

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

PRINTED: 03/15/2013  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185227	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/01/2013
NAME OF PROVIDER OR SUPPLIER  SUPERIOR CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  A recertification and an abbreviated survey (KY#19790) was conducted on 02/26/13 through 03/01/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of a "F". KY #19790 was substantiated with deficiencies cited.	F 000	<b>Preparation and 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. This Plan of Correction is prepared and executed solely because it is required by federal and state laws. The facility reserves the right to revise/improve corrective actions as determined to be warranted.</b>	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to implement the care plan for two (2) residents (#18, and #21), in the selected sample of sixteen (16) residents, related to not serving green, leafy vegetables.  Findings include:  1. A record review revealed Resident #18 was admitted to the facility, on 02/06/13 with diagnosis to include Metabolic Encephalopathy, Atrial Fibrillation, Malaise and Fatigue, Encephalopathy, Hypertension, Hypoxemia and Acute Kidney failure.	F 282	<u>F282</u>  1) Dietary staff were inserviced regarding resident's #18 and # 21 tray card instructions. The inservice was to specifically address green, leafy vegetable restrictions. Nursing assistants responsible for monitoring the dining rooms were inserviced one on one as well. There is now a designee assigned to review each meal prepared at the point of service in the dining room.	

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

TITLE

(X6) DATE

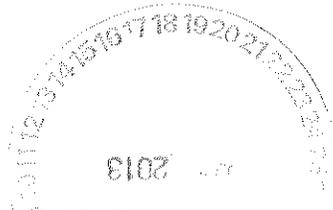
*[Signature]*

*Asst. Administrator*

3/28/13

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

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F 282	<p>Continued From page 1</p> <p>A review of the Comprehensive Care Plan, dated 02/13/13, revealed staff should serve Resident #18 a Therapeutic Diet (with no dark green leafy vegetables and no added salt).</p> <p>An observation of the lunch meal, on 02/26/13 at 1:05 PM, revealed the meal card instructions revealed Resident #18 should not receive dark, green, leafy vegetables. Observation of Resident #18's plate revealed Resident #18 was served spinach.</p> <p>2. A record review revealed Resident #21 was admitted to the facility with diagnoses to include Atrial Fibrillation, Hypertension, and Cardiomyopathy.</p> <p>A review of the Comprehensive Care Plan, dated 04/25/12, revealed staff should provide diet as ordered.</p> <p>A review of the Physician's Orders, dated 02/2013, revealed an order for no green leafy vegetables.</p> <p>An observation of the lunch meal, on 02/26/13 at 12:51 PM, revealed the meal card instructions stated Resident #21 should not receive dark green leafy vegetables. An observation of Resident 21's plate revealed the resident was served spinach.</p> <p>An interview with State Registered Nurse Aide (SRNA) #3, on 03/01/13 at 2:20 PM, revealed there was a double check system in place to ensure residents received their meals and assistive devices as ordered. She stated the kitchen staff was supposed to check the trays with the meal card when the trays were prepared</p>	F 282	<p>2) All residents taking coumadin have the potential to be affected.</p> <p>3) Dietary staff were inserviced related to dietary instructions on the tray cards. There will be a designee assigned to review each meal prepared at the point of service in the dining rooms.</p> <p>4) Residents with green, leafy vegetable restrictions will be monitored by the dietitian through the QA process by monitoring five of the affected resident's meals on Monday, Wednesday and Friday for one week, the following Tuesday, Thursday for one week. Five residents who receive coumadin will be monitored monthly thereafter. If the monthly QA process identifies a concern, all dietary and nursing staff will be reinserviced.</p> <p>5) Correction completion date: 4/10/13</p>	4/10/13	

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F 282	Continued From page 2 and nursing staff was supposed to check the trays with the meal card when the trays were served to the residents.  An interview with the Dietary Manager, on 03/01/13 at 2:42 PM, revealed the facility staff should have checked the meals cards to the trays for accuracy before delivering the meal trays to the residents.  An interview with the Registered Dietician, on 02/28/13 at 3:42 PM, revealed the physician's orders should have been followed related to the residents' diet orders. The staff who prepared the plates should have reviewed the meal card and followed the instructions on the card.  An interview with the Director of Nursing, on 03/01/13 at 2:14 PM, revealed staff should have checked the meal cards with the trays before the trays were served to the residents to ensure the residents had received the ordered diet.	F 282			
F 309 SS=D	<b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced	F 309	<u>F309</u>  1) To ensure care plans were followed for the residents #18 and #21 affected by the deficient practice, dietary staff were inserviced one on one regarding following tray card instructions which are derived from the care plans.  2) All residents taking Coumadin have the potential to be affected by this practice.		

