

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

PRINTED: 08/10/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185144	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/27/2012
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NAME OF PROVIDER OR SUPPLIER HOMESTEAD NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 VERSAILLES ROAD LEXINGTON, KY 40504
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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 Recertification and an Abbreviated Survey investigating KY#00018800 was initiated on 07/24/12 and concluded on 07/27/12. KY#00018800 was unsubstantiated with no deficiencies cited. Deficiencies were cited on the Recertification Survey with the highest Scope and Severity of an "F".

F.151 483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS
SS=D - FREE OF REPRISAL

The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure and protect the rights of one (1) of twenty-four (24) sampled residents (Resident #13). The facility failed to protect and ensure that Resident #13 had the right to exercise his/her rights as a resident of the facility and as a citizen or resident of the United States. Further the facility failed to protect and ensure the resident had the right to be free of interference related to his/her right to smoke.

The findings include:
Review of the facility's policy entitled "Homestead Nursing Center Smoking Policy", dated 01/30/08,

F 000

This Plan of Correction is the center's credible allegation of compliance.

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.

F 151

F151/N005
Resident #13 decided that he has "quit smoking" and that he "couldn't afford the cigarettes anyway."

There is only one resident in the facility that signs himself out to smoke and he will continue to be allowed to do so as long as he is safe to do so.

All other current residents and any future residents admitted to the facility will not be allowed to sign themselves out for the purpose of smoking. The entire facility campus will be Smoke Free starting 9-1-12.

Admissions Coordinator will ensure that all perspective admissions to the facility will be made aware of the policy that the facility is Smoke Free before final acceptance is made for admission.

Completion Date: 9-1-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Nancy Russell</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8-20-12</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 her 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 151	<p>Continued From page 1</p> <p>which was in effect when Resident #13 was admitted to the facility revealed the facility was a smoke free facility with designated smoking areas. The facility's policy further revealed that a safety assessment would be completed and supervision would be available if a resident needed it.</p> <p>Review of the facility's second policy entitled "Homestead Nursing Center Smoking Policy" revealed a type written date of 09/27/07 with a line through that date and a hand written date of 07/08/11. The facility's new policy revealed the facility was a smoke free facility and the resident must go outside off of the property to smoke. The facility's new policy further revealed that the resident must be his/her own responsible party and be able to sign his/herself out of the facility and back in upon return.</p> <p>Record review revealed the facility admitted Resident #13 on 04/19/11, with diagnoses which included Tobacco Abuse. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 07/07/12, revealed the facility assessed Resident #13 to have a Brief Interview of Mental Status (BIMS) score of fifteen (15), indicating the resident was cognitively intact and able to make his/her own choices. Further record review revealed Resident #13 was legally responsible for his/her own self and signed all legal documents. Record review revealed Resident #13 was assessed to utilized a wheel chair for mobilization.</p> <p>Observation during initial tour, on 07/24/12 at 9:00 AM, and each day of the survey (07/25/12, 07/26/12 and 07/27/12) at multiple times each</p>	F 151		
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F 151	<p>Continued From page 2</p> <p>day, revealed staff smoking in the designated staff smoking area of the court yard on the property of the facility. The staff smoking area of the court yard was located in the middle of the facility with resident rooms and resident areas surrounding this courtyard. The staff smoking area of the court yard was lined with glass windows and accessible through a door of a resident hallway located several feet from Resident #13's room and had an odor of cigarette smoke in the hall.</p> <p>Observation, on 07/25/12 at 9:55 AM, revealed the "off property" smoking area was located outside the back door, across the parking lot, through a gated area to the other side of the chain linked fence area behind the garbage dumpsters. Further observation, on 07/26/12 at 4:33 PM, revealed the "off property" smoking area was inaccessible because the gate to this area was locked. Further observation revealed the facility's property was surrounded by fencing, grass or a three (3) inch curb, which would be non-wheelchair accessible.</p> <p>Interview, on 07/25/12 at 9:30 AM, with Resident #13 revealed the Administrator took a lock box containing his cigarettes away from him. Resident #13 stated "they gave me no choice. She looked at me and said you "quit". Resident #13 further revealed that other residents and staff were allowed to smoke. Continued interview, on 07/27/12 at 10:15 AM, with Resident #13 revealed that he/she could smell the smoke from the staff smoking and it made him/her mad that they could smoke and he/she could not.</p> <p>Interview, on 07/26/12 at 11:55 AM, with</p>	F 151		

