

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

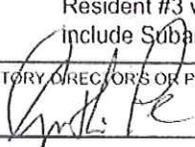
PRINTED: 08/19/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2010
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NAME OF PROVIDER OR SUPPLIER  OAKVIEW NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10456 US HWY 62 CALVERT CITY, KY 42029
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS  An annual recertification survey was conducted 08/03/10 through 08/06/10 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "D". Additionally, abbreviated surveys (KY #14942, KY #15069, and KY #15129) were conducted on 08/03-06/10. KY #14942 was unsubstantiated with no regulatory violations identified. KY #15069 was substantiated with no regulatory violations identified. KY #15129 was substantiated with deficiencies cited.	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to implement written policies and procedures that prohibit neglect of one resident (#3) in the selected sample of 20. Resident #3 was care planned for dressing changes twice every day. Registered Nurse (RN) #1 failed to provide the dressing changes as ordered; however, the RN documented the dressings changes were completed on 06/09/10, 06/10/10, and 06/13/10. Findings include:  Resident #3 was admitted with diagnoses to include Subarachnoid Hemorrhage, Aneurysm,	F 224	Resident # 3  Resident # 3's dressing was removed and the site evaluated. The surgical site showed no signs or symptoms of infection. The resident suffered no adverse reaction related to failure to change the dressing. The resident's physician and family were made aware of the failure to change the dressing.  All residents who have any type of treatment have the potential to be affected.  The problem with the failure to change the dressing was identified on 06/14/10 by the Director of Nursing and a Performance Improvement Plan was initiated. A skin assessment was completed on 06/14/10 by the Wing 1 Charge Nurse and a dressing change was completed. On 6/14/10, all residents with any type of dressings has skin assessments and treatment reviews to ensure treatments were being provided as directed. RN # 1 was counseled on 06/14/10 and	08/27/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 9/1/10
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 224 Continued From page 1

Aphasia and Convulsions. A review of the quarterly Minimum Data Set (MDS), dated 06/29/10, revealed the facility identified Resident #3 was severely impaired cognitively and required minimum to extensive assistance of one staff member with activities of daily living.

An observation of Resident #3, on 08/04/10 at 10:30 AM, revealed the resident was in a wheelchair, awake and alert, but did not respond to attempts to interviews by the surveyor.

A review of the Treatment Record for the month of June 2010, revealed the resident had a dressing change ordered twice a day to a temple wound. The treatment record revealed the dressing change was initiated daily except for 06/03/10 and 06/11/10.

An interview, on 08/05/10 at 5:54 PM with RN #1 revealed she initiated the treatment record which indicated she had completed the treatment as ordered; however, she did not complete the dressing change for Resident #3. She stated she could not remember the exact days in June this occurred. RN #1 stated if she was unable to complete a task during her shift, then she would report it to the on-coming shift but was uncertain if she reported about the dressing changes not being completed. RN #1 stated, "I did not intend to falsify documentation. I did not complete the treatment, but I did not go back and circle my initials to indicate it was not completed."

An interview with the Director of Nursing (DON), on 08/05/10 at 6:45 PM, revealed a former staff member alleged RN #1 had documented treatments were being completed but had not been completed as ordered. The DON stated

F 224

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received a Performance Improvement Plan to include a final written warning concerning job performance. RN # 1 resigned from her full-time position on 06/23/10 after counseling with the Director of Nursing and Administrator.

The Director of Nursing and Staff Development Coordinator conducted in-services on documentation and care provision to include conducting treatments per physician's orders on 06/24/10.

Audits five days a week of five residents with treatments were initiated on 06/14/10 and continued times four weeks by the Director of Nursing. The Director of Nursing currently is conducting weekly reviews of five residents with treatments and this review will continue times four weeks. Results have been reported to the Performance Improvement Committee and will continue to be reported in the meeting times four months.

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F 224	Continued From page 2 she checked Resident #3's dressing on 06/11/10 and the dressing to the resident's temporal wound was dated three days before (06/08/10). She checked the dressing, the treatment record, as well as the staff responsible for providing the treatment. The DON determined RN #1 was responsible for completing the dressing changes and had documented on 06/09/10 and 06/10/10 that they had been completed as ordered. On 06/14/10 the DON again checked the resident. The dressing was dated two days before (06/12/10). She investigated the incident and determined RN #1 had initialed the treatments were completed but they were not actually carried out as ordered. The DON stated RN #1 was neglectful in providing care to Resident #3 regarding the dressing changes to the resident's wound.	F 224	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and	F 225	No residents were affected by the failure to print the completed Nurse Aide Abuse Registry Check prior to hire.  All residents within the facility have the potential to be affected by the failure to complete the Nurse Aide Abuse Registry Check prior to hire.  The Abuse Registry Check was completed for employee #4 on 05/19/10, employee #5 on 06/10/10, and employee #6 on 07/06/10. Verbal counseling was completed with the Staff Development Coordinator on 08/23/10 regarding Abuse Registry Check requirements by the Director of Nursing. The Administrator and Director of Nursing conducted an in-service with the Staff Development Coordinator on 08/23/10 regarding the importance of checking and printing the abuse registry check prior to an	08/27/2010	