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F 309	<p>Continued From page 3</p> <p>by: Based on observation, interview and record review it was determined the facility failed provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for two (2) residents (#18 and #21), in the selected sample of sixteen (16) residents. Observation of the noon meal revealed the facility served Residents #18 and #21 spinach even though there was a physician order for the residents not to receive green leafy vegetables due to the effect the vegetables can have on a residents' prothrombin time (blood clotting time) and the residents were on Coumadin (blood thinner).</p> <p>Findings include:</p> <p>1. A record review revealed Resident #18 was admitted to the facility, on 02/06/13 with diagnosis to include Metabolic Encephalopathy, Atrial Fibrillation, Malaise and Fatigue, Encephalopathy, Hypertension, Hypoxemia and Acute Kidney failure.</p> <p>A review of a physician's order, dated 02/20/13, revealed Resident #21 was ordered Coumadin 3 mg. and 4mg. alternating every other day and should not receive dark, green, leafy vegetables.</p> <p>A review of the Comprehensive Care Plan, dated 02/13/13, revealed staff should serve Resident #18 a Therapeutic Diet (with no dark green leafy vegetables and no added salt).</p> <p>An observation of the lunch meal, on 02/26/13 at</p>	F 309	<p>3) Dietitian will confirm all Coumadin orders. Dietitian will ensure tray card instructions are accurate for no green, leafy vegetable restrictions as it relates to resident's care plans.</p> <p>4) The dietitian will monitor five residents monthly who take coumadin to ensure that care plans are in place as it relates to leafy green restrictions. These five residents tray cards will be reviewed to ensure the tray card reflects the restriction. The monitoring of five residents will continue monthly. If a problem is identified through the QA process, the responsible department will be reinserviced.</p> <p>5) Correction completion date: 3/29/13</p>	3/29/13

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F 309	<p>Continued From page 4</p> <p>1:05 PM, revealed the meal card instructions revealed Resident #18 should not receive dark, green, leafy vegetables. Observation of Resident #18's plate revealed Resident #18 was served spinach.</p> <p>2. A record review revealed Resident #21 was admitted to the facility with diagnoses to include Atrial Fibrillation, Hypertension, and Cardiomyopathy.</p> <p>A review of the Comprehensive Care Plan, dated 04/25/12, revealed staff should provide diet as ordered.</p> <p>A review of the Physician's orders, dated 02/2013, revealed an order for Coumadin 2 mg. every day and no green leafy vegetables.</p> <p>An observation of the lunch meal, on 02/26/13 at 12:51 PM, revealed the meal card instructions stated Resident #21 should not receive dark green leafy vegetables. An observation of Resident 21's plate revealed the resident was served spinach.</p> <p>An interview with State Registered Nurse Aide (SRNA) #3, on 03/01/13 at 2:20 PM, revealed there was double check system in place to ensure residents received their meals and assistive devices as ordered. She stated the kitchen staff was supposed to check the trays with the meal card when the trays were prepared and nursing staff should check the trays with the meal card when the trays were served to the residents.</p> <p>An interview with the Dietary Manager, on</p>	F 309		

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F 309	Continued From page 5 03/01/13 at 2:42 PM, revealed the facility staff should have checked the meals cards for accuracy before delivering the meal trays to the residents.  An interview with the Registered Dietician, on 02/28/13 at 3:42 PM, revealed the physician's orders should have been followed related to the resident's diet order. The staff who prepared the plates should have reviewed the meal card and followed the instructions on the card. She stated the reason the physician ordered no green leafy vegetables was because the residents' were on Coumadin and the consumption of the green leafy vegetables had the potential to affect the resident's prothrombin time blood levels.  An interview with the Director of Nursing, on 03/01/13 at 2:14 PM, revealed staff should have checked the meal cards with the trays before the trays were served to the residents to ensure the residents had received the ordered diet.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was	F 323	<u>F323</u>  1) Resident #17 was no longer on the low air loss mattress, therefore, no corrective action was taken at this time.  2) Any resident with a physician order for a low air loss mattress has the potential to be affected by this practice.	

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F 323	<p>Continued From page 7</p> <p>bruise on the left outer shin and a raised firm area to the left forehead. X-rays were obtained with negative results. Further record review revealed there was no evidence the facility assessed for the risks with the use of the low air loss alternating mattress.</p> <p>A review of a Fall Log and Post Fall Assessment, dated 02/13/13 at 7:00 AM, revealed Resident #17 was found on the floor next to the bed and sustained an abrasion to the left knee. Further record review revealed there was no evidence the facility assessed for the risks with the use of the low air loss alternating mattress.</p> <p>A review of a Post Fall Assessment, dated 02/15/13 at 12:30 AM, revealed Resident #17 was found on the floor a third time beside the bed and heat/air condition unit. The resident complained of a headache and had a skin tear to the right arm. Neuro checks were ordered and a steri strip was applied to the skin tear. The air mattress was replaced with a perimeter mattress at that time. Further record review revealed Resident #17 has had no falls from the bed since the mattress was removed.</p> <p>An interview with the Director of Nursing (DON), on 03/01/13 at 1:45 PM, revealed the facility assessed for the need of a specialty air mattress but did not conduct an assessment for the safe use of an alternating air mattress that included identified risks verses benefits. The DON stated Resident #17 was removed from the alternating air mattress because they thought the resident was hearing the air movement in the mattress. She revealed Resident #17 had not fallen from the bed since the mattress was removed.</p>	F 323			

