

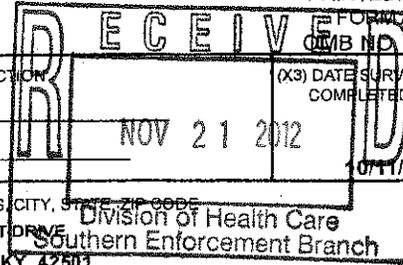
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Second SOD

PRINTED: 11/19/2012

FORM APPROVED

OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185173	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/11/2012
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NAME OF PROVIDER OR SUPPLIER CUMBERLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NORFLEET DRIVE SOMERSET, KY 42501 Division of Health Care Southern Enforcement Branch
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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 A standard health survey was conducted on 10/09-11/12. Deficient practice was identified with the highest scope and severity being at "E" level.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policy, the facility failed to ensure services provided met professional standards of quality for two of eighteen sampled residents (Residents #10 and #14). Facility staff received an order on 08/21/12 to discontinue side rails for Resident #14, however, observations on 10/09/12 and 10/11/12 revealed the side rails were in use on Resident #14's bed. In addition, Resident #10 had physician's orders dated 09/18/12 to discontinue the use of compression stockings but observations on 10/10/12 and 10/11/12 revealed Resident # 10 was wearing the compression stockings. The findings include: A review of the facility's policy titled Notification of Resident Change in Condition, (not dated) revealed all physician's orders would be followed as written or given verbally to a nurse by the physician.	F 281	F281 Residents #14 side rails were removed immediately by the Maintenance Director. The attending physician and the Medical Director were notified by the DON during the survey and there were no new orders. Resident # 10 had his compression hose removed immediately by the C.N A. The physician and family were immediately notified by the Unit Manager. No new orders noted.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Gill Spurgeon</i>	TITLE <i>Adm.</i>	(X6) DATE <i>11/21/12</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Received Time Nov. 21. 2012 4:04PM No. 2907

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F 281	<p>Continued From page 1</p> <p>1. A review of the medical record for Resident #14 revealed the facility admitted the resident on 07/05/12 with diagnoses that included Cerebral Vascular Accident, Hypertension, Dementia, and Urinary Retention. A review of a supplemental physician's order dated 08/21/12 revealed the use of side rails for Resident #14 was to be discontinued.</p> <p>Review of the Interdisciplinary Progress Notes, dated 08/21/12, revealed the Interdisciplinary Team had discussed Resident #14's inability to use side rails to assist with bed mobility and the side rails would be discontinued.</p> <p>Observations during the initial tour of the facility on 10/09/12 at 10:00 AM, revealed Resident #14 was lying in bed with two half side rails raised at the head of the resident's bed. Further observations on 10/09/12 at 6:15 PM, revealed staff delivered a dinner tray to Resident #14 and the two half side rails remained in the raised position. Continued observation on 10/11/12 at 9:30 AM, 10:00 AM, 11:30 AM, 2:20 PM, and 3:15 PM, revealed the side rails were on Resident #14's bed and in the raised position.</p> <p>Interview on 10/11/12 at 2:40 PM, with the Maintenance Supervisor (MS) revealed the Director of Nursing (DON) notified him when side rails were to be added or removed from resident beds. The MS stated Resident #14's family member had purchased a bariatric bed to be used by the resident. The MS stated approximately two months ago the DON notified him to remove the side rails from Resident #14's bed. The MS confirmed the side rails were removed from the bariatric bed. The MS stated</p>	F 281	<p>A one time audit of all physician orders will be completed by 11/09/12 by the Director of Nursing, (DON) the Unit Managers, (UM) and the Education and Training Director (ETD) to identify any assistive devices or adaptive equipment that is not being applied or removed per physicians order. Any issues identified will be corrected immediately and the physician and family notified. A one-time audit of all C.N.A. sheets and care plans will be completed by the DON, UM and ETD by 11/9/12 to identify any assistive device that is not on the care plan, identify any care plan that is not reflective of the physicians orders and to identify any assistive device or adaptive equipment that is not being applied per physicians orders. Any issue will be resolved immediately and physician and family notified.</p> <p>A one time audit of all residents will be completed by the DON/UM and ETD by 11/20/2012 to identify if all assistive devices are on the resident and standards of care are provided. Any issue identified will be corrected immediately and both physician and family will be notified.</p>		

