

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

PRINTED: 11/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185259	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/01/2012
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059
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F 441	<p>Continued From page 26</p> <p>room of Resident #12 to serve lunch without any protective equipment. She was observed putting a clothing protector (bib) on Resident #12 while the clothing of CNA #1 touched the bed linen of the resident. Her hands were noted touching the resident as she secured the clothing protector on the resident. CNA #1 did wash her hands prior to exiting the room of Resident #12, however, her uniform had been exposed to the bed linen of Resident #12 and she continued to work in her role as a CNA, which included entering the rooms of other residents assigned to her.</p> <p>Interview, on 11/01/11 at 12:35 PM, with CNA #1 revealed contact precautions meant to wear gloves. She stated the need for gloving was to prevent the spread of infection to others. She revealed she had been in-serviced on contact precautions; however, she did not follow those precautions when caring for Resident #12.</p> <p>Interview, on 11/01/12 at 4:40 PM, with CNA #4 revealed she was to wear a gown and gloves before entering the room of Resident #12. She revealed she would remove the gown and gloves before leaving the room and place them in the red box, then wash her hands. She revealed the reason for this was to protect other residents from being exposed to what the facility was trying not to spread.</p> <p>Interview, on 11/01/12 at 8:12 PM, with the Director of Nursing (DON) revealed staff and visitors would know who was on isolation by the facility posting signs. She revealed if the signs were not present, those entering the resident's room would be open to exposure (to what the resident was in isolation for). She revealed the</p>	F 441		
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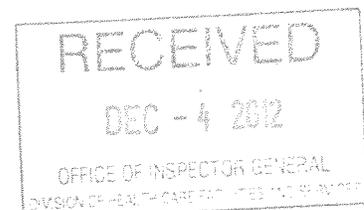
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F 441	Continued From page 27 CNA's were in-serviced on contact precautions and the CNAs were kept informed of a resident on precautions by their CNA assignment sheet. However, review of the CNA assignment sheet for Resident #12 revealed no indication the resident was on isolation or any type of precautions. She further revealed, the failure for a CNA to use the needed precautions for a resident could cause a cross-contamination, and expose the other residents.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to secure biohazardous material in a locked area. The one (1) of one (1) door with a Biohazardous Material label to the room in which the facility stored biohazardous material and waste was unlocked three (3) of three (3) times when checked on 10/30/12 and 10/31/12. The findings include: Review of the facility's policy regarding Regulated Waste from the Infection Control Manual, dated 08/2005, revealed the storage of biohazardous waste in a secured area with a lock was not included in the policy.	F 465	F 465 Staff F465 483.70(h) / Safe/Functional/ Sanitary /Comfortable Environment 1. During the annual survey conducted on 10/30/12 it was determined by the surveyor that the facility failed to secure the biohazard materials in a locked area. The one (1) of one (1) door with a Biohazard Material label to the door to which the facility stored biohazard material and waste was unlocked three (3) of three (3) times when checked on 10/30/12 and 10/31/12 2. The biohazard room was locked immediately and remains locked at all times when staff is not immediately in use of the room. Darob provides biohazard waste pickup twice each month with recent pickup on 11/2/12. Retraining of all staff to include environmental services supervisor was initiated on 10/31/12 and completed on 11/5/12 by the DON/Staff Facilitator to ensure understanding of risk and prevention measure related safety of residents to include the company that services facility biohazard/waste needs.	



