

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

PRINTED: 12/08/2010
FORM APPROVED
OMB NO. 0838-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/18/2010
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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504
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F 000	INITIAL COMMENTS A Recertification and an Abbreviated Survey were conducted 11/16/10 through 11/18/10. A Life Safety Code Survey was conducted on 11/17/10. Deficiencies were cited with the highest Scope and Severity of an "F". ARO KY00015514 and ARO KY00015516 were substantiated with no deficiencies. ARO KY00015590 and ARO KY00015515 were unsubstantiated with no deficiencies.	F 000	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. RECEIVED JAN - 7 2011 BY: This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure residents with limited range of motion receive appropriate care and services to increase range of motion or prevent further decrease in range of motion for one (1) of eighteen (18) sampled residents (Resident #6). The findings include: Review of Resident #6's medical record revealed diagnoses which included Multiple Sclerosis, Diabetes Mellitus, and Pressure Ulcers. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 09/22/10, revealed the facility	F 318	occurred as presented in the statements. <u>F 318 D Increase/Prevent Decrease in Range of Motion</u> <u>Targeted Residents</u> A Physician's order was obtained for Physical Therapy to rescreen resident #6 on 11-18-10. The resident has refused therapy evaluations in the past; however, she has recently agreed to allow therapy to evaluate her for contracture management. The resident is currently on therapy caseload with limited progress and will be discharged soon from therapy with a restorative nursing program for passive range of motion exercises and preventive contracture management.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 1/2/11
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any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 318	<p>Continued From page 1</p> <p>assessed the resident as moderately impaired in cognitive status, requiring total assistance for transfers, unable to ambulate, and as having limitations in range of motion of both feet and legs and partial loss of voluntary movement of both feet and legs.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 06/24/10, revealed the resident was dependent on staff for all Activities of Daily Living (ADL's). Further review revealed the resident was transferred per a mechanical lift and required the assistance of staff to turn and reposition in the bed.</p> <p>Review of the Comprehensive Plan of Care dated 06/24/10 revealed the resident had the potential for complications related to Multiple Sclerosis and required the assistance of staff for Activities of Daily Living related to diagnoses of Debility and Muscular Wasting. The interventions included assisting with ADL care and mobility.</p> <p>Further review of the medical record revealed the resident was discharged from the hospital on 11/12/10. Review of the Re-admission Physician's Orders dated 11/12/10, revealed orders for Physical Therapy and Occupational Therapy to treat as indicated per recommendation of a licensed therapist.</p> <p>Further review of the Physician's Orders dated 11/15/10, revealed orders to discontinue skilled Occupational Therapy and Physical Therapy and resume Restorative Nursing.</p> <p>Observation of a skin assessment on 11/17/10 at 3:00 PM revealed contractures of the resident's lower extremities.</p>	F 318	<p><i>Identification of Other Residents</i> The Residents who are not currently on a physical rehabilitation plan or on a nursing restorative program have been assessed for the need for a specific restorative program or a daily maintenance range of motion exercise program to prevent joint contractures. The RN Restorative Nurse and the MDS Coordinators completed this on 12-15-2010.</p> <p><i>Systemic Changes</i> The CNA care plans and assignment sheets have been revised to include maintenance ROM during ADL care to increase/prevent decrease in range of motion according to the resident's assessment care needs; this was completed on 12-12-10 by the MDS Coordinators. Also the resident's will be assessed by therapy services quarterly per their MDS assessment schedule for the need for skilled contracture prevention management by a physical or occupational therapist. In addition, the RN Staff Development Coordinator inserviced the CNA's on 12-1-10 thru 12-21-10 on providing range of motion exercises daily during ADL care and range of motion exercise competencies and post tests have been completed on all CNA's to validate comprehension of the new system and knowledge of range of motion exercises, this was also completed by the RN Restorative Nurse on 12-1-10 thru 12-21-10.</p>	

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F 318	<p>Continued From page 2</p> <p>Interview on 11/18/10 at 11:00 AM with the Restorative Aide for Resident #6's hall, revealed the resident did not receive restorative nursing. She stated the resident used to get Range of Motion (ROM) and splints for the lower extremities; however, it had been eight (8) months or so since the resident received restorative nursing.</p> <p>Interview on 11/18/10 at 12:00 PM with Certified Nursing Assistant (CNA) #7 revealed she was assigned to the resident that day, and was usually assigned to the resident. She stated the resident's legs were contracted; however, she did not perform ROM with the resident and had never been instructed to perform ROM for the resident. CNA #7 stated she referred to the Daily Care Plan Record and the Assignment Sheet when providing care. Review of the Daily Care Plan Record and the Assignment Sheet revealed there was no instruction for ROM on the Record.</p> <p>Interview on 11/18/10 at 2:00 PM with the Nurse Manager on Resident #6's hall, revealed the aides performed ROM with turning and repositioning the residents. She further stated she was unsure if there was to be a certain amount of repetitions for the ROM done per the CNA's or if the ROM was listed on the Daily Care Plan Records, or on the Assignment Sheets for the aides to reference.</p> <p>Review of the Information provided by the facility revealed the resident last received restorative nursing 10/09. Review of the Restorative Nursing Program dated 10/09, revealed the resident had decreased flexibility of the joints and decreased mobility. The approaches included assisting the</p>	F 318	<p><i>Monitoring</i> During the daily care plan compliance rounds the Unit Managers and House Supervisors will observe CNA's performing ADL care to ensure range of motion exercises are being performed. The observation compliance rounds will be submitted to the Director of Nursing daily.</p> <p><i>Correction Date:</i></p>	12-22-10

