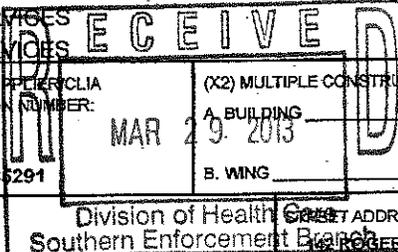


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/21/2013
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185291	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ MAR 29 2013 B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2013
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NAME OF PROVIDER OR SUPPLIER REDBANKS COLONIAL TERRACE	PHYSICIAN ADDRESS, CITY, STATE, ZIP CODE Division of Health Care Southern Enforcement Branch 100 ROBERT POWELL RD SEBREE, KY 42455
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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 000	INITIAL COMMENTS	F 000	This plan of correction is respectfully submitted as evidence of efforts made to comply with allegations of federal and state non-compliance, but does not constitute a written admission that deficiencies exist.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide maintenance services necessary to maintain an orderly and comfortable interior. Shower faucet covers were missing in the men's and women's shower rooms on Wing 1; a sink faucet was loose in resident room 36; an overbed table used for unsampled Resident F was cracked and chipped; a wheelchair cushion used for unsampled Resident G was cracked and torn; and Resident #13's wheelchair arm was torn with jagged edges. The findings include: A review of the facility maintenance policy titled "Standard Operating Guidelines for Preventative Maintenance," undated, revealed the Maintenance Supervisor or designee would conduct an annual inspection of resident equipment and any device that was deemed unsafe at the time of findings would be pulled from resident use until repairs could be made.	F 253	Specifically, the issues noted regarding these items have been repaired and/or replaced, with a complete resident-by-resident, and room-by-room survey done by the maintenance and nursing departments, to ensure compliance. Several additional notations were made as regards repair and replacement, and those issues have been addressed with corrective action and targeted purchase orders. Routine weekly wheelchair checks will be augmented with weekly skin assessment checks being expanded to include wheelchair checks by nursing, and monthly CQI will monitor compliance with a targeted monthly audit, times 3 months, to assess condition as related to wheelchair condition; cushion and armrest condition; and observations of potential safety triggers.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Ruth Buchanan* TITLE: *Administrator* (X6) DATE: *3-29-13*

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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NAME OF PROVIDER OR SUPPLIER REDBANKS COLONIAL TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 142 ROGER POWELL RD SEBREE, KY 42455		
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F 253	<p>Continued From page 1</p> <p>A review of the Mandatory cleaning schedule revealed the wheelchairs were checked by staff weekly. Based on documentation, LPN #1 had inspected wheelchairs on 03/06/13 and there were no concerns identified.</p> <p>Observation conducted during initial tour on 03/05/13 at 9:55 AM revealed an overbed table used for unsampled Resident F was chipped and torn with splintered edges. Additional observation during the tour revealed a wheelchair cushion for Resident G was cracked and torn.</p> <p>Observations conducted on 03/06/13 at 5:12 PM, revealed shower faucet covers were missing in the men's and women's shower rooms on Wing 1 and the faucet in resident room 36 was loose from the sink.</p> <p>Observation of Resident #13 on 03/07/13 at 10:30 AM revealed the right arm of the resident's wheelchair was torn with jagged edges.</p> <p>An interview conducted with State Registered Nurse Aides (SRNAs) #4 and #5 on 03/07/13 at 1:36 PM, revealed the SRNAs had utilized the shower rooms to bathe residents. However, the SRNAs had not reported the missing shower faucet covers. SRNA #5 stated she thought the faucets were supposed to be the way they were and was not aware the covers were missing and had not completed a work order.</p> <p>An interview conducted with SRNA #6 who was assigned to resident room 36 on 03/07/13 at 2:50 PM, revealed the SRNA was not aware the faucet was loose from the sink and had not completed a work order.</p>	F 253	<p>Regarding shower faucet repair, the noted issues have been corrected. This, too, is the case for sink faucet and overbed table repairs. The weekly nursing and maintenance checks for these items will be augmented by a CQI study, that focuses on a complete room-to-room audit of these items. This was initially completed with an audit of wheelchair conditions, and will be completed monthly times three months, and thereafter, quarterly by maintenance with assistance from continuous quality improvement nursing staff.</p> <p>A work order continues to be in place at the facility, coordinated by the Maintenance Director, with oversight by the Administrator.</p>	4/11/13	