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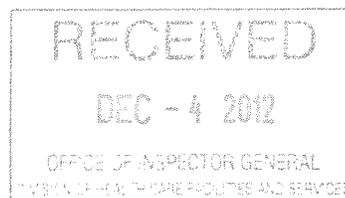
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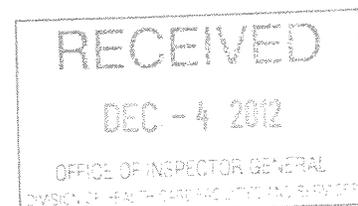
F 465	<p>Continued From page 28</p> <p>Observation, on 11/30/12 at 12:35 PM, revealed the door on the Yellow Hall marked Soiled Utility and Biohazard, with the biohazardous symbol present, was unlocked. There were red biohazard containers with biohazardous material (sharps containers, soiled dressings, bed pans) observed stored in the room.</p> <p>Observation, on 10/31/12 at 8:25 AM, revealed the above noted door was unlocked.</p> <p>Observation, on 10/31/12, at 2:15 PM, revealed the above noted door was unlocked.</p> <p>Observation, on 10/31/12 at 3:47 PM, revealed the contents of the room where the biohazardous material was stored included five (5) filled large red biohazardous storage bins. One (1) of the bins was not closed and a smaller Sharps Container was visible overflowing the biohazardous container in which it was located.</p> <p>Interview, on 10/31/12 at 2:15 PM, with the Environmental Services Supervisor revealed the door to the room where the biohazardous waste was stored had never been locked since he had been employed at the facility. He revealed full Sharps Containers were stored in the room. In addition, he revealed there were residents at the facility that wander and go into rooms that were not their own. He revealed if a resident were to get into the biohazard storage room with the Sharps Containers, a resident could put a needle in their mouth or stick themselves, which he stated would not be a good thing.</p> <p>Interview, on 10/31/12 at 4:45 PM, with the Director of Nursing (DON) revealed a biohazard</p>	F 465	<p><i>F 465 continued</i></p> <p>3. DON/Staff Facilitator initiated retraining of all staff on 10/31/12 and completed on 11/5/12 regarding biohazard room remaining locked at all times and to ensure understanding of risk and prevention measure related safety of residents. Daily rounds assigned to administrative nurses/weekend supervisor to be completed daily to ensure biohazard room is locked and secure.</p> <p>4. Unit Manager/ADON/Weekend Supervisor will complete daily rounds to ensure biohazard door is locked and secure beginning 12/1/12. The findings will be documented using the clinical nurse rounds tool. All finding will be forwarded to the DON/NHA for review and follow up if indicated daily. The results of these rounds will be forwarded to the Quality Assurance Committee monthly until sustained compliance then at least quarterly for review and recommendations. If concerns are identified during QA process, the committee will reconvene for additional recommendations until sustained compliance.</p> <p>5. Completion Date 12/2/12</p>	12/2/12
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F 465	Continued From page 29 was a contaminated, possibly hazardous infectious material and the room in which the biohazards were stored was to have been locked. She revealed any staff that entered that room should make sure it was locked when they leave because Sharps Containers were in there and other contaminated trash. In addition, she revealed hazardous material was stored in the room that the facility did not want people to have access to and the facility did have residents that were on alert for wandering. She revealed it was a risk to residents to keep the door to the biohazards unlocked. She revealed the staff should have been in-serviced during orientation to keep the room secure. She makes rounds frequently and spot checks rooms that should be locked, to include the medication room, shower rooms and storage rooms. She revealed the system failed when the staff did not ensure the room where biohazardous material was stored was locked. She stated there was not one person designated to be responsible for the security of the door, but that all staff were responsible. She revealed by not having one person responsible for the security of the door to the room where biohazards were stored contributed to the system failure.	F 465			



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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 V (111)</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was initiated on 10/30/12 and concluded on 10/31/12. Rivers Edge Nursing and Rehab Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility has one hundred (100) certified beds with a census of eighty nine (89) 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>Plan of Correction Disclaimer for Rivers Edge Nursing and Rehabilitation Center</p> <p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency.</p> <p>Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) ten days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed of considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	
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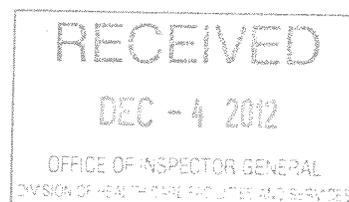
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *X. Jettie M. Carter* TITLE: *Administrator* (X6) DATE: *12/3/12*

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

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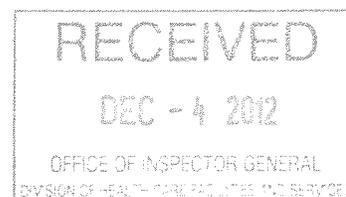
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K 000	Continued From page 1 Fire)	K 000		
K 025 SS=F	Deficiencies were cited with the highest deficiency identified at F level. NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff and visitors. The facility has one hundred (100) certified beds with a census of eighty nine (89) on the day of the survey. The findings include: Observation, on 10/30/12 between 2:30 PM and 4:00 PM, with the Director of Maintenance revealed the smoke partition, extending above	K 025	<i>Start R025</i> K 025 NFPA 101 Life Safety Code Standard-Smoke barriers are constructed to provide at least one half hour fire resistance rating in accordance with 8.3. 1. During the life safety tour on 10/30/12 it was determined by the surveyor that the smoke partition, extending above the ceiling above each cross corridor door had been penetrated by data lines and sealed with unrated quick foam or standard fiberglass insulation. 2. The nursing center administrator and the maintenance director completed 100% walk through inspection on 11/5/12 – 11/6/12 to determine any additional penetrations. No other areas identified. 3. The Nursing center administrator retrained the maintenance director and the maintenance assistant beginning 10/30/12 through 11/02/12 regarding the non use of unrated quick foam or standard fiberglass insulation. The maintenance staff corrected all penetrations by using mortar, instead of rated quick foam or standard fiberglass insulation by 11/09/12.	