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F 151	<p>Continued From page 3</p> <p>Unsampled Resident A revealed he/she was admitted 04/17/08 and was allowed to smoke in the court yard at the time of admission. Interview further revealed the facility informed residents on that smoking was no longer allowed on the property and the only options the residents were given was to use smoking cessation products. Interview further revealed the Ombudsman advised Unsampled Resident A that it was his/her right to smoke and he/she could go off property to do so.</p> <p>Record review of Social Service Notes, dated 05/04/11, revealed Resident #13 stated that being in the presence of the smoke made it too difficult for him/her to resist the desire to smoke. Interview, on 07/26/12 at 9:23 AM, with Licensed Social Worker (LSW) #15 revealed Resident #13 was assessed for smoking safety on 07/08/11 which determined he/she was safe to smoke independently. Record review of Resident #13's Care Plan, dated 07/08/11, revealed the resident had been continuing to request to smoke. Further review of the Care Plan, dated 04/19/12, revealed the resident had been continuing to request to smoke. Further interview with LSW #15 revealed Resident #13 had been requesting to smoke since his/her arrival and the issue was discussed in his/her care plan meeting on 05/04/12.</p> <p>Record review of Resident #13's Care Plan, dated 05/14/12, revealed the resident would no longer be permitted to smoke outside of the facility. Interventions put in place were to offer Resident #13 a nicotine patch, assist him/her in transferring to another facility which allowed smoking, encouraging the resident to participate in activities, and that Resident #13 could go</p>	F 151		

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F 151	Continued From page 4 outdoors in the secured court yard. Interview, on 07/26/12 at 10:10 AM, with the Administrator revealed she took Resident #13's lock box containing his/her cigarettes away but allowed him/her to retain the key to box. Additionally, the Administrator stated that she would not give Resident #13 the box back and told him/her that she would give it to his/her brother. The Administrator revealed that other residents were allowed to smoke off property and that staff were allowed to smoke on the property in the courtyard, which was within visualization of the residents. The Administrator stated in order to meet the needs and rights of the residents who smoked, the facility offered the residents a nicotine replacement patch.	F 151	<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/MISAPPROPRIATN 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 observation, interview, and review of the facility's policy, it was determined the facility failed to ensure the resident was free from misappropriation of personal property for one (1) of twenty four (24) sampled residents (Resident #12). Interview with the Resident #12's daughter revealed Resident #12 had a collapsible chair and	F 224	F224 Pink chair was found and returned to family. All current reports of missing items were reviewed and none were identified in which families/residents were not notified of any unfound items. Social Services is placing a copy of the notifications of missing items chronologically in a binder. Within 72 hours, Social Services signs each notification with the date and who was notified if the item was not found. Social Services will bring binder to Quality Assurance Meeting for review for the next three months. Completion Date: 8-21-12.	

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F 224 Continued From page 5
a specialized overbed tray which were missing from his/her room and hadnot been located in the facility. The facility failed to provide documented evidence of notification to the family of the search outcome.

The findings include:

Review of the facility's policy titled, "Policy and Procedure Missing Items", undated, revealed if missing item(s) were not located within a seventy-two (72) hour period, the complainant would be notified of the inability to locate the item. Further review of the policy revealed the complainant would be offered the opportunity to notify the local police department of the missing item per their request.

Review of the facility's Resident Missing Article Report, dated 05/14/12, revealed Resident #12's name and a description of a "pink folding chair and adjustable tray" under reported missing article(s) and "See Above" under Disposition of Reported Missing Articles. Continued review of the document revealed the document was signed by Social Services #1 on 05/14/12. Further review of this report revealed no documented evidence the resident and/or family were notified of the results of the investigation.

Observation of Resident #12's room, on 07/27/12 at 1:30 PM, revealed no collapsible chair or specialized overbed tray in the room.

Interview, on 07/27/12 at 11:30 AM, with Resident #12's daughter revealed she had purchased a "hot pink collapsible chair and an overbed tray that tilted with crossword books" for the resident's

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F 224	<p>Continued From page 6</p> <p>room. She revealed she reported the items as missing many months ago, but never heard back from anyone at the facility regarding the items.</p> <p>Interview, on 07/27/12 at 3:04 PM, with Social Services #1, revealed she completed the missing item log for the "hot pink camp chair", however she stated she was not aware of the missing "tilt table and crossword books". She further revealed Housekeeping had looked all over the facility for the chair, but never found it and she did not recall if she notified the family of the outcome of the search or not.</p> <p>Interview, on 07/27/12 at 6:25 PM, with the Administrator, revealed the policy stated the facility should notify the family of the outcome so they were aware the facility had searched for the item and not found it. Further interview revealed the family should have been notified in case they wanted to file a police report.</p>	F 224	<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>	
F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p>	F 278	<p>F278/N187</p> <p>No residents were affected by the deficient practice.</p> <p>There is no potential for residents to be affected by the deficient practice.</p> <p>MDS Nurses were inserviced to look at the immunization record for both the site where the vaccine was actually given and the administration date when completing the MDS by the SDC, the QA Nurse, or the DON on 8-21-12. Any MDS nurse not receiving the inservice by the date of compliance will receive it prior to working.</p>	

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F 278 Continued From page 7
Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review it was determined the facility failed to accurately assess the residents' status for one (1) of twenty-four (24) sampled residents (Resident #9).

The findings include:

Review of Resident #9's medical record revealed an admission date of 03/09/09. Review of Resident #9's Annual Minimum Data Set (MDS) Assessment, dated 01/12/12 and the Quarterly MDS Assessment dated 07/07/12, revealed the resident was assessed to have received the Influenza Vaccine and Pneumococcal Vaccines. Further review of the resident's medical record revealed an Immunization Record form. Review of the Immunization Record form revealed Resident #9 had refused the Influenza Vaccine and Pneumococcal Vaccine since admission to the facility in 2009.