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F 323	<p>Continued From page 6</p> <p>determined the facility failed to ensure the resident environment was free of accident hazards as is possible for one (1) resident (#17), not in the selected sample of sixteen (16) residents. The facility failed to ensure there was a system in place for an assessment for the safe use of a low air loss alternating air mattress for Resident #17. Resident #17 sustained three falls by the bed which resulted in minimal injuries.</p> <p>Findings include:</p> <p>1. A record review revealed Resident #17 was admitted to the facility with diagnoses to include Syncope, Malaise and Fatigue, Ischemic Heart Disease, Psychosis, Dementia and Congestive Heart Failure. A review of a Minimum Data Set (MDS) quarterly assessment, dated 12/12/12, revealed the facility had assessed the resident as severely cognitively impaired, non-ambulatory and required extensive assistance with bed mobility and transfers.</p> <p>A review of the Skin Breakdown Care Plan, dated 01/16/13, revealed staff had identified shearing to the upper left buttock of Resident #17. Further review revealed on 02/05/13, the facility identified a Stage III to the left upper buttock and an intervention was initiated for a low air loss alternating mattress to bed; however, review of the record revealed there was no evidence the facility assessed the resident for the risk and benefits related to the use of the low air loss alternating mattress.</p> <p>A review of a Fall Log, dated 02/07/13 at 2:35 PM, revealed Resident #17 was found on the floor next to the bed. The resident sustained a</p>	F 323	<p>3) Any resident with a physician order for a low air loss mattress will be assessed for risk vs. benefit prior to initiating the use of said device. If the mattress is deemed inappropriate, the physician will be notified with the assessed concerns.</p> <p>4) To ensure the low air loss mattresses are properly placed, an assessment for risk vs. benefit will be completed before implementation by the nursing staff. Mattresses will be reassessed again within 24 hours for the risk vs. benefit of its use, then weekly for the duration of its use. Reinservicing will take place with the appropriate staff, in the event any concern is identified during the assessment process.</p> <p>5) Correction completion date: 3/29/13</p>	3/29/13	

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F 369 SS=D	<p>483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS</p> <p>The facility must provide special eating equipment and utensils for residents who need them.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide an adaptive cup with two handles for one (1) resident (#22), not in the selected sample of sixteen (16) residents.</p> <p>Findings include:</p> <p>A record review revealed Resident #22 was admitted to the facility with diagnoses to include Diabetes Mellitis, Congestive Heart Failure, and Osteoarthritis.</p> <p>A review of the Comprehensive Care Plan, dated 10/10/12, revealed staff should provide an adaptive cup with two handles with meals for Resident #22.</p> <p>Observation of the noon meal on 02/26/13 at 12:51 PM, revealed Resident #22's meal card revealed the resident required the use of an adaptive cup with two handles. Observation of Resident #22 during the noon meal revealed the resident was drinking from regular cups and there was no adaptive cup noted on the meal tray.</p> <p>An interview with the Dietary Manager, on 03/01/13 at 2:42 PM, revealed the staff was expected to check and follow the meal cards regarding adaptive devices. She stated in order</p>	F 369	<p><u>F369</u></p> <p>1) Resident #22 was assessed by therapy to determine if the adaptive cup was still needed. The equipment was discontinued and therefore removed from the residents care plan and tray card.</p> <p>2) Any resident requiring special adaptive equipment or utensils have the potential to be affected by this practice.</p> <p>3) Therapy will provide a log listing all dietary adaptive equipment monthly and PRN, as it changes, to the dietitian. The dietitian will use the log to ensure the resident care plans and tray cards are correct. Dietary staff has been inserviced regarding providing adaptive equipment per the tray card instruction at the resident meal. Nursing has been inserviced regarding the tray card instruction to ensure the correct adaptive equipment is available to the resident.</p>	

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F 369	Continued From page 9 for an adaptive device to be changed or not used, speech therapy would have to reassess the resident.  An interview with the Registered Dietician, on 02/28/13 at 3:42 PM, revealed the Speech Therapy Department determined the need for adaptive devices for a resident and the dietician entered the information on the meal card. She stated the staff should have reviewed the meal cards prior to the delivery of the meal tray to ensure the adaptive equipment was on the tray.  An interview with the Director of Nursing, on 03/01/13 at 2:14 PM, revealed staff should have checked the meal cards with the trays before the trays were served to ensure the resident received the appropriate adaptive devices.	F 369	4) Three resident's requiring adaptive equipment for meals will be checked weekly by a dietitian for two weeks and then monthly through the QA process.  5) Correction completion date: 3/29/13	3/29/13	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy/procedure it was determined the facility failed to ensure food was stored, prepared and served under sanitary conditions.	F 371	<u>F371</u>  <u>Dating Food Items</u>  1) Prepoured glasses of beverages and prepared fruit plates, etc. will be dated at point of preparation, then refrigerated.  2) All residents have the potential to be affected by this practice.		