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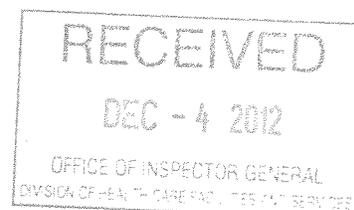
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K 025	Continued From page 2 the ceiling located above each cross corridor door had been penetrated by data lines and sealed with unrated quick foam, or standard fiberglass insulation. Interview, on 10/31/12 between 2:30 PM and 4:00 PM, with the Director of Maintenance revealed he was not aware quick foam and fiberglass insulation were not rated for use in a smoke partition. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. NFPA 101 LIFE SAFETY CODE STANDARD	K 025	<i>K 025 Continued</i> 4. The maintenance director will institute random weekly & PRN visual monitoring of penetrations and will ensure any identified penetrations are sealed with mortar after the area has been accessed by staff or vendors starting 11/12/12. Weekly & PRN monitoring will be documented using a log. Results will be forwarded to the Performance Improvement Quality Assurance committee monthly until sustained compliance then at least quarterly for review and recommendations. If concerns are identified during the QA process the team will reconvene for additional recommendations until sustained compliance is achieved. Completion: 11/13/12	11/13/12
K 027 SS=F		K 027	<i>Start K 027</i> K 027 NFPA 101 Life Safety Code. Standard-Door openings in smoke barriers have at least a 20 minute fire protection rating or at least 13/4 inch thick solid bonded wood core.	



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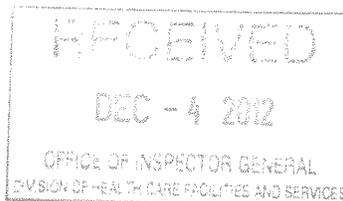
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K 027	<p>Continued From page 3</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of 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</p> <p>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 seven (7) of seven (7) smoke compartments, residents, staff and visitors. The facility has one hundred (100) certified beds with a census of eighty nine (89) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/31/12 between 10:00 AM and 1:00 PM, with the Director of Maintenance revealed the cross-corridor doors located throughout the facility, would not close completely when tested. This was due to the doors not having a coordinator to ensure the door without the t-astragal would close first.</p> <p>Interview, on 10/31/12 between 10:00 AM and 1:00 PM, with the Director of Maintenance</p>	K 027	<p><i>K027 Continued</i></p> <ol style="list-style-type: none"> 1. During the life safety tour on 10/31/12 it was revealed that the cross corridor doors located throughout the facility would not close completely when tested. This was due to the doors not having a coordinator to ensure the door without the t-astragal would close first. The coordinators were ordered on 11/5/12 and will be installed on or by 11/28/12. 2. The nursing center administrator and the maintenance director completed a 100 % audit of the entire building on 11/5/12 – 11/6/12. It was determined by the NHA that one other door leading to the dining room corridor would also require a coordinator. 3. The Nursing center administrator retrained the maintenance director and the maintenance assistant starting 11/1/12 to 11/2/12 regarding cross corridor doors throughout the facility in need of coordinators. 4. The maintenance director will institute visual monitoring of the cross corridor doors throughout the facility to ensure proper functioning as well as identify any other doors in need of coordinators during weekly rounds starting 12/1/12 for 12 weeks to ensure compliance is maintained. Results of the rounds will be forwarded to the Performance Improvement Quality Assurance committee monthly until sustained compliance then at least quarterly for review and recommendations. If concerns are 	



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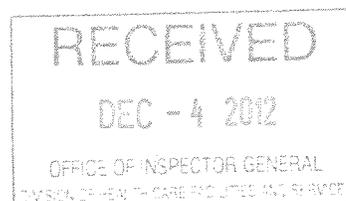
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K 027	Continued From page 4 revealed they were unaware the doors needed a coordinator to ensure the doors would close properly in the event of an emergency. NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke. Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 027	<i>K 027 Continued</i> identified during the QA process the team will reconvene for additional recommendations until sustained compliance is achieved. Completion: 12/2/12	12/2/12	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by.	K 029	<i>Start K 029</i> K 029 NFPA 101 Life Safety Code Standard- One hour fire rated construction (with 3.4 hour fire-rated 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. During the life safety tour inspection on 10/31/12 it was revealed that the door to the medical records storage office was hollow core and did not have a self closing device. 2. A non hollow self closing door was ordered on 11/6/12 and was installed on 11/21/12 by the maintenance staff. After completing a 100 % audit of the entire building on 11/5/12 - 11/6/12 by the administrator and		