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F 281	<p>Continued From page 2</p> <p>the bariatric bed did not work well and Resident #14 was placed in another bed approximately "three weeks ago." The MS confirmed the bed used to replace the bariatric bed did not have side rails. The MS stated he could not explain why side rails were now on Resident #14's bed.</p> <p>Interview with the DON on 10/11/12 at 3:15 PM, revealed a physician's order was obtained on 08/21/12 to discontinue the side rails from Resident #14's bed. The DON acknowledged the side rails had been assessed as an enabler and assisted the resident to reposition in bed and help with turning. However, Resident #14 could no longer use the side rails and the MS was notified to discontinue the side rails on 08/21/12. The DON confirmed she checked to ensure the side rails were discontinued. The DON stated she had no explanation for side rails being on Resident #14's bed on 10/09/12, 10/10/12, and 10/11/12.</p> <p>2. A review of the medical record for Resident #10 revealed the facility admitted the resident on 04/16/12 with diagnoses of fractured fibula, rheumatoid arthritis, and a total knee replacement. Documentation also revealed Resident #10 had residual edema in both lower extremities. A review of the physician's orders for Resident #10 revealed on 02/07/12 the physician had requested for compression hose to be applied to the resident's lower extremities bilaterally. Further review revealed the compression hose were to be applied in the morning and removed prior to the resident's bedtime. Continued review of the physician's orders revealed on 09/12/12 the resident's physician had discontinued the use of the compression hose due to the resident's refusal to</p>	F 281	<p>UM to complete a one time audit by 11/20/12 of all residents beds to identify any resident with bed rails up that do not have a physician order.</p> <p>Any issue identified will be corrected immediately and both the physician and family will be notified.</p> <p>The DON and/or the Regional Nurse Consultant will re educate the ETD and the Unit Managers by 11/19/2012 regarding following physicians orders, ensuring the care plan is correct and updated, ensuring the C.N A sheet is correct and that all care is provided per standard of care and follows the physicians orders.</p> <p>The ETD to re educate the C.N.A's by 11/20/2012 regarding following standards of care, following the care plan and C.N A sheet and all assistive devices and adaptive devices are on per physician's orders.</p> <p>DON, UMs and ETD will audit 5 residents' records weekly for 4 weeks beginning week of 11/15/2012 to ensure that the C.N A sheets, the care plans, and the physician orders match and are correct, and all care is provided per physician orders.</p>	

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F 281	<p>Continued From page 3 wear the hose.</p> <p>Observation of Resident #10 on 10/10/12 at 12:00 PM and 2:00 PM, and on 10/11/12 at 9:00 AM, revealed compression hose on both the resident's lower extremities and the hose were observed to be very tight and wrinkled. An interview with Resident #10 on 10/11/12 at 10:00 AM, revealed she/he wanted the compression hose removed because the hose were too tight and uncomfortable.</p> <p>An interview conducted on 10/11/12 at 9:30 AM, with the State Registered Nursing Assistant (SRNA) that provided care for Resident #10 on 10/11/12 revealed the SRNA had applied the compression hose on both of Resident #10's lower extremities on 10/11/12. The SRNA stated he/she was unaware the physician had discontinued the use of the resident's compression hose.</p> <p>An interview was conducted on 10/11/12 at 9:50 AM, with the Licensed Practical Nurse (LPN) providing care for Resident #10 on 10/10/12 and 10/11/12. The LPN stated the intervention for staff to apply the compression hose to both the resident's lower extremities was listed on the resident's Care Plan and the LPN stated she/he did not realize the compression hose had been discontinued in September.</p> <p>An interview was conducted with the facility Physical Therapist (PT) on 10/11/12 at 10:00 AM. The PT stated the compression hose on Resident #10 were too tight for the resident and could possibly create an injury to the resident's legs. The PT further stated the resident should be fitted</p>	F 281	<p>DON/UM to visually look at 10 residents on each hall beginning the week of 11/15/2012 x 4 weeks then 5 residents a week x 4 weeks to ensure all standard of care is provided, that resident care, assistive devices and adaptive equipment is on per the physician order.</p> <p>ETD to randomly audit 20 residents beds weekly beginning the week of 11/15 2012 x 6 weeks to ensure bed rails are on if ordered and are not on if not ordered.</p> <p>The Quality Assurance Committee consisting of at least the Administrator, the Director of Nursing, the Medical Director and the Education and Training Director, will meet at least monthly beginning 10/18/12, and will review all audit findings and revise plan as needed, until all issues are resolved.</p> <p>Date of completion: 11/22/2012</p>		

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F 281	Continued From page 4	F 281			
F 282 SS=D	<p>for another type of compression hose for the resident's comfort and the hose's effectiveness.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure services were provided according to the plan of care for one of eighteen sampled residents. Observations conducted on 10/09/12 and 10/11/12 revealed the facility failed to ensure Resident #5 utilized fingerless gloves and a No Lean cushion in the wheelchair as indicated in the plan of care.</p> <p>The findings include:</p> <p>An interview with the Regional Nurse Consultant (RNC) on 10/10/12 at 5:00 PM, revealed the facility did not have a written policy related to following the care plan. According to the RNC, staff was to follow whatever care needs were identified by physician's orders and resident assessment.</p> <p>A review of Resident #5's comprehensive care plan revealed a care plan intervention dated 12/14/11 for a No Lean cushion for the resident's wheelchair. In addition, an intervention dated</p>	F 282	<p>F282</p> <p>1. The facility made sure that Resident #5's fingerless gloves were applied and no lean cushion was provided immediately. The physician and family were notified by the DON and no new orders were noted.</p> <p>2. DON, UM's and ETD to complete a one time audit by 11/15/2012 of all residents C.N.A sheets, care plans and visually look at all residents to identify if any care plan is not being followed and to identify any care plan that is not reflective of the physicians orders. All C.N A. sheets will be compared to the care plan and physicians orders. Any issue identified will be immediately corrected and both the family and physician will be notified</p>		

