An extension cord to a lamp located in room #112. 2) A mini nebulizer was plugged into a power strip located in room #119. Interview, on 09/18/12 between 11:00 AM and 4:30 PM, with the Regional Plant Operations Director revealed he thought they had removed all power strips and extension cords that were being misused. Reference: NFPA 70 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the	K 147	K 147 NFPA 101 Life Safety Code Standard **Address what corrective action will be accomplished for those residents found to be affected by the deficient practice.** 1. On 9/20/12 the extension cord was removed from room #112, and mini-nebulizer plugged into proper outlet of room #119. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** 1. By 10/19/12, all (100%) of resident rooms were inspected by the Housekeeping Director to ensure that there were no improperly used extension cords, and/or medical equipment plugged into improper outlets. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** 1. On 10/4/12 the Administrator educated the Housekeeping Director and	11/3/12 K147

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K 147	Continued From page 18 following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	the Plant Ops Director that zero extension cords are to be used in resident rooms and that all medical equipment must be plugged into proper outlets, per regulation NFPA 70 400-8 & 99 3-3.2.1.2 D. 2. On 10/25/12 a letter to all Resident's Responsible Parties regarding regulation NFPA 70 400-8 & 99 3-3.2.1.2 D. was mailed out by the Administrator. Copy of letter is attached. 3. On 11/2/12 a staff in-service on Fire Safety policy is scheduled to be lead by the Plant Ops Director and Staff Development Coordinator. Any staff unable to attend will be in-serviced by written notice with the approval of the administrator. The Plant Ops Director and staff Development Coordinator are to maintain documentation of in-servicing and record keeping of attendance/completion. In-service completion to be reported to the Administrator.	11/3/12 K147

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U.S. DEPT. OF HEALTH AND HUMAN SERVICES

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

PRINTED: 10/03/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185358	A. BUILDING 01 - MAIN BUILDING B. WING _____	09/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF TRIMBLE COUNTY	50 SHEPHERD LANE BEDFORD, KY 40006

(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
		K147	**Indicate how the facility plans to monitor its performance to ensure that solutions are sustained** 1. All rooms will be inspected monthly to ensure that all medical equipment is plugged into an appropriate outlet and that there are no extension cords being used in resident rooms by the housekeeping supervisor or plant ops director. Any identified areas will be corrected immediately and reported to the administrator. 2. The monthly room audits will be documented within Safety Committee minutes on a permanent monthly basis by the Plant Ops Director. 3. The Safety Committee Minutes will be reviewed by the Administrator during the monthly QA process. QA meetings to be lead by Admin on a regular monthly basis.	11/3/12 K147

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