

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

PRINTED: 12/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  12/12/2013
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - ST MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207		
(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 initiated on 12/10/13 and concluded on 12/12/13 with deficiencies cited at the highest scope and severity of an "F". A Life Safety Code survey was initiated and concluded on 12/10/13 with deficiencies cited at the highest scope and severity of a "D".	F 000	1. The corrective actions accomplished for resident found to have been affected by the deficient practice are as follows: Resident #8 was given shower on Wednesday December 11th per shower schedule.		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility policy, it was determined the facility failed to provide Activities of Daily Living for one (1) of twenty-two (22) sampled residents, Resident #8. The facility failed to provide showers for Resident #8, five (5) out of nine (9) opportunities between 11/11/13 and 12/11/13.  The findings include:  Review of the facility nursing Policy and Procedures effective May 2001, revealed the purpose of a shower bath was to cleanse and refresh the resident, observe the skin, and provide increased circulation. Documentation should appear on any form used by the facility. Registered Nurses, Licensed Practical Nurses and Certified Nursing Assistants were responsible	F 312	2. Other residents having the potential to be affected by the same deficient practice identified and the corrective action is as follows: interviews conducted with all resident's able to participate and shower schedules reviewed and modified to ensure efficiency and capability. All resident's unable to participate in interviews were audited by nursing/CNA interviews of resident's compliance/cooperation with current shower schedule evidenced by lack of behaviors, lack of s/s of distress, and physical agreement based on body language by 1-8-14. 3. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: All nursing staff educated by 1-25-14 on shower schedule, shower sheets, and proper documentation in Caretracker, CNA documentation tool. The charge nurse is responsible for ensuring resident's showers are completed per shower assignment. The charge nurse signs the completed shower sheet after the CNA has completed the shower acknowledging that shower was given.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*X Allison Slays ED*  
*X Executive Dir*  
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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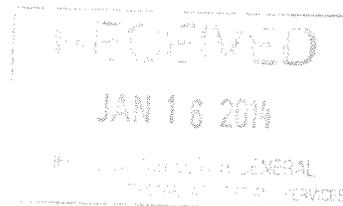
F 312	<p>Continued From page 1 for the residents' bath (shower) specific to state licensing requirements.</p> <p>Review of the medical record for Resident #8 revealed the facility admitted the resident on 08/20/13 with Diagnoses including Hypertension, Pyelonephritis, Leukemia, Depression, Diabetes Type 2, and Hyperlipidemia. Review of the quarterly Minimum Data Set Assessment completed on 11/18/13 revealed the facility completed a Brief Interview for Mental Status (BIMS) and assessed the resident at eleven (11), moderately impaired. The facility assessed the resident's mobility as requiring extensive assistance with one (1) assist for mobility, hygiene and bathing.</p> <p>Interview with Resident #8 on 12/11/13 at 9:32 AM revealed the resident stated when he/she was admitted to the facility and could name his/her nurse and aide providing care on that day. The resident complained of not receiving showers as scheduled two (2) times a week. The resident stated he/she would like to get a shower and have his/her hair washed.</p> <p>Review of the facility shower schedule revealed Resident #8 was to receive a shower on Wednesdays and Saturdays on second shift.</p> <p>Review of the bathing summary report for Resident #8 revealed from 11/11/13 through 12/11/13 the resident received one (1) shower out of nine (9) opportunities. Continued review of the bathing summary report revealed documentation of three (3) refusals and three (3) full bed baths.</p> <p>Interview with Certified Nursing Assistant (CNA) #5 on 12/12/13 at 10:00 AM revealed she was</p>	F 312	<p>All nursing staff educated by 1-25-14 on the proper procedure to follow when a resident refuses a shower to include if a resident refuses a shower the charge nurse must be notified. The charge nurse will ask the resident if he/she declines shower to assure no extenuating circumstances are present. If resident continues to refuse nurse will document in nursing documentation notes and CNA will also document in their documentation tool. Shower refusal option to check added to shower sheet documentation tool.</p> <p>4.UM/EVENING SUPERVISOR/ CHARGE NURSE will observe showers being given 3 x weekly for 4 weeks, 2 x weekly for 4 weeks, weekly x 4 weeks, then monthly. DNS/ADNS will interview/observe 5% of resident population 3 x weekly for 4 weeks, 2 x weekly for 4 weeks, weekly x 4 weeks, then monthly to ensure showers are being received.</p> <p>Alert and oriented residents will be asked if they are receiving their showers, while residents that are unable to express needs will be visualized to ensure cleanliness, lack of odors, and adequate grooming. DNS/ADNS will audit all shower documentation sheets, nursing documentation r/t all showers, in correlation with Caretracker documentation 3 x weekly for 4 weeks, 2 x weekly for 4 weeks, weekly x 4 weeks, then monthly for shower compliance and staff compliance and need for further shower schedule adjustments to ensure all resident needs and requests are met.</p>	<p>F312</p> <p>1/25/14</p>
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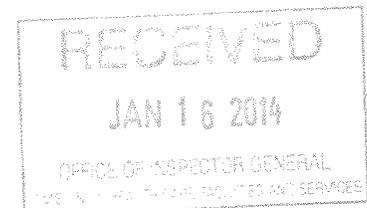
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F 312	Continued From page 2 normally assigned fourteen (14) to fifteen (15) residents on day shift with two (2) showers. She stated she normally got her assignment done unless they were short staffed. She stated that happened about one (1) time a week and then they had to do a three (3) way split. She stated they would be assigned twenty (20) to twenty-one (21) residents each and three (3) to four (4) showers. She stated on those days they could not get their work done. She stated the nurses were too busy to help or they told you to get your hall partner but they were busy too. She stated she had reported to the Assistant Director of Nursing about not getting the scheduled assignment complete.  Interview with Licensed Practical Nurse (LPN) #1 on 12/12/13 at 10:30 AM revealed CNA's were assigned fourteen (14) to fifteen (15) residents each and two (2) showers on first and second shift. She stated they were short staffed about one (1) time a week when staff called in and couldn't be replaced. She stated then CNA's would be assigned twenty-one (21) residents on day shift and three (3) to four (4) showers. When asked if it was possible for the staff to get their work done she stated maybe they would and maybe they wouldn't depending on the CNA, but it would be difficult. She stated the CNA's were given shower sheets everyday of resident assigned showers. She stated the CNA was required to complete the form and turn it in to the nurse who verified the showers were complete. She stated some staff would stay over to get their work done.  A request was made for Certified Nursing Assistant bath and skin reports for Resident #8 for the past thirty (30) days. Only two (2) were	F 312			