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F 225	<p>Continued From page 3</p> <p>to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to conduct Nurse Aide Abuse Registry checks for three employees, prior to employment in the facility (#4, #5 and #6), of nine employee personnel records reviewed. Findings include:</p> <ol style="list-style-type: none"> <li>1. A review of the personnel record of Employee #4, a State Registered Nursing Assistant (SRNA), revealed a hire date of 05/17/10; however, the Nurse Aide Abuse Registry check was not completed until 05/19/10.</li> <li>2. A review of the personnel record for Employee #5, a Licensed Practical Nurse, revealed a hire date of 06/07/10; however, the Nurse Aide Abuse Registry check was not completed until 06/10/10.</li> </ol>	F 225	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>employee being offered employment within the facility. On 08/23/10 the Staff Development Coordinator received verbal counseling by the Director of Nursing. The Staff Development Coordinator will complete a log which identifies prospective employees and will include the date the criminal records check was completed and printed which will be prior to hire.</p> <p>The Director of Nursing and/or Administrator will conduct weekly audits times four weeks of at least four new hires to ensure the criminal record check was completed and printed prior to hire. A monthly audit of new employees to ensure the criminal record check is completed will then be conducted monthly times four months. The results of the audits will be presented in the Performance Improvement meeting times four months.</p> <p>Completion date will be 08/27/10.</p>	

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F 225 Continued From page 4  
3. A review of the personnel record for Employee #6, a SRNA, revealed a hire date of 07/05/10; however, the Nurse Aide Abuse Registry check was not completed until 07/06/10.  
  
An interview with the Staff Development Coordinator, on 08/05/10 at 11:45 AM, revealed she was responsible for conducting the Abuse Registry checks. She completed the checks when the prospective employee came for an interview, but did not print the abuse check out on that date. She stated the facility's policy and procedure required the Nurse Aide Registry checks be completed prior to employee date of hire.

F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  
SS=D  
  
The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  
  
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  
  
In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

F 225  
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F 431  
No residents were using the expired feeding. 08/27/2010  
  
No residents were affected by the expired feeding.  
  
All residents on enteral feeding had the potential to be affected.  
  
The expired Jevity was discarded on 08/05/10. The Director of Nursing checked the expiration dates of all enteral feedings on 08/09/10. All licensed nurses are aware of the need to check expiration dates prior to administration; however, an all in-service was initiated on 08/23/10 and will be conducted with all licensed nursing staff about ensuring the expiration date is checked prior to administration of enteral feedings. This was conducted by the Staff Development Coordinator.

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F 431	<p>Continued From page 5</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, included the appropriate accessory and cautionary instructions and the expiration date, when applicable. The medication room contained two cases of Jevity 1.0 with an expiration date of 06/01/10 and 10 cases of Jevity 1.0 with an expiration date of 08/01/10. Findings include:</p> <p>Observation on 08/05/10 at 3:45 PM, in the medication room on Hall Two, revealed (24) 8 ounce cans of Jevity 1.0, with an expiration date of 06/01/10 and (120) 8 ounce cans of Jevity 1.0, with an expiration date of 08/01/10 were available for use.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 08/05/10 at 3:45 PM, revealed the materials supply person was responsible for checking the medication rooms for expired supplies and replacing the supplies. She stated,</p>	F 431	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Weekly audits of enteral feedings will be conducted by the Director of Nursing and/or Staff Development Coordinator times four weeks. Audits will then be conducted monthly times four months. Results of the audits will be taken to the Performance Improvement Committee on a monthly basis times four months.</p> <p>Completion date will be 08/27/10.</p>

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F 431 Continued From page 6  
"The feedings should have been discarded because they were expired".

An interview with Registered Nurse (RN) #2, on 08/05/10 at 3:50 PM, revealed the enteral feeding was checked by the nurse prior to administering it to a resident. She stated the expired feedings should have been thrown away if they were expired.

An interview with the Central Supply Clerk, on 08/05/10 at 4:00 PM, revealed he was responsible for ordering the supplies for the supply room. He stated, "I was told to order, rotate and put up enteral feedings. Some gentleman faxes a sheet to the facility and I fill out what feedings we need and how much, then I give it back to the case manager or Director of Nursing (DON). I don't check the dates. I just rotate and put up the enteral feedings".

An interview with the DON, on 08/05/10 at 4:10 PM, revealed the Central Supply Clerk was trained by the former case manager of the facility. She stated he was trained to check the supply rooms of the facility and remove expired items from the supply rooms.