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F 282	<p>Continued From page 5</p> <p>07/25/12 indicated the resident was to use fingerless gloves for skin protection.</p> <p>Observations on 10/09/12 at 11:25 AM, 12:30 PM, 2:30 PM, 5:00 PM, and 6:00 PM, and on 10/10/12 at 9:35 AM, 9:50 AM, and 11:10 AM, revealed Resident #5 was not wearing fingerless gloves and the cushion in the resident's wheelchair was not a "No Lean" cushion.</p> <p>An interview with State Registered Nurse Aide (SRNA) #1 on 10/10/12 at 2:25 PM, revealed the SRNA was aware that Resident #5 was supposed to have fingerless gloves, but had failed to ensure the resident wore the gloves. SRNA #1 stated, "I didn't find any in [his/her] drawer and I was too busy to ask the nurse for them."</p> <p>An interview with the Occupational Therapy Aide (OTA) on 10/10/12 at 11:45 AM, revealed the No Lean cushion was not in use for Resident #5. The OTA stated she was not sure why but she would investigate. A second interview with the OTA at 2:40 PM, revealed the resident had transferred to the hospital for a few days and when the resident returned staff had failed to place a No Lean cushion in the wheelchair; however, the staff had placed a pressure-relieving cushion in the resident's chair.</p> <p>An interview with the Occupational Therapist (OT) on 10/11/12 at 5:15 PM, revealed there were no records to indicate when or if Resident #5's wheelchair cushion was altered. According to the OT, when the new company bought the facility the old medical records were sent with the previous owners.</p>	F 282	<p>A one time audit of 25% of the residents will be completed by the ETD by 11/21/2012 to watch direct care to identify any care provided that is not being provided per plan of care.</p> <p>Any issue identified will be immediately corrected and both physician and family notified.</p> <p>ETD to re educate all nursing staff by 11/21/2012 regarding updating the care plan with change in orders or needs, following the care plan, updating the C.N A. sheet and monitoring care to ensure the care plan is followed.</p> <p>ETD and/or UM to monitor care being provided to 5 random residents weekly x 4 weeks beginning the week of 11/15/2012 then 3 residents a week x 4 weeks to ensure care is provided per the plan of care.</p> <p>DON/ETD to audit at least 10 records weekly beginning week of 11/15/2012 to ensure care plan and</p> <p>C.N.A sheet match the physician's orders.</p> <p>Regional Nurse Consultant to randomly audit 10 records monthly beginning 11/2012 x 3 months to ensure care plan matches C.N A sheet and care is being provided to the resident per the physicians orders.</p>	

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F 282	Continued From page 6 An interview with Licensed Practical Nurse (LPN) #2 on 10/10/12 at 1:50 PM, revealed she was responsible to monitor the SRNAs to ensure care was provided according to the resident's care plan. However, the LPN stated she had failed to note the resident was not utilizing the fingerless gloves or No Lean cushion. An interview with the Unit Manager (UM) on 10/11/12 at 2:20 PM, revealed the care plan interventions were to be monitored by the nurses and the nurses were monitored by the UM to ensure care was delivered according to the care plan.	F 282	The facility QA Committee will meet at least monthly beginning 10/18/12, to review audit findings and revise the plan as needed. These audits will continue until issue is resolved. Date of completion: 11/22/12		
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 observation, interview, and record review, it was determined the facility failed to ensure two of eighteen sampled residents (Residents #3 and #14) who were unable to carry out activities of daily living (ADL) received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility failed to provide nail care for Residents #3 and #14. Observations on 10/10/12, during a skin assessment, revealed Resident #3 had excessively long toenails. Additionally, observation of Resident #14's feet on 10/11/12	F 312	F312 Resident #3 and #14 immediately had their nails trimmed by the nurse. Resident #3 had an appointment made at the podiatrist office by the Social Service Director to ensure his toenails are trimmed. The DON notified the Medical Director on 10/11/2012 regarding this issue and no new orders were notified.		

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F 312	<p>Continued From page 7 revealed the resident's toenails were long.</p> <p>The findings include:</p> <p>The facility failed to provide a policy to direct staff related to providing nail care. According to the facility's Regional Nurse Consultant (RNC) staff was required to provide nail care to residents as needed and should follow the procedures of clipping nails as outlined in the latest edition of the Lippincott Manual.</p> <p>According to the Lippincott Manual, toenails that were allowed to grow too long could make wearing footwear uncomfortable, and the nails could become ingrown (where the nails grow into the skin causing injury and pain to the resident).</p> <p>1. Review of the medical record revealed Resident #3 was admitted to the facility on 05/15/12, with diagnoses of Diabetes, Cerebral Vascular Accident, Aphasia, and Dysphagia requiring a Percutaneous Endoscopic Gastrostomy (PEG) tube. Review of the monthly physician's orders for October 2012 revealed Resident #3 would receive podiatry, eye, dental, and psychiatric consultations as needed. Further review of the medical record revealed no documented evidence Resident #3 had received a podiatry consultation since admission to the facility.</p> <p>A list provided by the facility of residents that had been assessed/treated by the podiatrist during the podiatrist's most recent visits to the facility on 07/17/12 and 09/19/12 was reviewed and revealed Resident #3 had not been assessed by the podiatrist during those visits.</p>	F 312	<p>A one time audit of all residents was completed by the DON/UM/ETD and licensed nurses on 11/20/12 to identify any resident who needs their nails (toenails or fingernails) trimmed. Any issue identified will be immediately corrected and nails will be trimmed or a podiatrist appointment will be made immediately by the SSD (Social Service Director) and the family and physician will be notified.</p> <p>A one time audit of all residents was completed by the DON/ETD/UM and licensed nurses on 11/20/2012 to identify any grooming needs the resident has. Any issue identified will be immediately corrected and the physician and family will be notified.</p> <p>A one time audit of all care plans was completed by the DON/ETD and UM to identify meal assistance needs or oral care needs and identify any needed changes to their POC for oral or nutrition needs on 11/20/2012. Any issues identified will be immediately corrected and the physician and the family notified.</p>		