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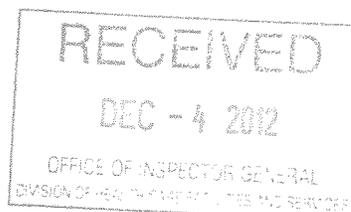
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185259	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2012
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059	
(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	<p>Continued From page 5</p> <p>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 one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility has one hundred (100) certified beds with a census of eighty nine (89) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/31/12 between 10:00 AM and 1:00 PM, with the Director of Maintenance revealed the door to the Medical Records Office was hollow core and did not have a self-closing device to protect the room containing hazardous storage.</p> <p>Interview, on 10/31/12 between 10:00 AM and 1:00 PM, with the Director of Maintenance revealed he was unaware the door was required to be rated and self-closing due to the storage within the room.</p> <p>18.3.2 Protection from Hazards. 18.3.2.1* Hazardous Areas. Any hazardous area shall be protected in accordance with Section 8.4. The areas described in Table 18.3.2.1 shall be protected as indicated.</p> <p>Table 18.3.2.1 Hazardous Area Protection</p> <p>Hazardous Area Description Separation/Protection Boiler and fuel-fired heater rooms 1 hour Central/bulk laundries larger than 100 ft² (9.3 m²) 1 hour Laboratories employing flammable or</p>	K 029	<p><i>K029 Continued</i></p> <p>maintenance director, one other door (nourishment room) was also replaced on 11/21/12 by the maintenance director.</p> <p>3. The facility administrator retrained the maintenance director and the maintenance assistant starting 11/1/12 to 11/2/12 regarding non hollow self closing door requirements.</p> <p>4. The maintenance director will institute weekly visual monitoring of doors throughout facility to ensure ongoing compliance starting 11/26/12. Results of the rounds will be forwarded to the Performance Improvement Quality Assurance committee monthly until sustained compliance then at least quarterly for review and recommendations. If concerns are identified during the QA process the team will reconvene for additional recommendations until sustained compliance is achieved.</p> <p>Completion Date: 11/27/12</p>	11/27/12



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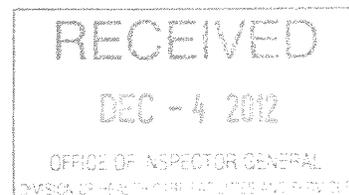
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185259	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2012	
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059		
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K 029	<p>Continued From page 8</p> <p>combustible materials in quantities less than those that would be considered a severe hazard See 18.3.6.3.4</p> <p>Laboratories that use hazardous materials that would be classified as a severe hazard in accordance with NFPA 99, Standard for Health Care Facilities 1 hour</p> <p>Paint shops employing hazardous substances and materials in quantities less than those that would be classified as a severe hazard 1 hour</p> <p>Physical plant maintenance shops 1 hour</p> <p>Soiled linen rooms 1 hour</p> <p>Storage rooms larger than 50 ft² (4.6 m²) but not exceeding 100 ft² (9.3 m²) storing combustible material See 18.3.6.3.4</p> <p>Storage rooms larger than 100 ft² (9.3 m²) storing combustible material 1 hour</p> <p>Trash collection rooms 1 hour</p> <p>8.4.1.3</p> <p>Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8.</p> <p>Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas 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</p>	K 029		



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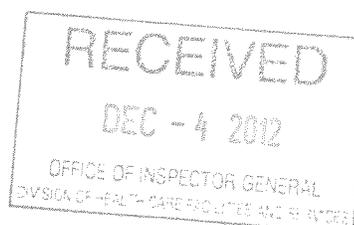
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K 029	Continued From page 7 from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), 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=D	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 lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation, and interview, it was	K 045	<i>Start K045</i> K 045 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 lighting in accordance with section 7.8.) 19.2.8 1. During the life safety tour on 10/31/12 it was revealed that the exterior exit located next to the Laundry room had a light outside with only one bulb to light the egress. The bulb was replaced immediately on 10/31/12. 2. The Nursing Center administrator and the maintenance director completed a 100% audit on the entire building on 11/5/12-11/6/12 for one light bulb in two bulb exit lighting and found none. However two other fixtures over the Dining room exits were replaced to include two bulb		



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K 045	Continued From page 8 determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility has one hundred (100) certified beds with a census of eighty nine (89) on the day of the survey. The findings include: Observation, on 10/31/12 between 10:00 AM and 1:00 PM, with the Director of Maintenance revealed the exterior exit located next to the Laundry Room had a light outside with only one bulb to light the egress path. Interview, on 10/31/12 between 10:00 AM and 1:00 PM, with the Director of Maintenance revealed he was not aware the lighting outside of exterior exits were required to have more than one bulb. Reference: NFPA 101 (2000 edition) 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	<i>K 045 Continued</i> systems on 11/6/12 by the maintenance staff. 3. The Nursing Center administrator reeducated the maintenance director and the maintenance assistance starting 11/1/12 to 11/2/12 regarding exterior exit lighting and illumination of means of egresses. 4. The maintenance director will institute visual monitoring of exterior exit lighting and illumination of means of egress into the weekly rounds starting 11/26/12 for 12 weeks then monthly to ensure compliance is maintained. Results of the rounds will be forwarded to the Performance Improvement Quality Assurance committee monthly until sustained compliance then at least quarterly for review and recommendations. If concerns are identified during the QA process the team will reconvene for additional recommendations until sustained compliance is achieved.		
K 056 SS=F	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	K 056	Completion: 11/27/12	11/27/12	