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F 253	Continued From page 2 An interview conducted with Licensed Practical Nurse (LPN) #1 on 03/07/13 at 1:50 PM, revealed the LPN made daily rounds to check resident equipment and wheelchairs for cleanliness and condition. LPN #1 stated she was not aware the wheelchair cushion for Resident G was cracked and torn, and had not completed a work order. A review of the facility work orders on 03/07/13 revealed the above items had not been identified nor had a work order been completed to notify Maintenance of items in need of repair. An interview conducted with the Maintenance Director on 03/07/13 at 1:15 PM, revealed the facility had a work order system and if an item needed repair a work order was completed by staff and placed in a box at the nurses' station. Further interview revealed the Maintenance Director checked the work orders daily to ensure items identified on the work orders were repaired; however, the Maintenance Director stated facility staff had not made him aware of the identified items in need of repair.	F 253		
F 323 SS-E	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.	F 323		

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F 323	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure the resident environment remained as free of accident hazards as was possible. A utility room on Wing 1 was observed to contain a hot water heater; however, the room was unsecured and allowed access by staff and/or residents. Exposed bolts with sharp edges were protruding two inches near door handles of the men's and women's shower room doors on Wing 2 and created a safety hazard.</p> <p>The findings include:</p> <p>An interview conducted with the Facility Administrator and the Maintenance Director on 03/07/13 at 2:45 PM revealed the facility did not have a policy regarding accident hazard or locking the utility room, or a policy related to safe environment.</p> <p>A review of a list provided by the facility on 03/07/13 revealed the facility had identified eight residents on Wing 1 and nine residents on Wing 2 that had wandering behaviors.</p> <p>Observations conducted during an environmental tour on 03/07/13 at 1:15 PM, of Wing 1 revealed a utility room that housed a hot water heater; however, the room was unsecured and allowed potential access by staff and/or residents. Further observations during the tour revealed two bolts, with sharp edges, in the men's and women's shower room doors that protruded approximately two inches and created a potential safety hazard.</p>	F 323	<p>Specifically for these noted items, the utility room door has been repaired and secured with an appropriate locking device. Likewise, maintenance has removed exposed bolts noted near door handles on doors on Wing 2, thus removing the hazard. A check of resident rooms and utility areas did not reveal any additional hazards. Maintenance routinely, weekly, observes for safety hazards, and this will continue, along with daily rounding by nursing, the Administrator, and continuous quality assurance.</p> <p>The Administrator also rounds with the Director of Nursing weekly, to note any new or previously unobserved potential hazards or issues. This will continue, and a CQI study will be performed by Weekend Call to specifically note any new hazards or potential issues. Weekend Call is assigned each weekend of month, of each quarter, to add extra "eyes" to facility upkeep and facility process.</p>	4/11/13	