F 278 The Assistant QA Nurse will review the MDS before completion for errors and report findings to the MDS Nurse doing the assessment for immediate correction. The Assistant QA Nurse will report any findings of errors to the DON for further review. The DON will present findings to the monthly QA meeting for discussion. Based on the findings and trends, the QA committee will determine the need for continued monitoring.

Completion date: 8-22-12.

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F 278	Continued From page 8 Interview, on 07/27/12 at 5:30 PM, with the MDS Coordinator revealed she had made a mistake on the MDS Assessments when she documented the resident had received the Influenza and Pneumococcal Vaccines. She stated she had looked at the Physician's Orders when completing the MDS Assessments and had misread what was documented on the Orders related to the Influenza and Pneumococcal Vaccines. She stated the Annual and Quarterly MDS Assessments were inaccurate related to the Influenza and Pneumococcal Vaccines.	F 278		
F 371 SS=F	483.35(j) 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 by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to follow proper sanitation and food handling practices to prevent the outbreak of	F 371	<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> <hr/> <p>F371/N283 No residents were identified.</p> <p>Residents residing in the facility who receive meals have the potential to be affected.</p> <p>All Dietary Staff were inserviced on hand washing procedures related to safe hygienic food handling techniques and proper use of sanitizer in sanitation bucket by the Dietary Manager, Assistant Dietary Manager, or Registered Dietician on 7-31-12 thru 8-20-12. Any staff who did not receive the inservice by the compliance date will do so prior to working..</p>	

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F 371	<p>Continued From page 9</p> <p>foodborne illness related to touching food with bare hands on the tray line, staff using a tissue to wipe their face while on the tray line, swiping a bare hand across a plate prior to placing food on the tray line, and not properly preparing the sanitation water bucket.</p> <p>The findings include:</p> <p>1. Review of the facility's policy, Safety and Sanitation, undated, revealed all dietary services personnel will practice safe hygiene food handling techniques.</p> <p>Review of the facility's policy, Hand Washing Procedures, undated, revealed hands must be washed after using a tissue or a handkerchief and after touching hair or skin.</p> <p>Observation, on 07/25/12 at 11:52 AM, during the lunch meal service revealed Dietary Cook #13 pushed a piece of chicken on a resident's tray with her bare finger. Continued observation revealed Dietary Cook #13, at 11:56 AM wiped her face with her left hand without washing his/her hands and continued serving food on the tray line. Further observation at 12:15 AM revealed Cook #13 removed a tissue from his/her pocket, wiped her face, and dropped the tissue on the counter and did not wash his/her hands and again continued serving food on the tray line. At 12:08 PM, Dietary Aid #14 was observed swiping a bare hand across a plate prior to it starting down the tray line.</p> <p>Interview, on 07/25/12 at 12:45 PM, with Dietary Cook # 13 revealed she should not have touched the food on the plate and should have washed</p>	F 371	<p>An audit tool was created to be completed on tray line once per day by the Dietary Manager, Assistant Dietary Manager, Registered Dietician, or Cook Supervisor for correct sanitation. Any concerns identified will be corrected immediately. The Dietary Manager will review the audits and present disciplinary action as warranted.</p> <p>Dietary Manager or Assistant Dietary Manager will report daily monitoring findings in the monthly QA meeting for further recommendations. Based on findings and trends, the QA committee will determine need for continued monitoring.</p> <p>Completion date: 8-21-12.</p>	

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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
F 371	<p>Continued From page 10</p> <p>her hands after touching her face due to cross contamination.</p> <p>Interview, on 07/25/12 at 12:55 PM, with Dietary Aid # 14 revealed she should not have brushed her hand across the plate prior to placing it on the tray line due to cross contamination.</p> <p>Interview, on 07/25/12 at 12:50 PM, with the Dietary Manager revealed staff should wash their hands when touching anything beside the trays due to cross contamination.</p> <p>2. Review of the facility's policy, Space and Equipment, revealed working surfaces, utensils, and equipment will be cleansed and sanitized after each period of use and dishwashing and utensil-washing equipment and techniques will result in sanitized serviceware and prevent contamination.</p> <p>Observation, on 07/27/12 at 2:40 PM, revealed Dietary Aide #9 used plain water to fill the sanitation bucket. The Dietary Manager spoke to the Dietary Aide who emptied the sanitation bucket and started to fill it again with plain water. Further observation revealed the Dietary Manager redirected her to the sanitizer station and the Accudose auto spout. The Dietary Aide then filled the sanitation bucket with water and sanitizer.</p> <p>Interview, on 07/27/12 at 2:40 PM, with Dietary Aid #9 revealed she should have used the sanitizer spout to fill her sanitation bucket. She stated she knew to use the sanitizer to fill the sanitizing water bucket prior to use to prevent contamination.</p>	F 371		