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F 312	<p>Continued From page 8</p> <p>Review of the initial admission Minimum Data Set (MDS) assessment completed on 05/22/12 revealed Resident #3 required extensive to total assistance of two staff members for all activities of daily living. Review of the comprehensive care plan for activities of daily living (ADL) revealed Resident #3 would receive nail care as needed by licensed professional staff due to the diagnosis of Diabetes. Review of the weekly skin assessments dated 09/13/12, 09/20/12, 09/27/12, and 10/04/12, revealed no documentation of the condition of Resident #3's toenails but the skin assessment sheets revealed Resident #3 had no new skin issues. Review of the September and October 2012 Treatment Administration Record (TAR) failed to reveal Resident #3 had been scheduled for nail care.</p> <p>Observation during a skin assessment provided by Registered Nurse (RN) #3 on 10/10/12 at 4:50 PM, revealed Resident #3's toenails were excessively long and extended out past the end of the toe. Interview with RN #3 during the skin assessment confirmed the resident's toenails were excessively long and needed trimming. RN #3 stated the nurses were responsible to trim Resident #3's nails because of the diagnosis of Diabetes. RN #3 stated nail care should be provided with the weekly skin assessment. Upon review of the TAR, RN #3 stated Resident #3 was scheduled for a weekly skin assessment every Tuesday by the night shift nurse.</p> <p>Interview on 10/10/12 at 5:00 PM, with Resident #3 after the skin assessment revealed the resident could answer yes or no questions or answer by use of a communication board.</p>	F 312	<p>ETD to re educate all nursing staff and Social Service Director by 11/21/2012 regarding providing grooming, nail care and oral care (ADL's) per the physician order and the care plan.</p> <p>DON/UM to audit every resident nails(fingernails and toenails) weekly x 8 weeks beginning the week of 11/15/2012 then at least every 2 weeks ongoing to ensure all nails are trimmed.</p> <p>DON/UM to audit all residents 2 x weekly x 8 weeks then every week x 8 weeks to make sure that ADL needs for grooming and oral care is provided and all ADL needs are met.</p> <p>Social Services Director to ensure all residents who have orders for podiatry are seen by the podiatrist and the list will be given to the DON to ensure all nail trimming needs are met beginning 11/2012 and is ongoing.</p> <p>The facility QA Committee will meet at least monthly beginning 10/18/12, to review audit findings and revise the plan as needed. These audits will continue until these issues are resolved.</p> <p>Date of completion: 11/22/12</p>	

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F 312	<p>Continued From page 9</p> <p>Resident #3 revealed to his/her knowledge staff had not trimmed his/her toenails since admission to the facility approximately five months ago.</p> <p>Interview on 10/11/12 at 8:45 AM, with the Unit Manager (UM) revealed nail care was conducted every Sunday. The UM stated Certified Nursing Assistants (CNAs) were responsible for each resident's nail care if the resident did not have a diagnosis of Diabetes. The UM confirmed licensed staff was required to trim the nails of residents with a diagnosis of Diabetes or, if the nails were extremely thick, a podiatry referral would be indicated. The UM stated staff should document nail care on the TAR, however, upon review of the TAR for Resident #3, nail care had not been included on the TAR. The UM stated Resident #3 "just slipped through the cracks."</p> <p>A phone interview was conducted on 10/11/12 at 9:00 AM, with Licensed Practical Nurse (LPN) #6, who worked night shift and had performed weekly skin assessments for Resident #3 on 09/13/12, 09/20/12, and 09/27/12. LPN #6 stated she was required to perform one to two skin assessments each night for residents. LPN #6 confirmed Resident #3's toenails needed trimming but she had been busy and didn't have time to trim Resident #3's toenails. LPN #3 stated the day shift does nail care every Sunday and she expected Resident #3's toenails would be trimmed at that time. LPN #6 stated she verbally informed nursing staff on the day shift that Resident #3's toenails needed trimming but was unable to remember to whom she reported the information. LPN #6 acknowledged she failed to document Resident #3's long toenails.</p>	F 312			