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F 371	<p>Continued From page 10</p> <p>Observations on 02/26/13 revealed various food items in the refrigerator units that were undated. A trash can was observed without a lid and touching a food preparation counter. Frozen chicken pieces were observed left out for forty minutes and then returned to the freezer. A build up of dust was observed on areas of the ceiling over the steam table and the food preparation area, and on the ceiling vents and the pot and utensil rack over the food preparation area. Additionally the free standing oven was observed with a build up of grime on the door surface as well as a build up of food debris between the glass panels of the oven door.</p> <p>A review of the facility's Census and Condition, dated 02/26/13, revealed there were 79 residents in the facility and one resident received tube feedings.</p> <p>Findings include:</p> <p>1. Observations during the initial tour of the kitchen, on 02/26/13 at 10:00 AM revealed:</p> <p style="padding-left: 40px;">A. Pre-poured glasses of chocolate milk, orange juice, apple juice and tea, a container of pureed fruit, three fruit plates, two containers of jello, a plate with cheese, lettuce, tomatoes and lunch meat and four small salads not labeled and dated in the refrigerators.</p> <p style="padding-left: 40px;">B. A build up of dust on the areas of the ceiling over the steam table and the food preparation area, and on the ceiling vents and the pot and utensil rack over the food preparation area.</p>	F 371	<p>3) Staff were inserviced one on one regarding dating prepoured drinks and fruit plates, etc. A follow up inservice has been completed as well.</p> <p>4) Assigned personnel on each shift will check daily to ensure food and drink items are dated properly. A monthly QA check will be done to ensure appropriate follow up as well.</p> <p>5) Correction completion date: 3/29/13</p> <p><u>Dietary Cleanliness</u></p> <p>1) All areas of concern have been cleaned thoroughly.</p> <p>2) All residents have the potential to be affected by this practice.</p> <p>3) Additional personnel have been hired and new cleaning schedules have been implemented.</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>SUPERIOR CARE HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3100 CLAY STREET PADUCAH, KY 42001</b>	
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F 371	<p>Continued From page 11</p> <p>C. A build up of grime on the door surface as well as a build up of food debris between the glass panels of the oven door of the free standing oven.</p> <p>An interview with the Dietary Manager, on 02/26/13 at 4:30 PM and 02/27/13 at 9:30 AM, revealed the free standing oven was cleaned as it was used and a deep cleaning was done every three months. The Dietary Manager stated she was responsible for overseeing the cleaning and there was a cleaning schedule but it was not being used now because the Registered Dietician had them and was changing them. She revealed the ceilings in the kitchen were to be maintained by the maintenance department and gave no explanation of how maintenance staff knew when to clean them.</p> <p>An interview with the Registered Dietician (RD), on 02/28/13 at 3:40 PM, revealed she expected the kitchen staff to ensure areas in the kitchen were clean.</p> <p>2. Observation of meal preparation area, on 02/26/13 starting at 11:30 AM, revealed a trash can positioned partly underneath a food preparation counter. The trash can was overflowing with trash that was several inches above the top of the can and touching the food preparation counter. The overflowing trash consisted of food items and empty food packaging. A flattened card board box that had contained a chicken product was observed lying on top of the counter near the trash can. Further observation during the meal tray preparation, at 12:20 PM and at 12:38 PM, revealed a kitchen staff member brought meat to the same counter</p>	F 371	<p>4) Cleanliness will be monitored monthly through the QA process to ensure results are maintained.</p> <p>5) Correction completion date: 3/29/13</p> <p><u>Oven Cleanliness</u></p> <p>1) The oven has been cleaned.</p> <p>2) All residents have the potential to be affected by this practice.</p> <p>3) Additional personnel have been hired and new cleaning schedules have been implemented.</p> <p>4) Cleanliness will be monitored monthly through the QA process to ensure results are maintained.</p> <p>5) Correction completion date: 4/8/13</p>	

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F 371	Continued From page 12 and ground it in the food processor which was located on the counter.  3. A review of the facility's policy, titled Frozen Food Safety, no date, revealed " In keeping with the guidelines for food safety, frozen foods are safe as long as the food has not gotten warmer than forty degrees for more than two hours. Therefore it is the policy of this facility when deep frying frozen foods (for example Chicken Fried Steaks or breaded frozen vegetables) it is the best practice to return the product to the freezer between batch cooking ".  Observation of meal preparation, on 02/26/13 at 12:20 PM, revealed a kitchen staff placed pieces of frozen chicken from a plastic bag into the deep fryer and then laid the remaining pieces of frozen chicken in the plastic bag next to the deep fryer. At 12:30 PM, a staff member placed additional chicken pieces into the deep fryer and again laid the bag with the remaining pieces of chicken next to the deep fryer. The pieces of chicken remained lying next to the deep fryer until 1:00 PM. Interview with the Dietary Manager, revealed it was "not the best practice" to leave the chicken pieces out and returned the chicken pieces to the freezer.  An interview with the Registered Dietician (RD), on 02/28/13 at 3:40 PM, revealed frozen meat should be returned to the freezer and not left out between batch cooking.	F 371	<u>Trash Can and Card Board Box</u>  1) The lid was replaced on the trash can and the card board was disposed. Trash will be taken out as needed throughout the day.  2) All residents have the potential to be affected by this practice.  3) All dietary staff has been inserviced one on one and at a follow up inservice related to the trash and the removal of all boxes from the area.  4) Cleanliness will be monitored monthly through the QA process to ensure results are maintained.  5) Correction completion date: 3/29/13  <u>Frozen Food Safety</u>	
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	F 441	1) Dietary manager was inserviced regarding frozen food safety policy.	