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F 323	Continued From page 4 An interview conducted with the Maintenance Director revealed the area near the hot water heater had previously been used as a storage room and had been kept locked. However, according to the Maintenance Director, the use of the room was changed a year ago and the room had been left unlocked. Further interview revealed the latch on the shower room doors had been changed (date unknown) and the bolts were not removed from the door. According to the Maintenance Director, he had not considered the unsecured door leading into the room housing the hot water heater or the protruding bolts a safety hazard.	F 323		
F 364 SS-D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to ensure food items that were to be served hot were served to residents when they were hot, and food items that were to be served cold were served cold. In addition, food items served to residents for the breakfast meal on 03/05/13 tasted bland and were not seasoned. The findings include:	F 364	Specific to these issues, corrective actions have been taken for all affected residents, i.e., condiments being placed on trays so residents may season their food to taste preference. This action was initiated on 3/8/13 and is being monitored daily by the Dietary Manager with assistance from the Continuous Quality Assurance Nursing staff. Residents having the potential to be affected by the same practice-residents with BIM scores of 11 or higher were interviewed to ensure their food was at appropriate temperature with acceptable taste. This practice will continue, and will include new residents admitted. The Dietary Manager, CQI Nursing, and dietary consultant will daily, weekly and monthly monitor this practice, as part of our CQI process, for consistency.	

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F 364	<p>Continued From page 5</p> <p>Review of the policy, Tray Line and Meal Service Temperatures, (undated) revealed, "The facility was to serve food to the residents at appropriate temperatures; that is, hot food acceptably hot and cold food cold."</p> <p>During the group interview with Residents #8, B, C, D, and E on 03/05/13 at 4:00 PM EST, residents complained of breakfast food often being cold. Residents also complained foods served by the facility were not always seasoned well and were bland.</p> <p>Review of the resident council minutes from the 12/26/12 council meeting revealed the residents complained of cold food. Further review of the minutes revealed on 02/26/13, the residents had complained that the food served by the facility was not seasoned for taste; e.g., the facility failed to salt certain food items.</p> <p>Observation of the breakfast meal on 03/05/13 revealed the second meal cart arrived at Wing 2 at 8:45 AM Eastern Standard Time (EST) and at 9:30 AM EST the last tray was removed from the cart and a taste test was conducted of the food items. In addition, temperatures of food obtained from the last tray on the meal cart were obtained by the Dietary Manager and were noted to be as follows: pureed sausage gravy - 110.1 degrees Fahrenheit, pureed eggs - 105.9 degrees Fahrenheit, and oats - 107.1 degrees Fahrenheit. The food items on the meal tray were taste tested by the surveyor and the Dietary Manager. The gravy, eggs, and oats on the test tray were noted to taste cold and the oats were bland to taste.</p> <p>The Dietary Manager acknowledged in an</p>	F 364	<p>Systemic change education was completed with nursing staff, as regards offering each resident condiments, assistance with opening and placement for taste preference. Education was also provided on tray delivery, meeting a 20 minute compliance window, as regards delivery of food for optimum serving temperature. The Dietary Manager with assistance from CQI nursing, will perform oversight and timings, to ensure the needed compliance. Week-end Call will also overview this practice. This will be performed a minimum of twice weekly for 30 days; then weekly thereafter. The Dietary consultant will also perform tray timings, condiment checks and observations of food preference honoring, to assess compliance.</p> <p>The Director of Nursing and staff training coordinator will perform additional trainings with staff, with compliance achieved not later than 4/11/13 for staff. Staff training will add this component for new staff orientation and CNA in-servicing for all future employees.</p> <p>Additionally, the Social Services Director, and Activities Director, will coordinate customer satisfaction CQI activities weekly, for a period of weekly for one month, then monthly for an additional three months, to ensure compliance. This will also be a targeted area for all future Resident Council Meetings, monthly.</p>	4/11/13

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NAME OF PROVIDER OR SUPPLIER REDBANKS COLONIAL TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 142 ROGER POWELL RD SEBREE, KY 42455
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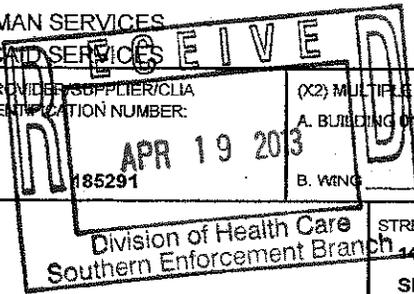
F 364	Continued From page 6 interview conducted on 03/05/13 at 9:30 AM the sampled breakfast tray had food items that tasted cold and that were not seasoned. The Dietary Manager said food should not sit undelivered on the food carts for more than 20 minutes. Further interview with the Dietary Manager on 03/06/13 at 9:00 AM revealed the facility did not utilize hot pellet plates on/under the pureed sampled breakfast tray because the kitchen staff was afraid the resident could sustain a burn from the plate/pellet.	F 364		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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2nd SOD