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STATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185144	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/27/2012
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F 371	Continued From page 11 Interview, on 07/27/12 at 2:40 PM, with the Dietary Manager revealed Dietary Aid #9 should have used the sanitizer spout to fill her sanitation bucket. He stated he knew Dietary Aide #9 knew how to complete the process and didn't know why she was so nervous. Further interview revealed the sanitizing bucket must be properly filled to avoid cross contamination of the surfaces in the kitchen.	F 371	<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 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined that the facility failed to dispose of garbage and refuse properly. The findings include: Review of the facility's policy titled "Waste Control", undated, stated garbage and trash would be stored in a sanitary manner until disposed of properly for infection control. The facility's policy further stated the dumpster must be kept closed at all times when not in use. Observation, on 07/24/12 at 11:15 AM, revealed the lid to the dumpster on the right to be broken and hanging down into the dumpster with the door on the side partially closed with bags of trash hanging out of the sliding door. Further observation revealed the dumpster on the left to	F 372	F372/N284 No residents were identified. No potentially affected residents were identified. All Dietary Staff, all Maintenance Staff, and all Housekeeping Laundry Staff were inserviced on proper procedures for disposing of garbage and trash in the dumpster, including picking up trash around the dumpster and keeping the door to the dumpster closed at all times by the Dietary Manager, the Assistant Dietary Manager, the Registered Dietician, the SDC, the QA nurse, the Weekend Nurse Supervisor, or the ADON on 7-28-12 through 8-27-12. Any staff who did not receive the inservice by the compliance date will do so prior to working. A replacement dumpster for the dumpster that was not in good repair was ordered from the company providing the dumpsters by the Administrator on 8-17-12. An audit tool for daily inspection of the dumpsters was created to be completed Monday through Friday by the Maintenance Director or his designee and to be completed on Saturday and Sunday by the Weekend Supervisor or her designee. Audits will be brought to the monthly QA meeting for	

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F 372	<p>Continued From page 12</p> <p>have the sliding door open. Additionally, behind the dumpster on the left was a large bag of trash and smaller bags of trash on the ground.</p> <p>Observation, on 07/25/12 at 5:00 PM, revealed behind the dumpster on the left was one (1) large bag of trash (with smaller bags inside) and five (5) smaller bags of trash on the ground and the sliding door on the side of the dumpster was open. Further investigation revealed the dumpster on the right had the lid broken and falling into the dumpster. Additionally there were two (2) bags of trash hanging out of the dumpster door. Further investigation revealed there was a "c" size battery, aluminum foil, and various paper trash on the ground around the dumpsters.</p> <p>Interview, on 07/27/12 at 2:45 PM, with the Maintenance Director and Environmental Services Director revealed the dumpsters were in need of repair. Both stated that it was not their responsibility to keep the dumpster area clean and sanitary and agreed that it was the responsibility of the Dietary Manager. The Maintenance Director stated that it was his responsibility to keep the dumpsters in good mechanical working order or to call the contracted company to do so and additionally to call the contracted company for additional pick ups. Both Directors stated that bags of trash and other loose trash should not have been on the ground due to infection control issues and that the doors to the dumpsters should have been closed when not in use.</p> <p>Interview, on 07/27/12 at 2:55 PM, with the Dietary Director revealed the dumpsters should not have bags of trash and other loose trash on</p>	F 372	<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>further recommendations for three months. Based on findings and trends, the QA committee will determine need for continued monitoring and audits.</p> <p>Completion date: 9-10-12.</p>	

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F 372	Continued From page 13 the ground due to infection control issues and the doors to the dumpsters should be closed when not in use. The Dietary Director denied knowing that it was his responsibility but stated it needed to be done. Interview, on 07/27/12 at 5:50 PM, with the Administrator during walking environmental rounds revealed the garbage should not have been on the ground and the doors should have been kept closed when not in use for infection control purposes. The interview further revealed that she believed all departments were responsible for the cleanliness of the area and the Maintenance Director was responsible for the repair of the dumpster and for additional garbage pick up requests.	F 372		
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 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	<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>F441/N144 No residents identified were affected.</p> <p>No other residents were affected.</p> <p>All Nursing Staff were inserviced on proper hand washing procedures related to safe hygienic food handling techniques on 7-28-12 through 8-27-12. All nurses will be inserviced on proper hand washing procedures when completing skin assessments on 7-28-12 through 8-27-12. Inservices were conducted by the Staff Development Coordinator, the Weekend Nurse Supervisor, the QA Nurse, the DON, or the ADON. Any staff who did not receive the inservice by the compliance date will do so prior to working.</p>	

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F 441	<p>Continued From page 14</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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 and review of facility's policy, it was determined the facility failed to 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 as evidenced by failure to follow proper infection control techniques when handling food, and failure to ensure the appropriate use of handwashing and glove use during skin assessments. Observation of Nursing Supervisor (NS) #11 revealed she used bare hands when handling bread; State Registered Nursing Assistant (SRNA) #4 placed a peeled banana on a resident's plate with her bare hands; and SRNA #5 did not sanitize her hands after she touched her clothing. Additionally, during two (2) skin</p>	F 441	<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>To ensure sustained compliance, an audit tool was created for the QA Nurse, the Staff Development Coordinator, or a nurse designated by the DNS, to conduct 1 observation per week of a licensed staff conducting a dressing change and handwashing. An audit tool was also created for the QA Nurse, the Staff Development Coordinator, or a nurse designated by the DNS, to conduct 3 observation per week of proper hand washing procedures during meal service. Any concerns identified will be corrected immediately and presented to the DON for review.</p> <p>The DON is responsible to present observation findings to the monthly QA meeting for discussion. Based on findings and trends, the QA committee will determine need for continued monitoring and audits.</p> <p>Completion date: 8-28-12.</p>	