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F 312	<p>Continued From page 3</p> <p>returned dated 12/07/13 when the resident refused and 12/11/13 when the resident received a shower.</p> <p>Interview with CNA #6 on 12/12/13 at 10:45 AM revealed she was assigned fourteen (14) residents and two (2) showers daily. She stated she had provided care for Resident #8 on occasion but the resident shower was not scheduled on her shift. She stated she had reported to Administration in staff meetings it was difficult to get their assignments done.</p> <p>Follow up interview with Resident #8 on 12/12/13 at 2:00 PM revealed the resident acknowledged refusal of showers on occasion but stated that didn't mean the resident didn't want them anymore.</p> <p>Interview with Registered Nurse #2 on 12/12/13 at 2:45 PM revealed CNA's do complete shower sheets on all residents on the day of their shower and return them at the end of the day to the nurse. She stated there had been times in the last three (3) to six (6) months when resident showers were not completed due to short staff, and lack of linens. She stated if the resident did not get a shower they would get a complete bed bath. She stated some residents had complained and they accommodated them that day with a shower. She stated staff had complained about not getting assignments done about one (1) time a week. She stated it had been voiced in staff meeting about short staff and they were told by administration "their hands were kind of tied". She stated they had voiced concerns about not enough linen and administrations' response was that staff were throwing away the linen.</p>	F 312			



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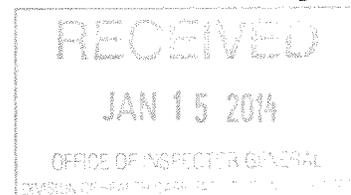
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F 312	Continued From page 4 Interview with the Director of Nursing on 12/12/13 at 5:00 PM revealed she was not aware showers were not getting done. She stated the Unit Managers oversaw the shower schedule. She stated there were no reports of showers not getting done that she was aware.  Interview with CNA # 2 on 12/12/13 at 5:35 PM revealed she was assigned on different hallways all the time. She stated if there were only three (3) CNA's instead of four (4), showers didn't get done. She stated concerns had been voiced in staff meetings about assignments not getting done. She stated she had taken care of Resident #8 and the resident had refused a shower at times.  Interview with the Administrator on 12/12/13 at 5:45 PM revealed she was not aware showers were not getting done and believed staff should be able to get their assignment completed taking care of fourteen (14) to fifteen (15) residents and two (2) showers a day.	F 312			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced	F 371	F371  1) The food carts and tables were cleaned immediately, by the dietary staff under the supervision of the Dietary Manager on 12/14/13, the fryer was cleaned by the Assistant Dietary Manager immediately on 12/14/13, the meat slicer was cleaned immediately by the Assistant Director on 12/14/13 and the floors were cleaned immediately on 12/14/13 by the dietary staff under the supervision of the Dietary Manager. The Vent Hood was cleaned by Richard Hood Cleaning		