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F 441	<p>Continued From page 13</p> <p>safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(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.</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 and review of</p>	F 441	<p>2) All residents have the potential to be affected by this practice.</p> <p>3) All dietary staff has been inserviced one on one and at a follow up inservice regarding frozen food safety. The policy related to frozen food safety has been reviewed.</p> <p>4) Food temperature will be taken by the cook through the batch cooking process to ensure food does not exceed 40 degrees in a two hour period.</p> <p>5) Correction completion date: 3/29/13</p>	4/8/13	

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F 441	<p>Continued From page 14</p> <p>the facility's policy/procedure it was determined the facility failed to follow isolation precautions for one (1) resident (#6), in the selected sample of sixteen (16) residents, and failed to ensure an ice scoop was stored appropriately when not in use.</p> <p>Findings include:</p> <p>A review of the facility's Infection Control Policy, dated 09/04/12, revealed the policy was to establish guidelines to minimize the effects of infections of residents and employees in order to provide a sanitary environment, to prevent the development and transmission of diseases and infections. The procedure revealed the facility should investigate, control and prevent infections in the facility, follow the guidelines for implementation of infection precautions by utilizing standard (universal) precautions for the handling of body fluids or other potentially infectious material, utilize specialized precautions with identified infections and educating staff through orientation and scheduled in-service training programs on the infection control program.</p> <p>1. A record review revealed the facility re-admitted Resident # 6 on 02/29/13 with diagnoses to include Acute Kidney Failure, Sepsis, Urinary Tract Infection, Clostridium Difficile (C-Diff), Dysphagia, Anemia, Alzheimer's Disease, Atrial Fibrillation, Orthostatic Hypotension, and Thrombocytopenia. The resident was in contact isolation for the C-Diff at the time of the following observation on 2/27/13.</p> <p>An observation, on 02/27/13 at 10:10 AM during</p>	F 441	<p><u>F441</u></p> <p><u>Skin Assessments</u></p> <p>1) The two RN's were inserviced regarding infection control and the c-diff policy and the protective wear related to c-diff. They were also inserviced regarding skin assessment contact precaution as well as how to perform skin assessments to be sure that proper infection control techniques are being maintained.</p> <p>2) All residents have the potential to be affected by this practice.</p> <p>3) An inservice with licensed nursing personnel was held to review the correct way to perform skin assessments to be sure that proper infection control techniques. Also, inserviced was infection control, the c-diff policy and the protective wear related to c-diff.</p>		

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F 441	<p>Continued From page 15</p> <p>a skin assessment of Resident #6, revealed Registered Nurse (RN) #1 and RN #2 washed their hands with soap and water and applied gloves. Both of the RN's began the skin assessment at the resident's bilateral feet and moved up to the resident's abdominal area where they removed the resident's incontinence brief. RN # 1 examined and touched the resident's frontal perineal and scrotal area; and RN #2 examined and touched the resident's posterior rectal area. Both of the RNs closed the resident's incontinence brief and removed the resident's shirt and touched his/her abdomen and upper bilateral extremities. RN #1 touched the resident's facial area, mouth, and ears. The RNs removed their gloves and washed their hands after completing the full skin assessment. The RNs failed to wear a gown during the skin assessment, and both of the nurses failed to remove their gloves, wash their hands, and re-apply clean gloves after contact with the resident's perineal and rectal area and prior to the examination of the resident's abdomen, bilateral upper extremities, and facial area.</p> <p>An interview with RN #1, on 03/01/13 at 2:05 PM, revealed she usually completes a skin assessment starting at the head and move down to the toes but because the resident was fully clothed she started at the feet. She stated she did not change gloves because the resident was not soiled. An interview with RN #2, on 03/01/13 at 2:20 PM, revealed she usually always started out at the feet when completing a skin assessment because it was easier to take off their socks first and begin there. She stated she usually washed her hands and changed gloves after examining the perineal and rectal area but</p>	F 441	<p>4) Licensed nursing personnel will receive skin assessment competency training upon hire and annually to ensure continued infection control technique. Monitoring of appropriate skin assessment precautions will be done for three months by the staff development nurse. Seven licensed personnel will be monitored monthly to ensure all licensed nursing staff has been reassessed by the end of three months. If concerns occur during the monitoring process, staff will receive reeducation on appropriate precautions.</p> <p>5) Correction completion date: 3/29/13</p> <p><u>Ice Pass Procedure</u></p> <p>1) New ice carts with ice scoop holders and ice chests have been implemented.</p> <p>2) All residents have the potential to be affected by this practice.</p>		