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F 441	<p>Continued From page 15</p> <p>assessment observations revealed the nurses involved did not change their gloves or wash their hands after assessing residents' perineal areas and proceeding to the lower body.</p> <p>The findings include:</p> <p>Review of the facility's "Infection Control Policy", undated revealed the facility had an active infection control program that practiced measures to "identify, control, and prevent infections acquired or brought into the facility from the community or other health care facilities. The goal of the facility's program is to improve resident care practices by reducing the potential for nosocomial (facility-acquired) infections."</p> <p>1. Observation of lunch service, on 07/24/12 at 12:15 PM, revealed State Registered Nursing Assistant (SRNA) #4 peeled a banana for an unsampled resident and used her bare hands to place it on the resident's plate. Further observation of lunch service, on 07/24/12 at 12:34 PM, revealed Nursing Supervisor (NS) #11 used her bare hands to retrieve bread from the serving sleeve and place it on the plate of another unsampled resident.</p> <p>Interview with Nursing Supervisor (NS) #11, on 07/27/12 at 5:25 PM, revealed her process for opening bread was to tear the serving sleeve and lay the sleeve and bread on the tray. She revealed she didn't recall opening the bread with her bare hands, but stated she shouldn't have because of cross contamination and infection control.</p>	F 441		

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F 441	<p>Continued From page 16</p> <p>Interview with SRNA #4, on 07/27/12 at 5:39 PM, revealed she peeled the banana all the way because the resident asked her to and she wasn't sure how else you would lay a peeled banana on someone's tray. She revealed she should not have touched it because of germs.</p> <p>2. Observation, on 07/25/12 at 12:00 PM, revealed SRNA #5 sanitized her hands after preparing a meal tray for a resident. She took another meal tray off of the cart, looked at the name, pushed the tray back on the cart and put her left hand on her hip. She pulled the tray off the cart and took the tray to the patient's room without sanitizing her hands.</p> <p>Interview, on 07/27/12 at 4:20 PM, with the Director of Nursing (DON) revealed the SRNA should have sanitized her hands after she touched her clothing. Hand sanitization was to control and prevent infections from spreading.</p> <p>Interview, on 07/27/12 at 4:55 PM, with the Administrator revealed the SRNA should have sanitized her hands after touching her hip.</p> <p>3. Observation, on 07/25/12 at 4:27 PM, during a head to toe skin assessment of Resident #12 revealed Licensed Practical Nurse (LPN) #6 assessed the resident's head and chest area, then assessed the perineal area. The LPN then, without changing gloves or washing her hands, proceeded to assess Resident #12's back.</p> <p>Interview, on 07/25/12 at 4:50 PM, with LPN #6 revealed she should have changed her gloves after touching Resident #12's perineal area.</p>	F 441		
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F 441	Continued From page 17 4. Observation, on 07/25/12 at 10:20 AM, during a head to toe skin assessment of Resident #9 revealed Licensed Practical Nurse (LPN) #5 assessed the resident's head and chest area, then assessed the feet and legs. LPN #5 proceeded to assess Resident #9's perineal area and buttocks. The LPN then, without changing gloves or washing her hands, adjusted the resident's clothing. Interview, on 07/26/12 at 1:45 PM, with Nursing Supervisor #15 revealed LPN #5 should have changed her gloves after touching Resident #9's perineal area. She stated "anytime you go from dirty to clean you should wash your hands and put on new gloves". Interview, on 07/27/12 at 6:15 PM, with the Infection Control Nurse revealed after assessing residents' perineal areas and buttocks nurses should change their gloves and wash their hands as these were considered "dirty" areas.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT 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: Based on observation and interview, it was determined the facility failed to provide a safe, comfortable and sanitary environment for	F 465	<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>F465 No residents were identified as affected.</p> <p>All residents residing in the facility have the potential to be affected.</p>	

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F 466 Continued From page 18 residents, visitors and staff as evidenced by cove base loose or missing in residents' rooms/bathrooms, dirt-like substances in cracks between floor tiles and walls, broken tiles in showers and whirlpool rooms, ants in the TV room (across from the Activities and Social Workers' offices, an outlet pulled away from the wall in a resident's room, parquet flooring missing under and behind a toilet, a hole in a wall in a resident's bathroom, damage to a resident's bathroom door and a missing knob to a timer switch, which exposed a metal rod, in a resident's bathroom.

The findings include:

Observation during the initial tour, on 07/24/12 at 10:15 AM, revealed in resident rooms 303, 305, 306 and 307 the cove base was missing from the wall and bathroom. There was a gap between the wall and the floor with a build-up of dirt and dust between wall and floor.