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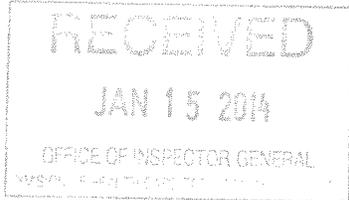
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F 371	<p>Continued From page 5 by: Based on observation, interview and facility policy review, it was determined the facility failed to ensure equipment and floors were properly cleaned. The meat slicer, deep fryer, cart and kitchen floors were not clean.</p> <p>The findings include: The facility did not provide a policy regarding kitchen cleanliness.</p> <p>Observation during the sanitation tour of the kitchen, on 12/12/13 at 2:45 PM, revealed the deep fryer grease was dark and had food particles in the grease and around the edges. The meat slicer had dark brown flakes behind the blade. The floor behind the deep fryer and stove had a cup, piece of plastic with white debris on it and the floor behind the dessert preparation table had grime, dust and white debris. A cart, containing pitchers used for residents, had dark stains on it and coffee ground looking substance on the cart.</p> <p>Review of the Daily Cleaning Schedule revealed the deep fryer would be cleaned after each use and the grease drained after five uses, the food slicer would be cleaned after each use and the kitchen floors would be swept and mopped daily. The cleaning schedule indicated, by initials, the deep fryer and food slicer had been cleaned on 12/09/13 and 12/10/13 and the floors had been mopped and swept on 12/09/13, 12/10/13 and 12/11/13.</p> <p>Interview with the Dietary Manager (DM), on 12/12/13 at 3:00 PM, revealed the meat slicer was cleaned before and after each use and she</p>	F 371	<p>Services on 12/14/13. No residents were affected due to the immediate cleaning of equipment.</p> <p>2) A limited number of residents have the potential to be affected based on diet orders/textures. No residents were affected due to equipment not being used before cleaned.</p> <p>3) The resident records were reviewed for GI signs and symptoms by the DNS for the next 72 hours, on 12/14/13, 12/15/13, 12/16/13, and 12/17/13. No residents displayed GI symptoms. The food carts and tables were cleaned immediately, by the dietary staff under the supervision of the Dietary Manager on 12/14/13, the fryer was cleaned by the Assistant Dietary Manager immediately on 12/14/13, the meat slicer was cleaned immediately by the Assistant Director on 12/14/13 and the floors were cleaned immediately on 12/14/13 by the dietary staff under the supervision of the Dietary Manager. The Vent Hood was cleaned by Richard Hood Cleaning Services on 12/14/13. Cleaning schedules detailing each positions job duties for cleaning equipment were posted by the Dietary Manager on 1/6/14. In-services were provided on 1/3/14 by the Dietary Manger and Executive Director with all dietary employees on 1) the importance of cleaning and sanitizing all equipment and contact surfaces in the dietary department 2) proper use and cleaning of the fryer and food slicer, including documentation of cleaning on the</p>	