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F 441	<p>Continued From page 16</p> <p>she did not this time. She stated she was nervous and forgot. Both of the nurses revealed they were aware of the facility's policies related to proper hand hygiene and gloving technique, as well as the facility's policy for contact isolation precautions with C-Diff. RN #1 and RN #2 were unable to provide an explanation as to why they did not wear a gown during the skin assessment.</p> <p>An interview with the Infection Control/Staff Development Coordinator, 03/01/13 at 11:45 AM, revealed all health care personnel were taught infection control principles during orientation and throughout the year and the facility reviewed and updated the staff as needed. She stated the nurses should have worn gowns during any procedure with a resident in contact isolation for C-Diff and because of the potential for exposure and contamination in the perineal/rectal area.</p> <p>An interview with the Director of Nursing, on 03/01/13 at 11:45 AM, revealed it was her expectation that all of the nursing staff follow the facility's policies and procedures for infection control during care of the residents on contact isolation for C-Diff.</p> <p>2. A review of facility policy titled, "Ice Machines and Ice Storage Chests", dated revised 10/2002, revealed the ice scoop should be kept on a clean, hard surface when not in use (e.g., uncovered stainless steel, plastic, or fiberglass tray).</p> <p>An observation, on 03/01/13 at 10:30 AM, revealed a red and white cooler on a white cloth towel covered cart. The ice scoop was laying directly on the towel. A random resident passed within arm's reach of the cart with the uncovered</p>	F 441	<p>3) Policies and procedures related to the new ice carts have inserviced with nursing personnel.</p> <p>4) Staff will be inserviced at the time of hire and annually on the proper ice pass procedure. The staff development nurse will monitor the ice pass for appropriate precautions for 30 days. This will be accomplished by monitoring ten ice passes during the thirty days. If a concern is identified during this period, staff will be reinserviced on the appropriate procedure.</p> <p>5) Correction completion date: 4/5/13</p>	4/5/13	

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F 441	Continued From page 17 ice scoop and was observed to sneeze.  An interview with the SDC, on 02/28/13 at 9:20 AM, revealed the ice pass was usually done three times a day (once on each shift) and that the ice scoop was normally left laying unprotected on the cart.	F 441			

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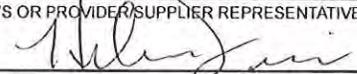
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NAME OF PROVIDER OR SUPPLIER  SUPERIOR CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1972.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1972, with 20 smoke detectors and 0 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1972.</p> <p>GENERATOR: Type II generator installed in 1972. Fuel source is Liquid Propane.</p> <p>A standard Life Safety Code survey was conducted on 02/26/13. Superior Care Home was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Eighty-Eight (88) beds with a census of Seventy-Nine (79) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p><b>Preparation and 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. This Plan of Correction is prepared and executed solely because it is required by federal and state laws. The facility reserves the right to revise/improve corrective actions as determined to be warranted.</b></p> <p><u>K018</u></p> <p>1) Resident doors identified as not closing in a single motion have had tie backs installed to hold privacy curtains out of the way of door closure. Resident doors identified with greater than the allowable gap when closed have been retrofitted.</p> <p>2) All residents have the potential to be affected by this practice.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 3/22/13
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  SUPERIOR CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001	
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K 000	Continued From page 1 Fire).	K 000	3) Resident doors identified as not closing in a single motion have had tie backs installed to hold privacy curtains out of the way of door closure. Staff have been inserviced regarding keeping the curtains in the tied back position when not in use to ensure proper door closure. Resident doors identified with greater than the allowable gap when closed have been retrofitted to meet the standard.	
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors.	K 018		

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K 018	<p>Continued From page 2</p> <p>The facility is certified for Eighty-Eight (88) beds with a census of Seventy-Nine (79) on the day of the survey. The facility failed to ensure five (5) resident doors could be closed with a single motion and nineteen (19) doors had over the allowable gap around the door jamb.</p> <p>The findings include:</p> <p>Observations, on 02/26/13 between 11:30 AM and 4:00 PM with the Administrator and Maintenance Supervisor, revealed the corridor doors to the resident rooms were blocked from closing. The rooms affected by this were rooms #103 with a privacy curtain blocking door, #102 privacy curtain blocking door, #106 bed blocking the door, #113 privacy curtain blocking door, and #218 with a privacy curtain blocking the door.</p> <p>Interviews, on 02/26/13 between 11:30 AM and 4:00 PM with the Administrator and Maintenance Supervisor, revealed they were unaware the items were blocking the doors from closing.</p> <p>Observations, on 02/26/13 between 11:30 AM and 4:00 PM with the Administrator and Maintenance Supervisor, revealed corridor doors to rooms #103, #109, #108, #106, #111, #119, #118, #203, #204, #214, #215, #220, #216, #218, #217, #205, #212, #210, and #208 had a gap larger than ½ inch around the jamb.</p> <p>Interview, on 02/26/13 between 11:30 AM and 4:00 PM with the Administrator and Maintenance Supervisor, revealed they were unaware of the acceptable gap around the doors.</p>	K 018		