Observation during the initial tour, on 07/24/12 at 10:30 AM, revealed in resident room 304 the baseboard in three (3) of the four (4) corners was peeling away from the was. Further observation in this room revealed the flooring was missing in some areas leaving exposed concrete with no tile covering the flooring. Further observation revealed the 300 hall between resident rooms 304 and 305 to have a crack in the floor with flooring material breaking away from the floor with dirt and dust collected in missing and cracked area.

Continued observation during the initial tour, on 07/24/12 at 10:45 AM, revealed in resident room

F 465

This Plan of Correction is the center's credible allegation of compliance.

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All areas of concern have been corrected or are being corrected by the following:

- Replaced missing or re-glue loose cove base.
- Cleaned area in cracks between floor tiles and walls.
- Replace broken tiles in shower and whirlpool room.
- Pest control company sprayed for ants.
- Outlet pulled away from wall placed back in wall.
- Parquet flooring missing around toilet was replaced.
- Hole in wall repaired.
- Resident bathroom door repaired or replaced.
- Missing knob on timer switch replaced.
- Repaired cracks in joints in hallway floor.

Maintenance Director (or Assistant if Director is out) and Administrator (or QA Nurse if Administrator is out) will make walking rounds weekly and report findings in monthly QA meeting for 3 months.

Completion date: 9-10-12.

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F 465	<p>Continued From page 19</p> <p>303, behind the first bed there was a six (6) junction electrical outlet pulled away from the wall. Further observation revealed there was no baseboard on the wall in front of the bathroom and there was a softball sized hole in the drywall. Observation of resident room 300 revealed the baseboard was loose from the wall in the bathroom with areas of rotted drywall. Observation revealed resident room 308 had broke/missing tile in the bathroom shower.</p> <p>Further observation during the initial tour, on 07/24/12 at 10:50 AM, revealed resident room 412 had a knob off the light switch in the bathroom leaving a metal rod protruding from light switch. Observation further revealed a restroom located in the hallway near resident room 409 had missing parquet flooring behind the toilet.</p> <p>Continued observation during the initial tour, on 07/24/12 at 10:55 AM, revealed in the 300 hall community TV area there were multiple ants crawling on the window sill below the portable air conditioning unit in window.</p> <p>Interview, on 07/26/12 at 1:26 PM, with the Director of Maintenance and the Director of Housekeeping revealed the missing baseboards, exposed concrete, the hole in the drywall, the rotted drywall, the missing parquet flooring and the ants crawling on the window sill were infection control issues. Interview further revealed the electrical outlet that was pulled away from the wall and the light switch with metal protruding were safety issues. Interview further revealed the broken and missing tiles in the residents' bathrooms and the cracked and missing flooring</p>	F 465		

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F 465	<p>Continued From page 20</p> <p>in the hallway were both infection control and safety issues.</p> <p>Interview, on 07/27/12 at 5:50 PM, with the Administrator revealed she was in agreement that the environmental issues identified were both safety and infection control issues. She further stated some areas of the facility were under repair and construction.</p> <p>Based on observation and interview it was determined the facility failed to provide a safe, comfortable and sanitary environment for residents, visitors and staff as evidenced by cove base loose or missing in residents' rooms/bathrooms, dirt-like substances in cracks between floor tiles and walls, broken tiles in showers and whirlpool rooms, ants in the TV room (across from the Activities and Social Workers' offices, an outlet pulled away from the wall in a resident's room, parquet flooring missing under and behind a toilet, hole in a wall in a resident's bathroom, damage to a resident's bathroom door and a missing knob to a timer switch, which exposed a metal rod, in a resident's bathroom.</p> <p>The findings include:</p>	F 465		

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1608 VERSAILLES ROAD LEXINGTON, KY 40504	
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F 465	Continued From page 21 Observation during initial tour on 07/24/12 at 10:15 AM, revealed in resident rooms 303, 305, 306 and 307 the cove base is missing from the wall and bathroom. There is a gap between the wall and the floor with a build up of dirt and dust between wall and floor. Observation during initial tour on 07/24/12 at 10:15 AM, revealed in resident room 304 had baseboard in three (3) of the four (4) corners peeling. Area of room had concrete exposed where tile not cut to fit area appropriately. Observation during initial tour on 07/24/12 at 10:15 AM, revealed in resident room 303 behind the first bed was a six (6) junction electrical outlet pulled away from the wall. There was a sign posted above the bed alerting staff of the electrical outlet hazard. There was no baseboard on the wall in front of the bathroom and a softball sized hole in the drywall. Observation during initial tour on 07/24/12 at 10:15 AM, revealed resident room 300 the baseboard loose from the wall in the bathroom with areas of drywall rotten. Observation during initial tour on 07/24/12 at 10:15 AM, revealed resident room 308 had the tile broke/missing in the bathroom shower. Observation during initial tour on 07/24/12 at 10:15 AM, revealed resident room 412 had a knob off the light switch in the bathroom leaving a metal rod protruding from light switch. Observation during initial tour on 07/24/12 at	F 465		