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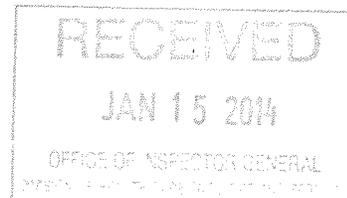
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F 371	Continued From page 6 could not explain the brown flecks behind the slicing blade. She stated the deep fryer had not been used recently. The cart holding drink pitchers was scheduled to be cleaned daily. She stated the floors were scheduled to be swept and mopped daily and as needed. The Dietary Manager reported the floors needed to be power washed to get them really clean. She could not explain why the plastic wrap, cup and white debris was left behind the stove, deep fryer and dessert preparation table. She stated sanitation is the key in the kitchen and very important for residents. Residents could get ill if the sanitation in the kitchen area was not good. The DM stated old food particles could get in the resident's food if the meat slicer was not cleaned properly and this could make the residents sick. She reported the dietary department had been short staffed and unfortunately sanitation was the first to go when short staffed. She reported there was a cleaning schedule but that was not always followed and she sometimes thought staff signed the cleaning had been done when it had not been completed. The DM stated she had not had time to follow up with the staff to ensure the work was done properly and she knew she was ultimately responsible for the sanitation of the kitchen area.	F 371	posted cleaning schedule 3) carts and floors are to be cleaned and sanitized during each shift as scheduled and documentation of completion on cleaning schedules. 4) The Dietary Manager implemented the use of a daily start- up check list to audit the cleanliness of the equipment and completion of documentation as assigned on 1/6/14. The Dietary Manager, Dietary Assistant, or shift supervisor will validate cleaning of equipment daily, effective 1/6/14. Dining Services will utilize and complete a daily closing check list effective 1/6/14 The Dietary Manager, Assistant, or Supervisor will audit and inspect the kitchen and equipment for completion effective 1/6/14. The Dietician will complete weekly sanitation audits for three months effective 1/13/14, then monthly. The results will be reported to the Dietary Manager, Dietary Consultant, and the Executive Director upon completion. Sanitation QI audit will be completed by the Dietician Consultant Quarterly, starting 1/22/14. All check list and audits will be reviewed for trends monthly. Trends and action plans will be reported to the QAPI Committee for the next three months and quarterly thereafter. The committee will re-evaluate the effectiveness of interventions monthly.		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by:	F 465		F371  1/25/14	



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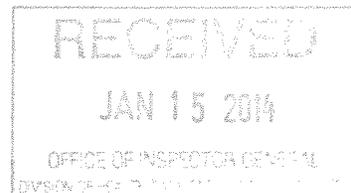
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F 465	<p>Continued From page 7</p> <p>Based on observation, interview, and review of facility policy, it was determined the facility failed maintain a safe and comfortable environment.</p> <p>The findings include:</p> <p>The facility stated they had no specific policy on facility routine maintenance.</p> <p>Observation during the initial tour on 12/10/13 revealed the nurses station on the 100 hall was dusty around the sides of the computers and on the cords behind the computer. The ceiling fan hanging at the 100 nurses station had dark debris around the edges of the fan paddles. The hand rails on the 100 unit had multiple nicks and some wood chipped off. The linoleum floor going from the administrative offices to the front entrance had multiple white streaks running throughout the brown linoleum. Room 204-2 had a fall mat split down the middle with the foam exposed. The center privacy curtain for room 206 had yellowish stain on the bottom of the curtain. Room 507 center privacy curtain observed with two reddish stains noted.</p> <p>Observation on 12/11/13 at 8:00 AM revealed in Room 201 the cold water faucet would not turn on. Room 203-1 behind the recliner chair, the wall was scuffed with drywall exposed. The hand rail across from room 308 was chipped with sharp edges. The hand rail across from room 322 was chipped with rough edges. The wheelchairs for room 304-2 and 311-2 were soiled with dust and debris on the wheels and the brakes. In room 504-2 the wall behind the bed was scuffed with black marks and tears in the wall with drywall exposed. In room 508-2 the wall behind the bed and recliner had black scuffs and the wall was</p>	F 465	<p>F 465</p> <p>1) The 100 Hall nurse station including counter area and sides of computer were cleaned immediately on 12/14/13 by the Housekeeper and the ceiling fan was cleaned per the Environmental Services floor tech immediately on 12/14/13. Nicked areas on railings for North Hall and hallway near 322 were filled with wood putty and sanded to ensure no rough edges on 12/14/13 per the maintenance assistant. New flooring was placed on the North unit per Schaeffer Flooring with project completion of 1/3/14. The linoleum for Administrative Hall is scheduled for replacement as soon as the product is delivered to facility. There is a current signed contract dated 1/10/14 per Schaeffer Co. and Golden Living for product and installation. See attached contract. The fall mat for 204-2 was discarded and replaced immediately with a new mat by the ED and Maintenance Assistant on 12/14/13. The privacy curtains for 206 and 507 were removed and replaced immediately on 12/14/13 immediately per Maintenance and Housekeeping. The cold water valve was opened in 201 immediately on 12/14/13 per the maintenance assistant. Rms. 203, 308, 504-2, 506-2 drywall was patched and sealed on 1/12/14 per the ED and the Maintenance Assistant. The walls are scheduled for painting by 1/24/14 per ED and Maintenance Assistant. Wheel</p>		