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K 018	<p>Continued From page 3</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with</p>	K 018			

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K 018	Continued From page 4 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.  A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018		
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 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  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for Eighty-Eight (88) beds with a census of Seventy-Nine (79) on the day of	K 027	<u>K027</u>  1) Cross-corridor doors on the 100 and 200 halls have been retrofitted to meet the 1/8" gap standard.  2) All residents have the potential to be affected by this practice.  3) Cross-corridor doors on the 100 and 200 halls have been retrofitted to meet the 1/8" gap standard.  4) The cross-corridor doors will be checked quarterly to ensure the gap standard remains met.  5) Correction completion date: 3/29/13	3/29/13

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K 027	Continued From page 5 the survey. The facility failed to ensure two (2) doors in the smoke barriers had a gap less than 1/8 inch where the doors meet.  The findings include:  Observation, on 02/26/13 at 2:38 PM with the Maintenance Supervisor, revealed the cross-corridor doors located on the 100 and 200 halls would not close completely when tested, leaving a gap of approximately one-quarter of an inch or greater between the pair of doors and would not resist the passage of smoke. Further observation revealed the door for the ADR room also had a gap larger than 1/8 of an inch.  Interview, on 02/26/13 at 2:38 PM with the Maintenance Supervisor, revealed he was unaware the doors would not close all the way leaving a gap between the doors in the closed position.  Reference: NFPA 101 (2000 edition)  8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.  Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.	K 027			
K 050	NFPA 101 LIFE SAFETY CODE STANDARD	K 050			

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K 050 SS=F	<p>Continued From page 6</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for Eighty-Eight (88) beds with a census of Seventy-Nine (79) on the day of the survey. The facility failed to vary the fire drills to ensure they are being conducted at unexpected times.</p> <p>The findings include:</p> <p>Fire Drill review, on 02/26/13 at 10:55 AM with the Administrator, revealed the fire drills were not being conducted at random times on all shifts. Second shift fire drills were conducted routinely between 3:20 PM and 4:15 PM, and third shift routinely between 6:00 AM and 6:40 AM.</p> <p>Interview, on 02/26/13 at 10:55 AM with the</p>	K 050	<p><u>K050</u></p> <p>1) Future fire drills will be held at unexpected times and under varied conditions.</p> <p>2) All residents, staff and visitors have the potential to be affected by this practice.</p> <p>3) Future fire drills will be held at unexpected times and under varied conditions according to the life safety code standard.</p> <p>4) Fire drill dates and times will be monitored quarterly through the QA process to ensure the life safety code standard is being met.</p> <p>5) Correction completion date: 3/29/13</p>	3/29/13	

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K 050	Continued From page 7 Administrator, revealed she was unaware the fire drills were not being conducted as required.  Referencè: NFPA 101 (2000 edition)  19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050		
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051	<u>K051</u>  1) The manual pull alarm at the back of the facility near the break room has been moved within five feet of the exit door to meet the life safety code standard.  2) Forty-four residents, staff and visitors have the potential to be affected by this practice.  3) The manual pull alarm at the back of the facility near the break room has been moved within five feet of the exit door to meet the life safety code standard.	

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K 051	Continued From page 8  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building fire alarm system was installed as required by NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, forty-four (44) residents, staff and visitors. The facility is certified for Eighty-Eight (88) beds with a census of Seventy-Nine (79) on the day of the survey. The facility failed to ensure the one (1) exit had a manual fire alarm pull station located within 5 feet.  The findings include:  Observation, on 02/26/13 at 2:38 PM with the Maintenance Supervisor, revealed the exit at the back of the facility next to the break room did not have a manual pull station located within 5 feet of the exit door.  Interview, on 02/26/13 at 2:38 PM with the Maintenance Supervisor, revealed the door at that exit had been moved back and the manual pull station was located where the door used to be.  Reference: NFPA 101 (2000 Edition).  19.3.4.2* Initiation. Initiation of the required fire alarm systems shall be by manual means in accordance with 9.6.2 and by means of any required sprinkler system waterflow alarms, detection devices, or detection systems.	K 051	4) The manual pull alarm at the back of the facility near the break room has been moved within five feet of the exit door to meet the life safety code standard, therefore, the standard is met and the alarm will not be moved. Quarterly checks performed by a contracted company will ensure proper working order of all pull alarms.  5) Correction completion date: 3/29/13	3/29/13