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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059
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K 056	<p>Continued From page 9 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 seven (7) of seven (7) smoke compartments, residents, staff and visitors. The facility has one hundred (100) certified beds with a census of eighty nine (89) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/31/12 between 10:00 AM and 1:00 P.M. with the Director of Maintenance revealed a standard response sprinkler head and a quick response sprinkler head in the same compartment located in the following areas:</p> <ol style="list-style-type: none"> 1) Main Lobby 2) 1st Street, 2nd Street, and 4th Street Halls 3) Rooms #1, 29, and 44. 4) Soiled Linen Room 5) Dining Room 6) Dish Room 7) Med Room 8) Beauty Shop <p>Further observation revealed a closet in the 4th Street shower room did not have sprinkler</p>	K 056	<p><i>Start K056</i></p> <p>K 056 NFPA 101 Life Safety Code Standard-sprinkler system for the entire building</p> <p>1. During the life safety tour on 10/31/12 it was revealed that a standard response sprinkler head and a quick response sprinkler head in the same compartment located in the following areas: (1) Main Lobby (2) 1st street, 2nd street, & 4th street halls, (3) rooms # 1, 29, & 44 (4) Soiled Linen room, (5) Dining room, (6) dish room, (7) Med room, and (8) beauty shop. The identified sprinkler heads were changed out to quick response sprinkler heads on 11/20/12 by Landmark Sprinkler Company. Further observation revealed that the 4th street shower room did not have sprinkler head protection. The sprinkler head is scheduled to be installed on or by 11/29/12 by Landmark Sprinkler Company.</p> <p>3. The Nursing Center administrator and the maintenance director completed a 100% audit on the entire building 11/5/12 & 11/6/12. There were three other areas identified. The identified sprinkler heads were changed to quick response sprinkler heads on 11/20/12 by Landmark Sprinkler Company.</p>	
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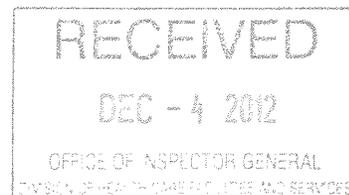
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059
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K 056	Continued From page 10 protection. Interview, on 10/31/12 between 10:00 AM and 1:00 PM, with the Director of Maintenance revealed they were not aware that the sprinklers had to have the same response time if the sprinkler heads are located in the same compartment. Further interview revealed he was not aware the closet in the shower room did not have sprinkler protection. Reference: NFPA 13 (1999 Edition) 7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary/temperature-rated sprinklers, standard response sprinklers shall be permitted to be used. Reference: NFPA 101 (2000 edition)	K 056	<i>K056 continued</i> 3. The Nursing Center administrator reeducated the maintenance director and Maintenance assistant assistance starting 11/1/12 to 11/2/12 regarding standard response sprinkler heads and a quick response sprinkler head in the same compartment areas as well as sprinkler head location requirements. 4. The maintenance director will institute visual monitoring of sprinkler heads in potential areas as well as standard response sprinkler head and a quick response sprinkler head in the same compartment into the weekly rounds starting 11/29/12 for 12 weeks then monthly to ensure compliance is maintained. Results of the rounds will be forwarded to the Performance Improvement Quality Assurance committee at least quarterly for further review and recommendations. The Performance Improvement Quality Assurance committee reporting will continue monthly times three months. If concerns are identified during the QA process the team will reconvene for additional recommendations until sustained compliance is achieved. Completion: 11/30/12	11/30/12
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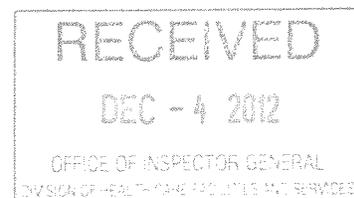
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059
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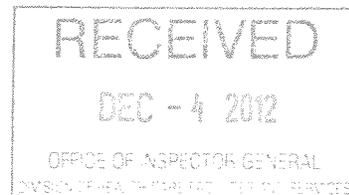
K 056	Continued From page 11 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception: Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.	K 056	<i>Start K064</i> K 064 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	
K 064 SS=D	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 it was determined the facility failed to ensure that fire extinguishers were maintained in accordance with NFPA standards. The deficiency had the potential to affect resident smokers, staff, and visitors. The facility has one hundred (100)	K 064	1. During the life safety tour inspection on 10/31/12 it was revealed that there was no fire extinguisher located in the designated smoking area. The maintenance director contacted the contracted vendor for fire extinguishers on 11/1/12 to order the fire extinguishers. The fire extinguisher was delivered and installed on 11/21/12 in the resident designated smoking area. 2. The Facility administrator and the maintenance director completed a 100% audit of the entire building 11/5/12 & 11/6/12 to determine the need for any additional fire extinguishers. Two additional areas were identified and two additional extinguishers were purchased for the outside employee break areas designated as employee smoke areas. The maintenance director contacted the contracted vendor for fire extinguishers on 11/1/12 to order the fire extinguishers. Three extinguishers were delivered and installed on 11/21/12 in the two designated employee smoke areas.	