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F 312	<p>Continued From page 10</p> <p>A phone interview was conducted on 10/11/12 at 9:15 AM, with LPN #7 who had performed the most recent skin assessment, dated 10/04/12 (five days prior to the survey). LPN #7 stated she was aware of Resident #3's long toenails and confirmed the toenails needed trimming. LPN #7 acknowledged she was afraid to cut the toenails of residents who were diabetic and should have made a referral for Podiatry to trim the nails. LPN #7 revealed she failed to report the long toenails and just assumed everyone knew the toenails were long.</p> <p>Interview on 10/11/12 at 10:15 AM, with CNA #6, who was assigned to provide care to Resident #3 on 10/10/12, revealed he provided a bed bath for the resident. CNA #6 confirmed Resident #3's toenails were very long but the nurses were responsible to trim the nails of residents who had a diagnosis of Diabetes. CNA #6 stated he assumed the nurse was aware Resident #3's toenails needing trimming. CNA #6 acknowledged he should have reported the long toenails to the nurse.</p> <p>2. Review of the medical record revealed Resident #14 was admitted to the facility on 07/05/07, with diagnoses of Cerebral Vascular Accident, Dementia, and Depression. Review of the quarterly Minimum Data Set dated 09/03/12 revealed the facility assessed Resident #14 to require extensive to total assistance with all ADLs. Review of the monthly physician's orders for October 2012 revealed Resident #14 would receive podiatry, eye, dental, and psychiatric consultations as needed.</p> <p>A list provided by the facility of residents that had</p>	F 312		

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F 312	Continued From page 11 been assessed/treated by the podiatrist during the podiatrist's most recent visits to the facility on 07/17/12 and 09/19/12 was reviewed and revealed Resident #14 had not been assessed by the podiatrist during those visits. Review of the care plan dated 09/13/12, regarding personal care, revealed an intervention that nail care would be provided each week and as needed. Review of the CNA assignment sheet revealed Resident #14's nail care was the responsibility of the CNAs. Observation on 10/11/12 at 10:00 AM, during the provision of care provided by CNA #5 revealed Resident #14's toenails were long and needed trimming. The UM acknowledged in an interview conducted on 10/11/12 at 10:00 AM, that Resident #14's toenails needed to be trimmed. The UM further acknowledged she had not performed "spot checks" to ensure nail care had been provided for residents. Interview conducted on 10/11/12 at 2:50 PM, with CNA #7 revealed she had been assigned to provide care to Resident #14 on 10/11/12. CNA #7 stated she provided a complete bed bath for Resident #14 at approximately 6:30 AM on 10/11/12, and stated she had rushed to give the bed bath that morning and had failed to wash Resident #14's feet or change the resident's socks. CNA #7 revealed it was her responsibility to trim Resident #7's nails but since she didn't expose the resident's feet during the bed bath she was not aware the toenails needed trimming.	F 312		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	<p>Continued From page 12</p> <p>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.</p> <p>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.</p> <p>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.</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 observation, interview, and review of manufacturer's guidelines, Centers for Disease</p>	F 431	<p>F 431</p> <p>Resident A's Novolin R was immediately discarded by a licensed nurse. No other resident was identified. All residents have the potential to be affected. All Fleets enemas were also disposed of and replaced by the center. The Medical Director was notified of the out of date meds, and no new orders were received.</p> <p>The DON, UM, and ETD completed a one time audit of all medication carts, insulin and multi-dose vials on 11/20/12 to identify any insulin that was opened and not dated, any multi dose vials that were not dated and initiated and any Fleets enemas that were outdated. Any issues identified were immediately corrected. The DON/ETD completed a one time audit of all medication to identify any medications that were not labeled on 11/9/12. No issues were noted. The DON/UM completed a one time audit of all narcotics to identify if the count was correct and all medications were labeled correctly, and no issues were identified. The DON/UM also completed a one time audit of all medication refrigerators to make sure all temp were correct and all multi does meds were properly labeled. There were no issues identified.</p>		

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F 431	<p>Continued From page 13</p> <p>Control (CDC) recommendations, and facility policies/procedures, it was determined the facility failed to ensure multi-dose vial medications were labeled in accordance with currently accepted professional principles. Multi-dose vials of Novolin R insulin, NovoLog insulin, and Lantus insulin were available for use for residents; however, staff failed to ensure the date the vials of insulin had been opened was documented on the vials of insulin as required. Additionally, ten Bisacodyl Fleet enemas were expired and remained available for resident use.</p> <p>The findings include:</p> <p>Review of the facility policy titled Medication Storage Recommendation, (dated as revised 03/27/12) revealed multi-dose vials were to be dated with the date opened and discarded 28 days after opening except for Levemir insulin, Novolin R, Novolin N, and Novolin 70/30 insulin that could be used up to 42 days after opening. Review of the facility policy titled Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles, (effective 12/01/07) revealed the facility would ensure drugs and biologicals that had an expired date on the labels or had been retained longer than recommended by the manufacturer or supplier's guidelines, would be stored separated from other medications until destroyed or returned to the supplier.</p> <p>According to CDC recommendations posted on the CDC website, multi-dose opened or accessed vials should be dated and discarded in 28 days unless the manufacturer specified a different (shorter or longer) date for the opened vial.</p>	F 431	<p>The ETD reeducated all licensed nurses and the Unit Managers regarding the storage of drugs and biologicals, temperatures for storage of drugs and biologicals, narcotic storage and count, dating and labeling multi dose vials, discarding meds and biologicals, along with checking dates prior to administration. This was completed on 11/21/12. DON/ETD/UM will complete an audit of both medication carts weekly for 8 weeks beginning 11/21/12 to ensure that drugs and biologicals are dated, initialed, and are not available for administration after expiration date. UM will audit the supply room weekly for 8 weeks beginning 11/22/12 to ensure no medications are available after their expiration date. The DON will audit 10 narcotic records weekly for 8 weeks beginning the week of 11/15/12 to ensure that narcotics area counted and labeled correctly.</p> <p>The facility QA committee will meet at least monthly beginning 10/18/12, to review audit findings and revise the plan as needed. These audits will continue until all issues are resolved.</p> <p>Date of Completion: 11/22/12</p>	