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185291	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/06/2013
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NAME OF PROVIDER OR SUPPLIER REDBANKS COLONIAL TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 142 ROGER POWELL RD SEBREE, KY 42455
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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: 1973</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: Five</p> <p>FIRE ALARM: Complete fire alarm system installed in 1973 and upgraded in 2008, with 31 smoke detectors and 4 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1973.</p> <p>GENERATOR: Type II generator installed in 2008. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 03/06/13. Redbanks Colonial Terrace was found in noncompliance with the requirements for participation in Medicare and Medicaid. The facility is certified for 87 beds with a census of 66 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 Fire).</p>	K 000	<p>This plan of correction is respectfully re-submitted as evidence of efforts made to comply with allegations of federal and state non-compliance, but does not constitute a written admission that deficiencies exist.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rick Anderson TITLE: Administrator (X6) DATE: 4-19-13

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, approval of plan of correction is requisite to continued program participation.

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K 000	Continued From page 1	K 000		
K 029 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect four of five smoke compartments, forty-eight residents, staff, and visitors. The facility is certified for 87 beds with a census of 66 on the day of the survey. The facility failed to ensure eight rooms were properly protected due to the storage of combustibles in the rooms.</p> <p>The findings include:</p> <p>Observation on 03/06/13 between 10:05 AM and 2:10 PM with the Maintenance Director and the Environmental Supervisor, revealed:</p>	K 029	<p>Specifically for the noted issues, the Activities office; Activities storage; nurse aide classroom; staff development office; have new door closures installed per citation.</p> <p>The office storage area, and nursing supply area on Wing I have new doors and closures installed, per citation.</p> <p>The Dietary Manager office and receptionist area combustibles have been removed. Inservice training has been performed and completed for staff of the effective areas, and will be made part of new employee orientation training, as well as monthly CQI for environmental services, as regards life safety, with particular attention to the issue of combustibles as potential hazards.</p> <p>The facility, via the Director of Environmental Services, has completed a thorough systemic review of the entire facility to ensure that other areas are properly protected and meet the requirements for protection from hazards in accordance with NFPA standards. This review is completed weekly by the Director as part of his quality assurance.</p> <p>To ensure that no deficient practice recurs, the Director of Environmental Services, Laundry Supervisor and Director of Nursing, with assistance from Weekend call, will observe door closure compliance and condition, as well as storage of combustibles and other items that may create potential hazards.</p>	

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K 029	Continued From page 2 -The activities office did not have a door closer installed due to the storage of combustibles in the room. -The activities storage area did not have a door closer installed due to the storage of combustibles in the room and a wall was not finished. -The office storage area did not have a door installed and was over 50 square feet with combustibles stored. -The nurse aide classroom did not have a door closer installed due to the storage of combustibles in the room. -The staff development office did not have a door closer installed due to the storage of combustibles in the room. -The dietary manager office did not have a door closer installed due to the storage of combustibles in the room. -The nursing supply on Wing 1 did not have a door installed and was over 50 square feet with combustibles stored. -The receptionist area did not have a door closer installed due to the storage of combustibles in the room. Interview on 03/06/13 between 10:05 AM and 2:10 PM with the Maintenance Director and the Environmental Supervisor revealed they were not aware the areas listed above were considered hazardous storage thus requiring a door, a self-closer, and separation. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas	K 029	Additionally, all support services staff have been inserviced on NFPA standards as applied, and now know how to view the entire facility and extended property as it relates to hazard protection. The Director of Environmental Services is now incorporating an extended hazard review into his monthly CQI process. An inspection of the entire facility by the Director of Environmental Services was Completed on 4/12/13. All areas were Reviewed for compliance with automatic Sprinklers; interconnectivity of the system With the fire alarm system; audible and Visual signaling compliance; smoke Resisting partitions; and smoke resisting Doors. All LSC required repairs were put into motion per requirements, and the needed communications maintained with the LSC inspector throughout the process. Inspections will be noted in terms of CQI, monthly, times 12 months. Staff have maintained daily and weekly observations of the noted areas.	4/21/13