F 431  
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K 000	INITIAL COMMENTS  A life safety code survey was initiated and concluded on August 9, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are 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  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to utilize proper access doors and properly seal the fire/smoke wall assembly in the attic area. The facility also failed to maintain fire/smoke dampers in the fire/smoke barrier walls. This deficient practice affected five (5) of six (6) smoke compartments, staff and all of the residents. The facility had the capacity for 106 beds with a census of 96 the day of survey.  The findings include:	K 025	Contracted vendor to remove current access panels and replace with fire rated access panels. Cable will be re-adjusted and re-aligned to not penetrate access panels. Panels will then be sealed and caulked with fire rated caulk at all areas.  HVAC Contractor will inspect and replace fuse length in damper. Four year fire inspection completed and documented.  Completion date will be 09/23/10.	09/23/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 8/23/10
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K 025	<p>Continued From page 1</p> <p>Observation during the Life Safety Code survey on August 9, 2010, at 4:30 p.m., with Maintenance staff, in the attic above the cross corridor doors at Hall 1, revealed an unapproved wooden make shift door in the fire/smoke barrier wall. This door could not be shut because of wiring and cables running through the door. This type of access door is required to be of an approved design and rating. Unsealed penetrations of wiring, conduit and sprinkler piping were also noted in the fire/smoke barrier wall. These areas must be filled with a suitable material to prevent the passage of fire and smoke in a fire situation. An interview with Maintenance staff on August 9, 2010, at 4:30 p.m., revealed outside contractors must have done the damage to the fire/smoke barrier wall and made the access door inoperable. Maintenance staff was not aware of the damage to the wall. The fire/smoke barrier wall at Hall 2 was observed to have the same damage and unapproved access door as Hall 1.</p> <p>An interview with the Director of Maintenance on August 9, 2010, at 5:30 p.m., via telephone, revealed fire dampers were in the ductwork that ran through fire/smoke barrier walls. A fire damper closes to prevent fire and hot gases from penetrating the fire/smoke barrier wall and is required to be inspected and maintained every four (4) years. The Director of Maintenance was unaware of the requirements pertaining to fire dampers.</p> <p>Reference: NFPA 101 2000 edition</p> <p>19.3.7.3 Any required smoke barrier shall be constructed</p>	K 025	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185195</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/09/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>OAKVIEW NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>10456 US HWY 62 CALVERT CITY, KY 42029</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 2 in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.  8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.  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: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) 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 meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall	K 025	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	

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K 025	<p>Continued From page 3</p> <p>meet one of the following conditions:</p> <p>a. It shall be made on either side of the smoke barrier.</p> <p>b. It shall be made by an approved device that is designed for the specific purpose.</p> <p>Reference: NFPA 90a 1999 edition</p> <p>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.</p>	K 025	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	
K 056 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure a combustibile canopy at the back of the facility was sprinkler protected as required.</p>	K 056	<p>Contracted vendor to install sidewall sprinkler head (freeze proof) at the back of the facility.</p> <p>Completion date will be 09/23/10.</p>	09/23/2010

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K 056	<p>Continued From page 4</p> <p>The findings include:</p> <p>During the Life Safety Code survey on August 9, 2010 at 3:45 p.m., with the Maintenance staff, a combustible canopy approximately 7'x9', located at the back of the facility was noted not to be sprinkler protected. Combustible canopies exceeding four foot in width must be sprinkler protected. An interview revealed Maintenance staff was not aware of this requirement.</p> <p>Reference: NFPA 13 1999 edition</p> <p>5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.</p>	K 056	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	
K 130 SS=D	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain gas clothes dryers by manufacture's recommendations. This deficient practice affected one (1) of six (6) smoke compartments, staff and approximately thirty (30) residents. The facility had the capacity for 106 beds with a census of 96 the day of survey.</p> <p>The findings include:</p>	K 130	<p>Contracted Healthcare Services Group will clean lint following each cycle in the dryer unit. Maintenance to perform preventative maintenance on exterior of dryer weekly and remove lint as needed. Maintenance Director to audit weekly and document results. Results to be reported to Administrator on a weekly basis.</p> <p>Completion date will be 09/23/10.</p>	09/23/2010



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K 144	<p>Continued From page 6</p> <p>106 beds with a census of 96 the day of survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on August 9, 2010, at 3:40 p.m., an interview with Maintenance staff revealed the generator battery was not connected to a permanent battery charger as required. The battery must be fully maintained to start the generator in case of an electrical power failure at the facility. Maintenance staff stated the battery is manually connected to a battery charger when the battery needs charging. Maintenance staff was not aware the generator battery is required to be permanently connected to a battery charger.</p> <p>5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturer's recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.</p>	K 144	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	