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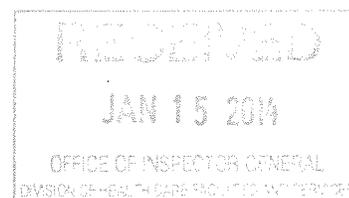
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F 465	<p>Continued From page 8</p> <p>torn through to the dry wall. Outside rooms 500, 501, 503, 505, and 506 there were multiple holes in the wall covered with clear material. The fire doors to the 300 unit, 400 unit and 500 unit had multiple paint chips exposing a brown surface underneath. In addition, the bottom edge of the fire door on the 400 unit was splintered.</p> <p>Observation on 12/12/13 at 3:30 PM during a tour of the facility with the Administrator, Maintenance Director and Housekeeping supervisor found the previous noted observations the same as observed on 12/10/13 and 12/11/13 during survey.</p> <p>Interview on 12/12/13 at 3:30 PM with the Administrator revealed nursing should have put work orders in the computer when they see privacy curtains stained, holes in the walls in resident rooms, and if resident equipment was in disrepair like the fall mats. She stated there was a wheelchair cleaning schedule but was not aware of the frequency of the cleaning. The Maintenance Director stated the other maintenance worker had just completed a general maintenance check and had completed some repair work about two (2) weeks ago but it was not documented what was completed. He stated he was not aware of chips in the handrails, holes in the walls in resident rooms or of the cold water not working in room 201. He went on to say they had some projects going on at the time and was not as focused on facility maintenance. He stated he could see where the chipped wood could be a potential for injury to the residents. Interview with the Housekeeping Supervisor revealed housekeeping did not check the privacy curtain for soilage when they cleaned the rooms daily but should have checked them on the</p>	F 465	<p>chairs for 304-2 and 311-2 were cleaned immediately per CNA, 12/14/13. Clear caulk was removed from small nail holes outside of rooms 500, 501, 503, 505, and 506 and replaced with joint compound and repaired by the maintenance assistant on 1/3/14. 300, 400, and 500 unit fire doors were repaired and painted by maintenance, 1/3/14.</p> <p>2) All residents have the potential to be affected. Audits of resident areas will be completed by the interdisciplinary Team to identify Environmental and Maintenance needs beginning 1/13/14. Items identified will be reported, entered into a computer system by the IDT team when the need is noted. Maintenance will review the work orders, prioritize needs and address accordingly.</p> <p>3) Staff in-services were provided on 1/6, 7 &amp; 14/14 by the Executive Director, Director of Nursing Service, and the Educator regarding process for reporting environmental and maintenance needs using Building Engines software. On 1/7/14 the Environmental Director, re-educated the Environmental staff on cleaning check list and responsibilities, including changing of privacy curtains, dusting, ceiling fans, and reporting repairs. Beginning on 1/13/14 Maintenance Director and/or designee will review Building Engines for environmental and</p>	



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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - ST MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207		
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F 465	Continued From page 9 monthly deep cleaning schedule. She stated the privacy curtains identified on tour as soiled had not been reported.	F 465	<p>maintenance needs five times a week and correct as indicated. Beginning on 1/15/14 the Executive Director will review Building Engines for environmental and maintenance needs two times a week and address as indicated.</p> <p>4) The Interdisciplinary Team will complete non-clinical rounds daily for seven days, then weekly for thirty days, biweekly next thirty days, then monthly for three months. Results of audits will be presented to the QAPI Committee to determine if additional actions are needed and continuance of auditing.</p>	F465 1/25/14	



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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: 1965</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story with a partial basement, Type III Unprotected.</p> <p>SMOKE COMPARTMENTS: Nine (9) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 12/10/13. Golden Living Center St. Mathews was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</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		
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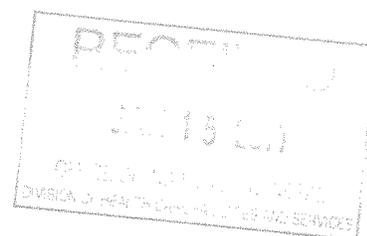
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X. Allipson Sharp, ED</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>1/15/14</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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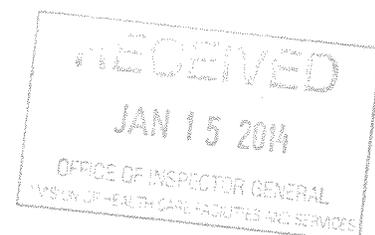
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K 000	Continued From page 1 Deficiencies were cited with the highest deficiency identified at a D level.	K 000			
K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, approximately twenty (20) residents, staff and visitors. The facility had one-hundred and twenty-five (125) certified beds and the census was one-hundred and six (106) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 12/10/13 at 9:46 AM, with the Administrator and the Assistant Maintenance Director revealed the closet containing two (2) water heaters, located within the MDS Office, had</p>	K 029	<p>K029</p> <p>1) The holes in the MDS closet were sealed immediately upon completion of the tour with fire rated caulk on 12/12/13 per the Maintenance Assistant.</p> <p>2) A smoke barrier audit was completed throughout the entire living center per the Maintenance Assistant, 12/13/13. No other areas identified. No residents were affected.</p> <p>3) On 12-12-13 the Executive Director in-serviced the maintenance assistant regarding regulation and use of fire caulk. The Maintenance Director and Assistant Maintenance Director will review work areas</p>		