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NAME OF PROVIDER OR SUPPLIER REDBANKS COLONIAL TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 142 ROGER POWELL RD SEBREE, KY 42455	
(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 029	Continued From page 3 shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 045 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency	K 045		

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

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K 045	<p>Continued From page 4 lighting in accordance with section 7.8.) 19.2.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards to ensure that in the failure of any single lighting unit, the illumination level would not be less than 0.2 ft-candle in any designated area. The deficiency had the potential to affect five of five smoke compartments, all residents, staff, and visitors. The facility is certified for 87 beds with a census of 66 on the day of the survey. The facility failed to ensure the emergency lights had two bulbs at five exits.</p> <p>The findings include:</p> <p>Observation on 03/06/13 between 10:30 AM and 2:10 PM with the Maintenance Director and the Environmental Supervisor revealed the exterior exits at the generator exit, rear exit of kitchen, carport south exit, Wing 1 south, and Wing 1 north only had a single light for illumination of the outside of the exit.</p> <p>Interview on 03/06/13 between 10:30 AM and 2:10 PM with the Maintenance Director and the Environmental Supervisor revealed they were unaware the lighting fixtures serving the exterior exits must include more than one bulb for illumination of the egress path.</p> <p>Reference: NFPA 101 (2000 Edition).</p>	K 045	<p>Specifically, for the issues noted, single bulb fixtures in the areas of concern noted have been removed. New multi-bulb fixtures have been installed as replacements.</p> <p>In the event there is a bulb failure, said fixtures will now continue to provide the needed illumination, meeting the outlined requirements.</p> <p>The facility, via the Director of Environmental Services, has completed a thorough systemic review of the building to ensure that other areas of the facility are properly protected and meet the requirements for lighting protection, in accordance with NFPA standards. This review will be done as part of Both monthly and quarterly CQI, for consistency.</p> <p>An inspection of all egress was made by the Director of Environmental Services on 3/13/13. Of the seven Exits found not in compliance, all fixtures Were replaced, bringing full compliance with LSC. All future purchase and replacements will meet LSC code.</p> <p>Additionally, all support services staff have been inserviced on NFPA standards as applied, and now know how to view the entire facility and extended property as it relates to lighting protection. The Director of Environmental Services is now incorporating an extended lighting review into his monthly CQI process.</p> <p>Additionally, to ensure no deficient practice recurs, the Director of Environmental Services and Laundry Supervisor view facility and extended building services for lighting and exit compliance as part of weekly and monthly reviews. Should any problems exists, these staff and their</p>	