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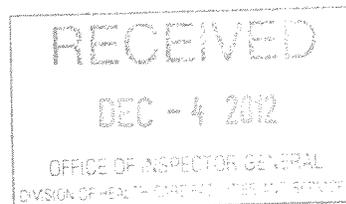
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K 064	<p>Continued From page 12</p> <p>certified beds with a census of eighty nine (89) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/31/12 at 11:40 AM, with the Director of Maintenance revealed there was no fire extinguisher located in the designated smoking area.</p> <p>Interview, on 10/31/12 at 11:40 AM, with the Director of Maintenance revealed he was unaware that there needed to be an extinguisher located in the smoking area.</p> <p>Reference: NFPA 10 1999 4-3.2.1 Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d) Safety seals and tamper indicators not broken or missing (e) Fullness determined by weighing or "hefting" (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place 4-3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 4-3.2 (a), (c), (h), and (i), immediate corrective action shall be taken.</p>	K 064	<p><i>Moby continued</i></p> <p>3. The facility administrator retrained the maintenance director and the maintenance assistant starting 11/1/12 to 11/2/12 regarding fire extinguisher located in the designated smoking areas.</p> <p>4. The maintenance director will institute visual monitoring of fire extinguishers, into the weekly rounds starting 11/26/12 for 12 weeks then monthly to ensure compliance is maintained. Results of the rounds will be forwarded to the Performance Improvement Quality Assurance committee monthly until sustained compliance then at least quarterly for review and recommendations. If concerns are identified during the QA process the team will reconvene for additional recommendations until sustained compliance is achieved.</p> <p>Completion: 11/27/12</p>	11/27/12	



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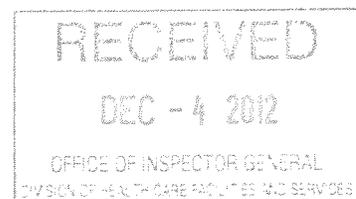
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185259	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2012
NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059		
(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 066 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area in accordance with NFPA standards. The deficiency had the potential to affect resident smokers, staff and visitors. The facility has one hundred (100) certified beds with a census of eighty nine (89) on the day of the survey.</p>	K 066	<p><i>K 066 continued</i></p> <p>K 066 NFPA 101 Life Safety Code Standard- ...metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>1. During the life safety tour inspection on 10/31/12 it was revealed that the facility failed to provide a metal container with a self closing lid to dump the ashtrays in the designated smoking area.</p> <p>2. The Facility administrator and the maintenance director completed a 100% audit of the entire building 11/5/12 & 11/6/12 to determine the need for additional metal containers with a self closing lid to dump the ashtrays in the designated smoking area. The container(s) were ordered on 11/05/12 and delivered on or by 11/26/12.</p> <p>3. The facility administrator retrained the maintenance director and the maintenance assistant starting 11/1/12 to 11/2/12 regarding the need for additional metal containers with a self closing lid to dump ashtrays in the designated smoking area(s).</p>		



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K 066	Continued From page 14. The findings include: Observation, on 10/31/12 at 11:40 AM, with the Director of Maintenance revealed the facility failed to provide a metal container with a self-closing lid to dump the ashtrays, located in the designated smoking area. Interview, on 10/31/12 at 11:40 AM, with the Director of Maintenance revealed they were not aware of the requirement for metal containers with a self-closing lid for dumping ashtrays. Reference: NFPA Standard 101 (2000 Edition), 19.7.4 Smoking (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066	<i>K 066 continued</i> 4. The maintenance director will institute weekly visual monitoring of metal containers with a self closing lid starting 12/1/12 to ensure containers are in place in the designated smoking area(s). Results of the rounds will be forwarded to the Performance Improvement Quality Assurance committee monthly. If concerns are identified during the QA process additional recommendations will be discussed until sustained compliance is achieved. Completion Date: 12/2/12	
K 068 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure combustion air and ventilation for boilers, incinerators, and heater rooms were installed in accordance with NFPA standards. The deficiency had the potential to affect four (4) of seven (7) smoke compartments, residents, staff and visitors. The facility has one hundred (100) certified beds with a census of eighty nine (89) on the day of the survey	K 068	<i>Start K 068</i> K 68 NFPA 101 Life Safety Code Standard-Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged into the outside air. 19.5.2.2 1. During the life safety tour on 10/31/12 it was revealed that vents in mechanical rooms with gas fired equipment did not vent to the outside but instead were open to the attic located in the 1 st , 2 nd , 3 rd , and 4 th street halls. It has been validated by the fire marshal and the deputy fire marshal on 11/26/12 that the water heaters are vented to the outside and the vent lines does extend up to and through the roof in all four areas. The fresh air vent is also vented to the outside and also extends up to and through the roof in all four areas. It is concluded that the vents going to the attic is from the something that once occupied the space but is not longer in existence.	12/2/12