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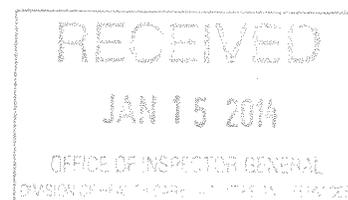
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K 029	Continued From page 2 small holes on the interior side of the room where copper piping had recently been replaced. The penetrations had not been filled with a rated sealant and not capable to resist the passage of smoke in the event of an emergency.  Interview, on 12/10/13 at 9:46 AM, with the Administrator and the Assistant Maintenance Director revealed they were not aware of the holes not being filled smoke tight and not able to resist the passage of smoke in the event of an emergency.  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 (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2),	K 029	after completion of contract work for damaged seals and proper use of fire grade caulk. Immediate repairs will be completed. The Executive Director will validate with the Maintenance Director or assistant that this work was completed monthly beginning on 1/14/14  4) The QAPI committee will review with the Executive Director and the Maintenance Director that all smoke barriers are filled with fire rated caulk after any entrance or work completed monthly beginning 1/22/14. This item will be added to monthly QAPI minutes.	K029  1/25/14



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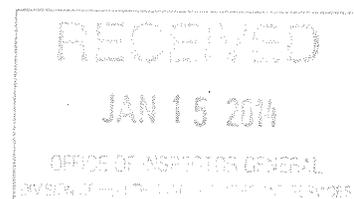
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K 029	Continued From page 3 including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029		
K 147 SS=D	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect each of the nine (9) smoke compartments, residents, staff and visitors. The facility had one-hundred and twenty-five (125) certified beds and the census was one-hundred and six (106) on the day of the survey. The facility failed to ensure three (3) feet of clearance around the main electrical panel located in the Basement.  The findings include:  Observation, on 12/10/13 at 10:41 AM, with the Administrator and the Assistant Maintenance	K 147	K 147  1) Items in front of electrical panel were immediately removed from area upon completion of inspection tour, 12/10/13 per Maintenance Assistant.  2) Other electrical panels were immediately audited for compliance by the Maintenance Assistant on 12/12/14. No other issues identified. No residents affected.  3) The Executive Director immediately educated the Assistant Maintenance Director,	



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K 147	<p>Continued From page 4</p> <p>Director revealed the main electrical panel within the Electrical Room located in the Basement, had chairs stacked and stored within 3 feet of access to the panel.</p> <p>Interview, on 12/10/13 at 10:41 AM, with the Administrator and the Assistant Maintenance Director revealed they were unaware of the stacked chairs being temporarily stored within three (3) feet of the electrical panel.</p> <p>Reference: NFPA 70 (1999 edition) 110-26. Spaces</p> <p>10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> <p>(A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code.</p> <p>(1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.</p> <p>Table 110.26(A)(1) Working Spaces</p>	K 147	<p>Environmental Director and assistant on 12/12/14. Staff education was provided regarding three foot clearance on 1/6, 7, &amp; 14/14.per ED, DNS, and Educator. The Maintenance Director and/or Assistant Maintenance Director will audit electrical areas weekly to ensure compliance initiated 1/6/14. Beginning 1/6/14, the Executive Director will validate with the Maintenance Director or assistant completion of weekly audits for three months and then monthly.</p> <p>4) Audit results will be reviewed with the QAPI Committee monthly. This item will be included in monthly QAPI minutes beginning 1/22/14.</p>	K147 1/25//14	



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K 147	Continued From page 5  Nominal Voltage to Ground      Minimum Clear Distance Condition 1      Condition 2      Condition 3 0-150 900 mm (3 ft)    900 mm (3 ft)    900 mm (3 ft) 151-600      900 mm (3 ft)    1 m (3½ ft) 1.2 m (4 ft)	K 147		