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K 051	Continued From page 9	K 051		
K 056 SS=D	<p>Exception No. 1: Manual fire alarm boxes in patient sleeping areas shall not be required at exits if located at all nurses' control stations or other continuously attended staff location, provided that such manual fire alarm boxes are visible and continuously accessible and that travel distances required by 9.6.2.4 are not exceeded.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, forty-four (44) residents, staff and visitors. The facility is certified for Eighty-Eight (88) beds with a census of Seventy-Nine (79) on the day of the survey. The facility failed to ensure two (2) areas of the</p>	K 056	<p><u>K056</u></p> <p>1) The sun porch attached to room 204A and the room behind the dryers have had sprinkler protection installed to meet the life safety code standard.</p> <p>2) Forty-four residents, staff and visitors have the potential to be affected by this practice.</p> <p>3) The sun porch attached to room 204A and the room behind the dryers have had sprinkler protection installed to meet the life safety code standard.</p>	

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K 056	<p>Continued From page 10 building had proper sprinkler coverage.</p> <p>The findings include:</p> <p>Observation, on 02/26/13 at 2:38 PM with the Maintenance Supervisor, revealed the sun porch of room # 204A did not have sprinkler protection and the room behind the dryers did not have sprinkler protection.</p> <p>Interview, on 02/26/13 at 2:38 PM with the Maintenance Supervisor, revealed he was not aware that the areas listed did not have proper sprinkler protection.</p> <p>Reference: NFPA 13 (1999 Edition) 5-13 8.1</p> <p>Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.</p> <p>Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:</p> <p>(1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed</p>	K 056	<p>4) The sun porch attached to room 204A and the room behind the dryers have had sprinkler protection installed to meet the life safety code standard.</p> <p>5) Correction completion date: 3/29/13</p>	3/29/13

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K 056	Continued From page 11: maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.  Reference: NFPA 13 (1999 edition) 5-13.8.1. Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056	<u>K064</u>  1) Maintenance director has checked all extinguishers and initialed the extinguisher tags to meet the life safety code standard.  2) All residents, staff and visitors have the potential to be affected by this practice.  3) Maintenance director has checked all extinguishers and initialed the extinguisher tags to meet the life safety code standard. The maintenance director will complete this task every 30 days.  4) The extinguisher check will be monitored through the QA process monthly to ensure compliance.  5) Correction completion date:	3/29/13
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the installed fire extinguishers in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for Eighty-Eight (88) beds with a census of Seventy-Nine (79) on the day of the survey. The facility failed to ensure the fire extinguishers in the facility were being properly checked monthly.  Findings include:  Observation, on 02/26/13 at 2:38 PM with the Maintenance Supervisor, revealed the ABC fire	K 064		

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K 064	<p>Continued From page 12</p> <p>extinguishers located throughout the facility were not being checked every 30 days.</p> <p>Interview, on 02/26/13 at 2:38 PM with the Maintenance Supervisor, revealed he was unaware the fire extinguishers were supposed to be checked at 30 day intervals.</p> <p>Reference NFPA 10 (1998 Edition).</p> <p>4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require.</p> <p>4-3.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items:</p> <ul style="list-style-type: none"> <li>(a) Location in designated place</li> <li>(b) No obstruction to access or visibility</li> <li>(c) Operating instructions on nameplate legible and facing outward</li> <li>(d) *Safety seals and tamper indicators not broken or missing</li> <li>(e) Fullness determined by weighing or " hefting "</li> <li>(f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle</li> <li>(g) Pressure gauge reading or indicator in the operable range or position</li> <li>(h) Condition of tires, wheels, carriage, hose, and</li> </ul>	K 064		

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NAME OF PROVIDER OR SUPPLIER  SUPERIOR CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001
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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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K 064  K 144 SS=F	<p>Continued From page 13 nozzle checked (for wheeled units) (i) HMIS label in place</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the emergency generator was maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for Eighty-Eight (88) beds with a census of Seventy-Nine (79) on the day of the survey. The facility failed to check the generator 2 weeks out of the year.</p> <p>The findings include:</p> <p>Observation, on 02/26/13 at 11:26 AM with the Administrator, revealed the generator was not being maintained on a weekly basis as required. The generator was not checked the 1st week of September 2012 or the 3rd week of October 2012.</p>	K 064  K 144	<p><u>K144</u></p> <p>1) The generator will be checked weekly on Friday by the maintenance director. When the maintenance director is not available, a designee will be responsible for checking the generator and documenting said check.</p> <p>2) All residents, staff and visitors have the potential to be affected by this practice.</p> <p>3) The generator will be checked weekly on Friday by the maintenance director. When the maintenance director is not available, a designee will be responsible for checking the generator and documenting said check.</p> <p>4) The generator checks will be monitored monthly through the QA process to ensure compliance.</p> <p>5) Correction completion date: 3/29/13</p>	3/29/13
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185227	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  02/26/2013
NAME OF PROVIDER OR SUPPLIER  SUPERIOR CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001	
(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 144	Continued From page 14  Interview, on 02/26/13 at 11:26 AM with the Administrator, revealed she was not aware the generator was not checked when the Maintenance Supervisor was off on Friday.  Reference: NFPA 110 (1999 Edition).  6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction  6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established  6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.  6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.	K 144		