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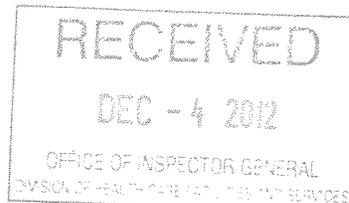
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059
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K 068	<p>Continued From page 15</p> <p>The findings include:</p> <p>Observation, on 10/31/12 between 10:00 AM and 1:00 PM, with the Director of Maintenance revealed vents in mechanical rooms with gas fired equipment did not vent to the outside but instead were open to the attic located in the 1st, 2nd, 3rd, and 4th Street Halls.</p> <p>Interview, on 10/31/12 between 10:00 AM and 1:00 PM with the Director of Maintenance revealed they were unaware the vents were not to be open to the attic.</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition) Section 19.5 Building Services 19.5.2.2 Any heating device other than a central heating plant shall be designed and installed so that combustible material will not be ignited by the device or its appurtenances. If fuel-fired, such heating devices shall be chimney connected or vent connected, shall take air for combustion directly from the outside, and shall be designed and installed to provide for complete separation of the combustible system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed</p>	K 068	<p><i>K 068 Continued</i></p> <p>2. The Nursing Center maintenance director and the administrator completed a 100% audit on the entire building on 11/5/12-11/6/12 for any additional rooms with gas fired equipment that did not vent to the outside. No others were identified. The fire marshal and deputy fire marshal confirmed this on 11/26/12. A licensed contracted plumber toured/inspected the building along with state compliance officer, Division of plumbing on 11/27/12, both stated there was sufficient fresh air exchange with full ventilation up through the roof as well as sufficient ventilation from the gas water heater that is vented through the roof. It was suggested/identified that the vents going to the attic is no longer needed and could be closed off. On 11/27/12 the grids were removed and the areas were sealed off using a fire rated drywall to prevent smoke from circulating or compartmentalizing in the attic and to meet the intent of the standard.</p> <p>3. The Nursing Center administrator reeducated the maintenance director and the maintenance assistance starting 11/1/12 to 11/2/12 regarding rooms with gas fired equipment that do not vent to the outside areas.</p> <p>4. The maintenance director will institute visual monitoring of rooms with gas fired equipment to ensure proper venting to the outside into the weekly rounds starting 12/1/12 for 12 weeks then monthly to ensure compliance is maintained. Results of the rounds will be forwarded to the Performance Improvement Quality Assurance committee at least quarterly for further review and recommendations. The Performance</p>	
K 070 SS=D		K 070		



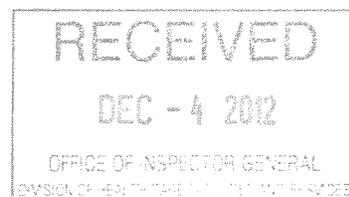
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K 070	<p>Continued From page 16</p> <p>212 degrees F. (100 degrees C) 19.7.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments residents, staff and visitors. The facility has one hundred (100) certified beds with a census of eighty nine (89) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/31/12 between 10:00 AM and 1:00 PM, with the Director of Maintenance revealed a portable space heater located in the MDS Office.</p> <p>Interview, on 10/31/12 between 10:00 AM and 1:00 PM, with the Director of Maintenance revealed he was aware the heaters could not exceed 212°F in non-sleeping, staff, and employee areas. However, he was not aware someone had brought the heater into the facility.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).</p>	K 070	<p><i>K 068 continued</i></p> <p>Improvement Quality Assurance committee reporting will continue monthly times three months. If concerns are identified during the QA process the team will reconvene for additional recommendations until sustained compliance is achieved.</p> <p>Completion: 12/2/12</p> <p><i>Defect K070</i></p> <p>K 070 NFPA 101 Life Safety Code Standard- Portable space heating devices are prohibited in all healthcare occupancies, except in non-sleeping staff and employee areas where heating elements of such devices do not exceed 212 degrees F (100 degrees C) 19.7.8</p> <p>1. During the life safety tour inspection on 10/31/12 it was revealed that a portable space heater was located in the MDS office. The identified space heater was removed immediately on 10/31/12.</p> <p>2. The Facility administrator and the maintenance director completed a 100% audit of the entire building 11/5/12 & 11/6/12 to determine if there were any additional portable space heaters in the facility, there were none.</p>	12/2/12