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F 431	<p>Continued From page 14</p> <p>Observation of the medication cart located on the A Hall on 10/11/12 at 3:00 PM, revealed an opened vial of Novolin R insulin prescribed for Resident #3. The vial was not dated to indicate when the vial had been opened for resident use. Observation of the Novolin R insulin revealed the vial had been dispensed from the pharmacy on 05/15/12.</p> <p>Observation of the medication cart located on the B Hall on 10/11/12 at 3:25 PM, revealed an opened vial of NovoLog for Resident A and a vial of Lantus insulin for Resident B. Observation of the pharmacy label revealed the NovoLog for Resident A had been dispensed on 08/22/12, and the NovoLog for Resident B was dispensed on 10/04/12. Further observation revealed the vials were not dated to indicate the date the vials were opened.</p> <p>Observation of the Nursing Supply Room on 10/11/12 at 3:30 PM, revealed ten Bisacodyl Fleet enemas were expired and available for resident use. Further observation revealed four Bisacodyl Fleet enemas had an expiration date of February 2009 and six Bisacodyl Fleet enemas had expired in April 2009.</p> <p>Interview on 10/11/12 at 3:00 PM, with Registered Nurse (RN) #3, assigned to administer medications to residents who resided on the A Hall, revealed staff was required to date and initial all multi-dose vials when they were opened to ensure they would be discarded in 30 days.</p> <p>Interview on 10/11/12 at 3:25 PM, with Licensed Practical Nurse (LPN) #4, responsible for medication administration to residents who</p>	F 431			

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F 431	Continued From page 15 resided on the B Hall, revealed all multi-dose vials were to be dated when opened and discarded after 30 days. Interview with the Supply Clerk on 10/11/12 at 4:45 PM, revealed she frequently checked for expired items stored in the Nursing Supply Room. The Supply Clerk stated she only checked items she had ordered such as tube feedings or intravenous supplies. The Supply Clerk stated she was not responsible for the Bisacodyl Fleet enemas in the Nursing Supply Room since they were purchased at a local pharmacy. Interview with the Director of Nursing (DON) on 10/11/12 at 3:40 PM, revealed nurses were supposed to check insulin vials every day to ensure the vial had been dated when opened. The DON stated the Bisacodyl Fleet enemas had recently been purchased from a local drug store; however, the expiration date had not been noticed.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	F441 Resident # 8 physician and the facility Medical Director were notified regarding contact precautions by the DON immediately and no new order were noted.	

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F 441	<p>Continued From page 16</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policy, the facility failed to ensure proper infection control practices were maintained for one of eighteen sampled residents (Resident #8). A review of facility policies revealed staff was to wear disposable gloves and gowns upon entering the room of a resident with Contact Precautions. Observations on 10/09/12 and 10/10/12 revealed a sign on Resident #8's doorframe that indicated Contact Precautions were to be utilized when entering the room, however, there were no gowns available and staff</p>	F 441	<p>The DON/UM will complete a one time audit of all residents records to identify any resident with infectious disease that is not in precautions and /or has PPE available. Any issues identified will be corrected immediately. Also the physician and family will be notified. ETD will complete a one time audit by 11/21/12 of 10 residents care to identify any staff member not wearing gloves, not following facility contact precautions and/or no handwashing. The DON will complete an audit of any resident with infectious disease by 11/21/12 to identify if roommate is appropriate, or if they need to temporarily relocate to another room. Any issues identified will be corrected immediately. The DON will audit all supply rooms by 11/21/12 to identify if PPE is available and there is adequate supply for future needs. Any issues identified will be immediately addressed.</p> <p>The ETD to reeducate all staff, including the Unit Managers, regarding infection control recommendations for any type of precaution, following care plan for precautions, where PPE is</p>		