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K 045	Continued From page 5 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045	support service cohorts replace any deficient lighting or exit lighting upon discovery. Weekend supervision and weekend call also review these areas. All means of egress will be inspected at least weekly for proper illumination. This will be noted in terms of CQI, monthly, times 12 months.	4/21/13
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observations 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 two of five smoke compartments, twenty residents, staff, and visitors. The facility is certified for 87 beds with a census of 66 on the day of the survey. The facility failed to ensure two areas of the building had proper sprinkler coverage. The findings include: Observation on 03/06/13 between 10:29 AM and	K 056	K056 Specifically for the issues cited, the closet in the nurse aide classroom has been modified and finished out, with 5/8" fire code sheetrock. A new metal storage cabinet has been installed as per conversation, during the survey process. Also, the top of the closet at nurse station 1 has been removed, as per conversation during the survey process. The removal allows for adequate sprinkler coverage, from the sprinkler head located adjacent to the cabinet. An inspection of the facility by the Director of Environmental Services was completed 3/13/13, of all structural components related to this area. Further inspection of the facility and outliers, find no additional issues as related. All required sprinklers are now in place, and continue to be maintained weekly. The facility, via the Director of Environmental Services, has completed a thorough systemic review of the building to ensure that other areas of the facility are properly protected and meet the requirements for sprinkler protection, in accordance with NFPA standards.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 056	Continued From page 6 2:10 PM with the Maintenance Director and the Environmental Supervisor, revealed the closet in the nurse aide classroom and the closet at the nurses' station on Wing 1 did not have proper sprinkler coverage. Interview on 03/06/13 between 10:29 AM and 2:10 PM with the Maintenance Director and the Environmental Supervisor revealed they were not aware the areas were not sprinkler protected.	K 056	This review will be done as part of Both monthly and quarterly CQI, for consistency. All required inspections are conducted by KY licensed sprinkler contractors per NFPA requirements. Additionally, all support services staff have been inserviced on NFPA standards as applied, and now know how to view the entire facility and extended property as it relates to sprinkler protection. The Director of Environmental Services is now incorporating an extended sprinkler review into his monthly CQI process.	4/21/13
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the kitchen had signage in place for the proper use of the Class K portable fire extinguisher and failed to ensure the kitchen hood system was in accordance with NFPA standards. The deficiency had the potential to affect one of five smoke compartments, residents, staff, and visitors. The facility is certified for 87 beds with a census of 66 on the day of the survey. The facility failed to ensure the kitchen hood suppression system was inspected semi-annually and that the Class K extinguisher was properly marked. The findings include: Observation on 03/06/13 at 10:55 AM with the Maintenance Director and the Environmental Supervisor revealed there was no signage stating that the hood suppression system must be used before the Class K fire extinguisher. This type of	K 069	K069 Specifically, signage for the Class K extinguisher has been installed. The sign is located directly above the class K extinguisher. The sign measures 10' by 7" and is highly visible. The sign states "warning in case of appliance fire, use this extinguisher after fixed suppression system has been activated." This action provides compliance with the required signage requirement. Regarding the issue noted pertaining to kitchen hood inspection, the following corrective actions and changes have been made. After multiple attempts to obtain proper documentation, per specifications, from the contracted provider, the provider was unable or unwilling to provide documentation, per our request. Eagle 1 Fire Protection, a current certified KY inspector had performed for the record, had performed said inspections. Upon this inability to secure the needed documents, the facility Administrator authorized a new contract with Vanguard Fire Systems of Evansville, Indiana	

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K 069	<p>Continued From page 7</p> <p>extinguisher is used as a secondary measure to the range hood extinguishing system.</p> <p>Interview on 03/06/13 at 10:55 AM with the Maintenance Director and the Environmental Supervisor revealed they were unaware of the signage requirement.</p> <p>Record review on 03/06/13 at 9:15 AM with the Maintenance Director and the Environmental Supervisor revealed there was no documentation of a kitchen hood inspection.</p> <p>Interview on 03/06/13 at 9:15 AM with the Maintenance Director and the Environmental Supervisor revealed they were under the impression the proper inspection was being completed.</p> <p>Reference: NFPA 10 (1998 Edition).</p> <p>2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.</p> <p>Reference: NFPA 96 (1998 Edition).</p> <p>8-3 Cleaning.</p> <p>8-3.1* Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a Extinguishers. properly trained, qualified, and certified company</p>	K 069	<p>which completed a new, follow-up inspection, and has provided the necessary forms required, which were then faxed, with verification of effort. Eagle 1 Fire Protection has been dismissed as a vendor.</p> <p>The facility, via the Director of Environmental Services, has completed a thorough systemic review of the building to ensure that other areas of the facility are properly protected and meet the requirements for extinguisher protection, in accordance with NFPA standards. This review will be done as part of Both monthly and quarterly CQI, for consistency.</p> <p>Additionally, all support services staff have been inserviced on NFPA standards as applied, and now know how to view the entire facility and extended property as it relates to extinguisher protection. The Director of Environmental Services is now incorporating an extended fire extinguisher review into his monthly CQI process.</p> <p>The Director of Environmental Services has completed a thorough review of extinguisher signage at the facility, and staff on all shifts have been inserviced regarding proper signage. The Director, with assistance from the Laundry Supervisor, will daily and weekly ensure that compliance is maintained with signage requirements, including those for Class K portable fire extinguishers. Should Non-compliance occur, the Director will make the needed corrections to sustain compliance in these noted areas.</p>	