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F 318	<p>Continued From page 3</p> <p>resident to perform Active Range of Motion (AROM) to all extremities, ten (10) repetitions per joint for fifteen (15) minutes a day, for six (6) days a week.</p> <p>Interview on 11/18/10 at 2:30 PM with the Restorative Nurse revealed each time a resident was hospitalized, restorative nursing was automatically discontinued without a discharge note being written. She further stated, each time a resident returned to the facility from the hospital, Physical Therapy and Occupational Therapy Orders were received from the Physician for a screen and evaluation if needed. She further stated she wrote Restorative Nursing Care Plans based on the referral of the Physical Therapist's (PT) and Occupational Therapist's (OT) recommendations when the resident was discharged from PT and OT.</p> <p>Continued interview with the Restorative Nurse revealed the resident was not receiving restorative nursing. She stated, if the residents were in the restorative nursing program, the restorative aides performed the restorative nursing as per the instructions in the Daily Care Plan Book. She further stated once the residents were discontinued from the restorative nursing program, the aides on the floor would provide movement of the residents' extremities with dressing, turning and positioning, and ADL care. She stated there was no plan for repetitions or for specific ROM if the residents were not in the restorative nursing program.</p> <p>Review of the Interdisciplinary Resident Data Collection Form completed by the OT and dated 11/15/10, revealed the resident was currently on the nursing restorative program and the nursing</p>	F 318		

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F 318	<p>Continued From page 4</p> <p>restorative program was appropriate with no change from the last review. The Form further stated the resident was bedridden and functioning at baseline.</p> <p>Interview with the Occupational Therapist (OT) and Physical Therapist (PT) on 11/18/10 at 12:30 PM, revealed the OT had screened the resident for OT and PT on 11/15/10. The OT stated she had written the Physician's Order to discontinue PT and OT and to continue the restorative nursing because she reviewed the last restorative note in the chart which was outdated, and thought the resident was receiving restorative nursing prior to the last hospital admission. She further stated, she had completed the screening on 11/15/10 and did not collaborate with the restorative nurse. She stated she should have spoken with the restorative nurse during the screening to find out exactly what interventions restorative was providing before writing the order to resume restorative nursing. Continued interview revealed the PT/ OT screen was a "chart review only". She further stated the resident "needs passive ROM for limbs".</p> <p>Review of the facility "Policy and Procedure for Range of Motion", revealed "residents identified as a risk for contractures will have a ROM program a minimum of 6 days/ week unless that frequency is contraindicated. Ten repetitions will be performed on each specified joint unless contraindicated. The ROM includes the programs provided to prevent contractures and keep joints as limber as possible".</p>	F 318		
F 328 88-E	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive</p>	F 328		

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F 328	<p>Continued From page 5.</p> <p>proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure proper maintenance of equipment for contracted respiratory services. Oxygen concentrator filters were observed to be dirty.</p> <p>The findings include:</p> <p>Observation on environmental tour on 11/17/10 at 10:00 AM revealed oxygen concentrator filters in rooms 9B, 24B, 31B, 62A, 62B, and 69B had an accumulation of dust and dirt.</p> <p>Observation of the oxygen concentrator filter in room 54B with the Unit Manager on 11/17/10 at 10:30 AM, revealed a build up of dust and dirt on the filter. Interview with the Unit Manager at the time, revealed the filter was dirty and needed to be changed.</p> <p>Interview on 11/17/10 at 10:40 AM with the Director of Nursing, revealed respiratory care services and equipment were provided through contract and the contract company was responsible for maintenance of the oxygen</p>	F 328	<p>F 328 E Treatment/Care for Special Needs</p> <p><i>Targeted Residents</i> On 11-17-10 the Representative from the Respiratory Contract Company cleaned the oxygen concentrator filters identified in rooms 9B, 24B, 31B, 62A, 62B, 69B and 54B. These filters are being cleaned per facility policies and according to manufacturer's recommendations.</p> <p><i>Identification of Other Residents</i> All residents requiring special services have the potential to be effected including those residents receiving respiratory care services. All of the oxygen concentrators were checked and filters cleaned on 11-19-10 by the respiratory contract company and are being cleaned weekly. The Quality Assurance Nurse audited residents receiving oxygen on 11-24-10 for physician's orders, that the oxygen flow sheet is being completed which includes a respiratory assessment by the resident's nurse every shift, and that oxygen signage is on the door, and that the oxygen tubing is dated and changed timely, and that the oxygen cannula is in a clean bag if not used and dated, and that the nebulizers are being stored appropriately, and that oxygen filters are cleaned, and that the nebulizer flow sheet assessment is completed with each treatment given. This complete audit is done each week by the Quality Assurance Nurse.</p>	