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F 441	<p>Continued From page 17</p> <p>was observed providing care using gloves only. In addition, the policy indicated residents with contact precautions should be assigned a private room, a room with a low risk roommate, or cohorted. Observations on 10/09/12 and 10/10/12 revealed Resident #8 sitting in the dining room with other residents.</p> <p>The findings include:</p> <p>A review of the facility's Contact Precaution Policy, (dated 09/13/12) revealed staff was to wear gloves as required by Standard Precautions and to wear a disposable gown upon entering the Contact Precautions room. In addition, the policy indicated the resident was to have a private room if possible or, if a private room was not available, the facility was to assess various risks associated with other resident placement options, for example, placing the resident in a room with a low risk roommate or cohorting. The policy further indicated for individuals with skin lesions, excretions, secretions, or drainage that was difficult to contain, precautions were to be maintained to minimize the risk of transmission to other residents and contamination of environmental surfaces or equipment when the resident was transported to another area.</p> <p>A review of Resident #8's medical record revealed the facility admitted the resident on 09/14/12 with diagnoses that included Alzheimer's Dementia, Hypertension, Failure to Thrive, Diabetes, and Anxiety. On 10/01/12, the physician diagnosed Resident #8 with Shingles of the left upper chest. An antiviral medication was ordered and Contact Precautions were initiated.</p>	F 441	<p>located and the CDC guidelines for the use of PPE. The DON/ETD will randomly monitor 10 people providing care weekly for 8 weeks beginning 11/21/12 to ensure that gloves are worn, precautions are followed, and PPE is available, and where it is located. The ETD is to follow up with reeducation regarding precautions and PPE every time the next 5 people are placed on precautions of any kinds. This will begin 11/15/12. The RNC to audit supplies of PPE at least monthly for three months beginning 11/21/12. The RNC will monitor 5 employees during handwashing monthly for 3 months, beginning 11/21/12. The RNC will assist the DON with room placement of the next 10 residents requiring isolation by phone or in person for 3 months beginning 11/21/12.</p> <p>The facility QA committee will meet at least monthly beginning 10/18/12, to review audit findings and revise the plan as needed. These audits will continue until all issues are resolved.</p> <p>Date of Completion: 11/22/12</p>		

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F 441	<p>Continued From page 18 .</p> <p>Observations on 10/09/12 at 9:55 AM, revealed a handwritten sign on the doorframe of Resident #8's room that indicated "Contact Precautions, See nurse before entering." There was no Personal Protective Equipment (PPE) available except the disposable glove dispenser on the wall of the resident's room. Further observations revealed the resident's room was semi-private and another resident was observed in the "B" bed. Continued observations on 10/09/12 at 11:25 AM, 12:05 PM, and 12:25 PM, revealed Resident #8 was fully dressed and sitting in the dining room eating lunch.</p> <p>An interview with State Registered Nurse Aide (SRNA) #2 on 10/09/12 at 2:25 PM, revealed the SRNA wore gloves and used standard precautions when caring for Resident #8. SRNA #2 stated the resident had shingles but "we don't really do anything different when we care for [him/her]."</p> <p>An interview with Licensed Practical Nursa (LPN) #1 on 10/09/12 revealed Resident #8's precautions were due to a diagnosis of Shingles. According to LPN #1, "We use standard precautions and wear gloves but don't do anything other than that."</p> <p>An interview with the Unit Manager (UM) on 10/11/12 at 11:25 AM, revealed staff was to use gloves for care, but was only to use a gown if they came into contact with the resident's shingles rash. The UM further stated she was unaware of the Contact Precautions Policy, but she knew hand washing and the use of gloves was required for Contact Precautions. The UM also stated Contact Precautions and Universal Precautions</p>	F 441			

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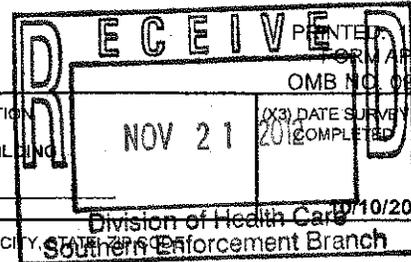
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185173	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/11/2012
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F 441	Continued From page 19 were the same.	F 441			
F 502 SS=D	<p>An interview with the Director of Nursing (DON) and the Regional Nurse Consultant on 10/11/12 at 1:40 PM, revealed gowns were kept in the supply closet and staff could have obtained them if needed. The DON also stated she had not checked the Centers for Disease Control guidelines for recommendations and she had not assessed the resident's roommate for a history of chickenpox or shingles.</p> <p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide laboratory services for one of eighteen sampled residents (Resident #5). A review of physician's orders revealed Resident #5 had an order for a Hemoglobin A1C to be obtained every three months. A review of Resident #5's medical record revealed the A1C was obtained in May 2012; however, a review of documentation revealed facility staff failed to ensure the A1C was obtained for Resident #5 when due in August 2012.</p> <p>The findings include:</p> <p>An interview with the Regional Nurse Consultant (RNC) on 10/10/12 at 5:00 PM, revealed the facility did not have a policy related to laboratory</p>	F 502	<p>F502</p> <p>The lab that was missed for Resident #5 was obtained the next morning. The physician and family was notified by the UM and there were no new orders. The Medical Director was also notified with no new orders</p> <p>A 100% lab audit for the last two months (9/5/2012-11/06/2012) will be completed by the DON/UM/ETD by 11/21/12. Any issues identified will be immediately corrected and both the physician and family will be notified.</p> <p>A 100% audit of all records will be completed by DON/UM and ETD to identify any upcoming labs and ensure they are in the lab binder to be completed per physician order. This will be completed by 11/22/2012.</p> <p>Any issues identified will be corrected immediately and physician and family will be notified.</p>		