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F 465	<p>Continued From page 22</p> <p>10:15 AM, revealed a restroom located in the hallway near resident room 400 the have flooring missing behind the toilet. Further observation revealed the 300 hall between resident rooms 304 and 305 to have a crack in the floor with flooring material breaking away from floor, dirt and dust collecting in missing and cracked area.</p> <p>Observation during initial tour on 07/24/12 at 10:15 AM, revealed in the 300 hall community TV area multiple ants crawling on window sill below the portable air conditioning unit in window. Window was open with exhaust vent from air conditioner duct taped to window.</p>	F 465	<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>	
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the facility's policy, it was determined the facility failed to accurately document the services provided in accordance with current professional</p>	F 514	<p>B 005/F514/N354</p> <p>No residents were affected by the deficient practice. This issue is related to documentation..</p> <p>No other residents had the potential to be affected.</p> <p>All nurses were inserviced on 7-28-12 through 8-27-12 for the correct method for documentation of TB skin test results by the Staff Development Coordinator, the Weekend Nurse Supervisor, the QA Nurse, the DON, or the ADON. Any staff who did not receive the inservice by the completion date will do so prior to working.</p> <p>The QA nurse will verify that all TB skin tests are documented on the MAR as well as on the Resident Immunization Record and report findings to in the QA Meeting every month, for three months.</p> <p>Completion Date: 8-28-12.</p>	

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F 514	<p>Continued From page 23</p> <p>standards and practices for two (2) of twenty four (24) sampled residents (Residents #12 and #21) as evidenced by the results of tuberculin (TB) skin testing not documented accurately and no date documented.</p> <p>The findings include:</p> <p>Review of the facility policy titled, "Documentation of Immunization", undated, revealed the administration of an immunization would be documented on the residents' Medication Administration Record (MAR), including results if the immunization was a tuberculin skin test.</p> <p>1. Record review, on 07/25/12 at 12:30 PM, of the MAR of Resident #12 revealed the annual Tuberculin (TB) skin test was administered on 07/02/12, but there was no documented evidence of the TB skin test being read. The MAR was not initialed, marked as negative or positive, nor marked with millimeters (mm's) of induration.</p> <p>2. Record review, on 07/26/12 at 9:30 AM, of the MAR of Resident #21 revealed no documented evidence of the second step TB skin test administered on 04/23/12 and initialed on 04/25/12. The MAR was not marked with mm's of induration or an indication of negative or positive.</p> <p>Record review, on 07/26/12 at 9:30 AM, of the immunization record of Resident #21 revealed the date of 05/24/12 as the date the TB skin test was read. Further review revealed under, Results in mm's, to be only a negative symbol circled with no initials and no indication of mm's.</p>	F 514		

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F 514	<p>Continued From page 24</p> <p>Interview, on 07/26/12 at 10:36 AM, with Nursing Supervisor #11 revealed TB skin tests should list the results as positive or negative, the number of mm's and list the correct date of reading.</p> <p>Interview, on 07/26/12 at 10:42 AM, with Licensed Practical Nurse (LPN) #2 revealed the immunization sheet and the MAR should have both been listed as negative and the number of mm's along with the correct date of reading.</p>	F 514		

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K 000	INITIAL COMMENTS Building: 01 Survey under: NFPA 101 (2000 Edition) Existing Plan approval: 06/21/71 Facility type: SNF/NF Type of structure: V (111) Smoke Compartment: Thirteen (13) Fire Alarm: Complete fire alarm with smoke detectors in corridors and initiating devices at exits. Sprinkler System: Complete sprinkler system (dry) Generator: Type II (Natural Gas) upgraded in 2012. A Life Safety Code survey was conducted on 07/25/12. Homestead Nursing Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was one hundred fifteen (115). The facility is licensed for one hundred thirty six (136). The following findings demonstrate noncompliance with the highest scope/severity at "F" level.	K 000		
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated	K 027	<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>	

REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Nancy Russell</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8-20-12</i>
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 027	<p>Continued From page 1</p> <p>protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke doors that would close and resist the passage of smoke. The deficient practice affected ten (10) of ten (10) smoke compartments, staff and all residents. The facility has the capacity for one hundred thirty-six (136) beds with a census of one hundred fifteen (115) on the day of survey.</p> <p>Findings include:</p> <p>Observation, on 07/25/12 between 9:30 AM and 1:30 PM, revealed that the doors in the smoke barriers had astragals installed on doors and no door coordinators so doors could completely close to resist the passage of smoke as required by NFPA Code. Doors in smoke barriers are required to be self-closing to resist the passage of smoke. All smoke barrier doors in building one (1) were identified as deficient.</p> <p>Interview with the facility's Maintenance Supervisor, on 07/25/12 at 10:30 AM, revealed the facility was not aware the doors were required to have a door coordinator installed on the doors.</p>	K 027	<p>K-027</p> <p>No residents were identified as affected.</p> <p>Residents in each smoke compartment of the facility have the potential to be affected by doors that might not close properly and resist the passage of smoke. The facility ordered a door coordinator for each set of affected doors in the facility on 8-17-12 to be installed.</p> <p>Maintenance Director will inspect doors after each fire drill to ensure proper closure and document issues.</p> <p>Documentation will be reviewed by the QA committee. Based on findings and trends, the QA committee will determine the need for continued monitoring.</p> <p>Compliance date: 9-10-12.</p>	