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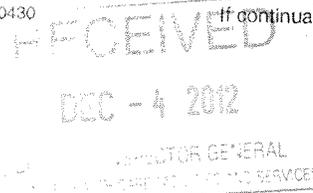
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059
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K 072 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to egress items, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility has one hundred (100) beds with a census of eighty nine (89) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/31/12 between 10:00 AM and 1:00 PM, with the Director of Maintenance revealed linen carts stored in the egress corridor near exit by the Laundry Room.</p> <p>Interview, on 10/31/12 between 10:00 AM and 1:00 PM, with the Director of Maintenance revealed these items were routinely stored in this corridor.</p> <p>Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire</p>	K 072	<p><i>K 072 Continued</i></p> <p>3. The facility administrator reeducated the MDS staff on 11/2/12 as the maintenance director was fully aware that portable space heater were not allowed in the facility without being cleared by the maintenance director for correct elements. The DON/STAFF FACILITATOR/Environmental services supervisor re-educated all staff that portable space heater are not allowed in the facility without being cleared by the maintenance director for correct elements starting 11/2/12 to 11/05/12.</p> <p>4. The maintenance director will institute visual monitoring for portable heaters into the weekly rounds starting 10/29/12 for 12 weeks then monthly to ensure compliance is maintained. Results of the rounds will be forwarded to the Performance Improvement Quality Assurance committee at least quarterly for further review and recommendations. The Performance Improvement Quality Assurance committee reporting will continue monthly times three months. If concerns are identified during the QA process the team will reconvene for additional recommendations until sustained compliance is achieved.</p> <p>Completion: 11/30/12</p>	11/30/12
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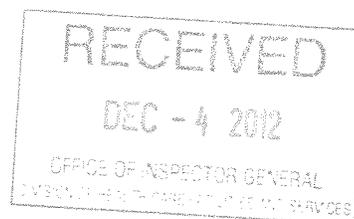
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<p>K 072</p> <p>K 147 SS=D</p>	<p>Continued From page 18 or other emergency.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff, and visitors. The facility has one hundred (100) certified beds with a census of eighty nine (89) on the day of the survey.</p> <p>The findings include: Observations, on 10/31/12 between 10:00 AM and 1:00 PM, with the Director of Maintenance revealed a power strip plugged into another power strip located in the MDS Office.</p> <p>Interview, on 10/31/12 between 10:00 AM and 1:00 PM, with the Director of Maintenance revealed they were aware of the proper use of power strips, but not aware they had been installed and misused.</p> <p>Reference: NFPA 70 400-8 (Extensions Cords) Uses Not Permitted, Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following. (1) As a substitute for the fixed wiring of a</p>	<p>K 072</p> <p>K 147</p>	<p><i>Start K 072</i></p> <p>K 072 NFPA 101 Life Safety Code Standard- Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits 7.1.10.</p> <p>1. During the life safety tour inspection on 10/31/12 it was revealed that one linen cart was stored in the egress corridor near exit by Laundry room. The linen cart was removed on 10/31/12.</p> <p>2. The Facility administrator and the maintenance director completed a 100% audit of the entire building 11/5/12 & 11/6/12 to determine if there were any other areas of concern regarding egress obstructions or impediments, none were found.</p> <p>3. The Nursing Center administrator reeducated the maintenance director and the maintenance assistance starting 11/1/12 to 11/2/12 regarding the means of egress to continuously be maintained free of all obstructions or impediments. The DON/STAFF FACILITATOR re-educated all staff that Means of egress are continuously maintained free of all obstructions or impediments to full</p>	
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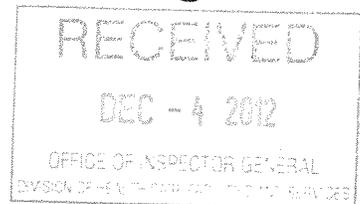
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NAME OF PROVIDER OR SUPPLIER RIVERS EDGE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6301 BASS ROAD PROSPECT, KY 40059
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K 147	<p>Continued From page 19 structure</p> <p>(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</p> <p>(3) Where run through doorways, windows, or similar openings</p> <p>(4) Where attached to building surfaces</p> <p>Referance: NFPA 99 (1999 edition) 3-3.2.1.2 n</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147	<p><i>K072 Continued</i></p> <p>instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits starting 11/2/12 to 11/05/12.</p> <p>4. Starting 11/5/12 the maintenance director instituted daily visual monitoring of egresses to ensure linen carts and no other equipment obstructs or impedes egresses. Results of the rounds will be forwarded to the Performance Improvement Quality Assurance committee monthly. If concerns are identified during the QA process additional recommendations will be discussed until sustained compliance is achieved.</p> <p>Completion Date: 11/06/12</p> <p><i>Start R147</i></p> <p>K 147 NFPA 101 Life Safety Code Standard- Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code 9.1.2</p> <p>1. During the life safety tour inspection on 10/31/12 it was revealed by the surveyor that a power strip was plugged into another power strip located in the MDS office.</p> <p>2. The above was corrected immediately on 10/31/12 by the maintenance director.</p>	11/6/12
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K 147	Continued From page 19 structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	<i>K 147 continued</i> 3. The facility administrator re-educated the MDS staff on 11/1/12 regarding electrical maintenance standards to include no power strips or surge protectors to be plugged into another power strips or surge protectors. The maintenance director was fully aware of the standard. All other staff was re-educated 11/2/12 - 11/05/12. 4. The maintenance director will conduct weekly rounds time four weeks starting 11/5/12 then monthly rounds to ensure extension cords/surge protectors are not used out of compliance of the NFPA 70, National electric code. Results of the rounds will be forwarded to the Performance Improvement Quality Assurance committee monthly. If concerns are identified during the QA process additional recommendations will be discussed until sustained compliance is achieved. Completion Date: 11/6/12	11/6/12	

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