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F 502	<p>Continued From page 20</p> <p>testing; however, the RNC stated the facility's practice was to ensure that all laboratory tests were obtained as ordered by the physician.</p> <p>A review of the medical record for Resident #8 revealed the resident's physician had ordered a Hemoglobin A1C to be obtained every three months. A review of documentation revealed a Hemoglobin A1C was obtained in May 2012 and would have been due to be obtained again in August 2012; however, there was no evidence the Hemoglobin A1C was obtained until October 10, 2012.</p> <p>An interview with the Unit Manager (UM) on 10/10/12 at 1:50 PM, revealed the facility's system was to "FAX" the physician's orders to the Laboratory, the Laboratory would confirm receipt of the request by "FAX", and the UM was to enter the lab order into the facility's laboratory tracking book. According to the UM, once the confirmation was placed in the lab book she did not check to ensure the test was actually obtained by the Lab. The UM stated apparently the Lab missed it and she "just missed it too."</p>	F 502	<p>All nursing staff to be re educated by the ETD regarding lab procedure, following physician's orders and ensuring that all labs are completed timely. This will be completed by 11/21/2012.</p> <p>DON to audit 20 records weekly x 6 week beginning week of 11/15/2012 to ensure that labs are completed per physicians order, then 10 records weekly x 6 weeks and this will be ongoing.</p> <p>ETD to audit lab book and compare 10 records to ensure lab slips are in binder to be completed weekly x 12 weeks beginning 11/21/2012.</p> <p>RNC to audit at least 10 records each month x 3 months beginning 11/2012 to ensure labs are completed per physicians order.</p> <p>The facility QA Committee will meet at least monthly beginning 10/18/12, to review audit findings and revise the plan as needed. These audits will be ongoing until resolved.</p> <p>Date of completion: 11/22/12</p>		

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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1985 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type II (000) SMOKE COMPARTMENTS: 8 COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (WET SYSTEM) EMERGENCY POWER: Type II natural gas generator A life safety code survey was initiated and concluded on 10/10/12, for compliance with Title 42, Code of Federal Regulations, §483.70 (a). The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.	K 000		
K 143 SS=D	Deficiencies were cited at a "D" level. NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or	K 143		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Gill Spurgeon* TITLE: *Adm.* (X6) DATE: *11/21/12*

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 143	<p>Continued From page 1</p> <p>treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain a liquid oxygen storage room according to NFPA standards. This deficient practice affected one of eight smoke compartments, staff, and residents. The facility has the capacity for 92 beds with a census of 87 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 10/10/12, at 10:30 AM, with the Director of Maintenance (DOM) a door to a liquid oxygen storage room located in the physical therapy area was observed not to have a 45-minute rated door as required. Combustible storage was also located within five feet of the liquid oxygen tanks. An interview with the DOM on 10/10/12, at 10:30 AM,</p>	K 143	<p>K 143</p> <p>No specific resident was identified. All residents have the potential to be affected. The door was replaced with a 1 hour fire rated door on 11/15/12 by the Maintenance Director.</p> <p>The Director of Maintenance and the Administrator will complete a one time audit of all doors to identify any door that is not 1 hour fire rated by 11/15/12. Any issues identified will be immediately corrected. Administrator to audit all rooms where oxygen is stored to identify if it is stored on a concrete surface, and the room is mechanically vented as per NFPA guidelines. this will be accomplished by 11/20/12.</p>		

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K 143	<p>Continued From page 2</p> <p>revealed he was not aware the door was required to be rated. The DOM stated staff was aware of storage requirements within the oxygen room but would not maintain the proper clearances.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <p>a. Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and</p> <p>b. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and</p> <p>c. The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted. Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures. The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.2.3.2.3.1 Every opening in a fire barrier shall be protected</p>	K 143	<p>Administrator will re educate the Director of Maintenance related to all doors must be 1 hour fire rated and where the fire rating is located on all doors, by 1/15/12. Administrator will audit all doors at least monthly, beginning 11/20/12 to ensure they are all 1 hour fire rated. This will be ongoing. The Director of Maintenance is to audit all Oxygen storage areas at least monthly beginning 11/20/12, to ensure Oxygen is stored on concrete flooring and the room is vented properly.</p> <p>The facility QA committee will meet at least monthly beginning 10/18/12, to review audit findings and revise the plan as needed. These audits will continue until all issues are resolved.</p> <p>Date of Completion: 11/22/12</p>		

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K 143	Continued From page 3 to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. The fire protection rating for opening protectives shall be as follows: (2) 1-hour fire barrier - 1-hour fire protection rating where used for vertical openings or exit enclosures, or 3/4-hour fire protection rating where used for other than vertical openings or exit enclosures, unless a lesser fire protection rating is specified by Chapter 7 or Chapters 11 through 42.	K 143			