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K 027	Continued From page 2 NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke. Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 027		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to maintain the fire sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect all smoke compartments, all residents, staff, and visitors. The facility is licensed for one hundred thirty-six (136) beds with a census of one hundred fifteen (115) on the day of the survey.	K 062	<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>K-62</p> <p>No residents were identified as affected.</p> <p>Residents residing in the facility have the potential to be affected should sprinklers fail.</p>	

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K 062	<p>Continued From page 3</p> <p>The findings include:</p> <p>Record review, on 07/25/12 between 9:30 AM and 1:30 PM, with the Maintenance Director revealed the facility was due for Internal Pipe Inspection. Record review revealed no record of Internal Pipe Inspection being performed. All Fire Sprinkler Inspection records reviewed during the survey indicated that the Internal Pipe Inspection was required and the last date the Internal Piping Inspection was completed in 2003. Also one (1) quick response sprinkler head was identified near room #414 in the corridor with six (6) regular response heads. Mixed sprinkler heads are not allowed in compartments.</p> <p>Interview, on 07/25/12 at 12:30 PM, with the Maintenance Director revealed he thought the sprinkler company would keep everything up to date that was required.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System</p>	K 062	<p>Inspection was completed on 8-16-12. Any issues found will be corrected by the compliance date. Sprinkler heads were changed to all be matching within each compartment.</p> <p>Maintenance Director will ensure that this inspection is completed 2017.</p> <p>Compliance date: 9-10-12.</p>	

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K 062	<p>Continued From page 4</p> <p>Inspection, Testing, and Maintenance Item Activity Frequency Reference</p> <p>Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2</p> <p>Control valves Inspection Weekly/monthly Table 9-1</p> <p>Alarm devices Inspection Quarterly 2-2.6</p> <p>Gauges (wet pipe systems) Inspection Monthly 2-2.4.1</p> <p>Hydraulic nameplate Inspection Quarterly 2-2.7</p> <p>Buildings Inspection Annually (prior to freezing weather) 2-2.5</p> <p>Hanger/seismic bracing Inspection Annually 2-2.3</p> <p>Pipe and fittings Inspection Annually 2-2.2</p> <p>Sprinklers Inspection Annually 2-2.1.1</p> <p>Spare sprinklers Inspection Annually 2-2.1.3</p> <p>Fire department connections Inspection Table 9-1</p> <p>Valves (all types) Inspection Table 9-1</p> <p>Alarm devices Test Quarterly 2-3.3</p> <p>Main drain Test Annually Table 9-1</p> <p>Antifreeze solution Test Annually 2-3.4</p> <p>Gauges Test 5 years 2-3.2</p> <p>Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3</p> <p>Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2</p> <p>Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1</p> <p>Valves (all types) Maintenance Annually or as needed Table 9-1</p> <p>Obstruction investigation Maintenance 5 years or as needed Chapter 10</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.5.3* Where this Code permits exceptions for</p>	K 062		

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K 062	Continued From page 5 fully sprinklered buildings or smoke compartments and specifically references this paragraph, the sprinkler system shall meet the following criteria: (1) It shall be installed throughout the building in accordance with Section 9.7. (2) It shall be electrically connected to the fire alarm system. (3) It shall be fully supervised. (4) It shall be equipped with listed quick-response or listed residential sprinklers throughout all smoke compartments containing patient sleeping rooms. Exception No. 1: Standard response sprinklers shall be permitted to be continued to be used in existing approved sprinkler systems where quick-response and residential sprinklers were not listed for use in such locations at the time of installation. Exception No. 2: Standard response sprinklers shall be permitted for use in hazardous areas protected in accordance with 19.3.2.1.	K 062	<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>	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072	K- 72 No residents were identified as affected.	

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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
K 072	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with National Fire Prevention Association (NFPA) standards. The deficiency had the potential to affect ten (10) of ten(10) smoke compartments, all residents, staff, and visitors. The facility is licensed for one hundred thirty-six (136) beds with a census of one hundred fifteen(115) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/25/12 between 9:30 AM and 1:30 PM, with the Maintenance Director revealed medication carts were stored and not in use in corridors at nurses stations A, B, C, and D. Mechanical lifts were observed stored and not in use near room #201. Means of egress must remain clear of all obstructions and impediments at all times in case of emergency or fire.</p> <p>Interview, on 07/25/12 at 11:45 AM, with the Maintenance Director revealed he was aware the facility routinely stored the medication carts and lifts in the corridors.</p> <p>Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p>	K 072	<p>Residents residing in the facility have the potential to be affected by not having egress in an emergency.</p> <p>Designated storage areas for all items were identified and all staff were inserviced on 7-28-12 through 8-27-12 by the SDC, the QA Nurse, the Weekend Manager, the Administrator, the DON, or the ADON on not allowing items which are not in use to remain in hallways. Any staff not receiving this inservice prior to the compliance date will receive it prior to working.</p> <p>Unit Managers, ADNS, Weekend Managers, and all Supervisors will monitor for compliance of not allowing items to be left in hallways. QA nurse will submit findings of non-compliance to the QA committee. Based on findings and trends, the QA committee will determine the need for continued monitoring.</p> <p>Compliance date: 8-28-12.</p>	