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K 069	Continued From page 8 or person acceptable to the authority having jurisdiction in accordance with Table 8-3.1. Table 8-3.1 Exhaust System Inspection Schedule Type or Volume of Cooking/-Frequency Systems serving solid fuel cooking operations/-Monthly Systems serving high-volume cooking operations such as 24-hour cooking, charbroiling or wok cooking/-Quarterly Systems serving moderate-volume cooking operations/-Semiannually Systems serving low-volume cooking operations, such as churches, day camps, seasonal businesses, or senior centers/-Annually	K 069	Additionally, to ensure no deficient practice recurs, the Director of Environmental Services and Laundry Supervisor view facility and extended building services for signage and extinguisher compliance as part of weekly and monthly reviews. Should any problems exist, these staff and their support service cohorts will report such to the Director. Weekend supervision and weekend call also review these areas.	4/21/13
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the	K 144	Specifically as it related to this issue, on 3/15/13 our provider, EVAPAR, moved the battery charger output wire from the terminal post on the battery, to the starter on the generator. This was completed per conversation the survey process, and now provides compliance in accordance with NFPA standards. The Director of Environmental Services has identified and can secure, as required, other emergency generators, from the vendor, that would be accessible upon demand, to meet NFPA compliance.	

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K 144	<p>Continued From page 9</p> <p>emergency generator was maintained in accordance with NFPA standards. The deficiency had the potential to affect five of five smoke compartments, all residents, staff, and visitors. The facility is certified for 87 beds with a census of 66 on the day of the survey. The facility failed to ensure the generator battery charger was not hooked directly to the battery.</p> <p>The findings include:</p> <p>Observation on 03/06/13 at 10:32 AM with the Maintenance Director and the Environmental Supervisor revealed the generator's battery charger was hooked directly to the generator battery.</p> <p>Interview on 03/06/13 at 10:32 AM with the Maintenance Director and the Environmental Supervisor revealed they were not aware that the battery charger could not be hooked directly to the battery.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers' recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.</p>	K 144	<p>The facility, via the Director of Environmental Services, has completed a thorough systemic review of the building to ensure that all areas of the facility are properly protected and meet the requirements for generator protection, in accordance with NFPA standards. This review will be done as part of Both monthly and quarterly CQI, for consistency. The Director keeps a thorough log of generator maintenance, in accordance with standards. Test logs are regularly maintained. The Director maintains the generator as Specified, by NFPA standards.</p> <p>Additionally, all support services staff have been inserviced on NFPA standards as applied, and now know how to view the entire facility and extended property as it relates to generator protection. The Director of Environmental Services is now incorporating an extended review into his monthly CQI process.</p> <p>Additionally, to ensure no deficient practice recurs, the Director of Environmental Services and Laundry Supervisor now facility and extended building services for generator and test compliance as part of weekly and monthly reviews. Should any problems exist, these staff and their support service cohorts will report such upon discovery. Weekend supervision and weekend call also review these areas.</p>	4/21/13