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F 328	<p>Continued From page 6</p> <p>concentrators, and cleaning of the oxygen concentrator filters.</p> <p>Interview on 11/17/10 at 11:00 AM with the Service Technician, who was in the facility completing his rounds, revealed he cleaned the oxygen concentrator filters every two (2) weeks by rinsing them under the faucet and squeezing them dry, and then placed them back in the oxygen concentrator. He further stated, "they are pretty dirty today".</p> <p>Review of the "User manual for the Invacare Perfecto Series Oxygen Concentrator" provided by the facility revealed the oxygen concentrator filter should be cleaned at least once a week depending on environmental conditions, and may require more frequent cleaning of the filters. Further review revealed the filter should be cleaned with a vacuum cleaner or washed in warm soapy water and rinsed thoroughly, and dried before reinstallation.</p> <p>Review of the Oxygen Service Agreement with the contractor, provided by the facility, revealed the Agreement included bi-weekly inventory management of oxygen equipment and supplies, and bi-weekly equipment checks and cleaning.</p>	F 328	<p>The Quality Assurance Nurse audits physician's orders and compares them to the Medication Administration Records (MAR) daily to ensure medications and injections are being administered appropriately, the facility currently has no resident receiving IV therapy, we currently have 6 residents receiving tube feeding which is audited daily by the Quality Assurance Nurse for administration accuracy, site cleanliness, tube feeding bag and tubing labeled and dated correctly, and that pump rate is accurate, the facility currently has 3 colostomy's and 2 residents with a urostomy which is checked daily by the facility treatment nurse for any signs of discomfort or skin breakdown, all issues are reported to the physician. The facility currently has no resident with a tracheostomy. The facility has a contract with a Podiatrist for foot disorders who visits monthly and performs assessment and treatment. The facility currently has no resident with artificial limbs or eyes. No issues were identified thru the audit process other than the oxygen filters needed cleaning.</p>	
F 441 88=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and Infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control</p>	F 441		

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F 441	<p>Continued From page 7</p> <p>Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to establish and maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection for one (1) of eighteen (18) sampled residents (Resident #6) and for one (1)</p>	F 441	<p>Systemic Changes</p> <p>The facility changed the contract with the Respiratory Company to clean and maintain the concentrators on a weekly basis instead of bi-weekly on 11-26-10. The facility's Quality Assurance Nurse will continue auditing the special needs equipment and services as prior to the survey, but now this audit has been updated to include the oxygen concentrators and oxygen concentrator filters for cleanliness and making sure the equipment is working properly and submitting the audits to the Director of Nursing for review.</p> <p>Monitoring</p> <p>The Director of Nursing will submit findings to the Quality Assurance Committee Meetings Monthly for review and recommendations.</p> <p>F441D Infection Control, Prevent Spread, Linens</p> <p>Targeted Residents</p> <p>Resident #6 was assessed by the Advanced Registered Nurse Practitioner (ARNP) on 12/09/2010. Resident #6 has experienced no negative outcome related to this event. The nurse involved with resident #6 was immediately educated on 11/18/2010 on hand hygiene and gloving by the Director of Nursing. The nurse involved with the unsampled resident was also immediately educated on 11/18/2010 on proper infection control practice during routine resident care by the Director of Nursing.</p>	12-22-2010

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F 441	<p>Continued From page 8 unsampled resident.</p> <p>The findings include:</p> <p>1. Review of Resident #6's medical record revealed diagnoses which included Multiple Sclerosis, Diabetes Mellitus, and Pressure Ulcers.</p> <p>Observation of a skin assessment and dressing change on 11/17/10 at 3:00 PM revealed Licensed Practical Nurse (LPN) #5/Wound Nurse, painted the right lateral foot Pressure Ulcer with Betadine and then applied a non-adherent dressing, and wrapped the foot with Kerlex. She then proceeded to change gloves and paint the left medial lower leg open area with Betadine, covered the area with a foam dressing, and wrapped with Kerlex and changed her gloves.</p> <p>The nurse then removed the soiled DuoDerm dressing from the left heel Pressure Ulcer which had serous drainage, changed gloves and cleansed the area with wound cleanser, patted the area dry, and placed DuoDerm on the area. Further observation revealed she changed gloves and removed the soiled dressing from the old non-healing abdominal surgical site, changed gloves and cleansed the area with wound cleanser, and applied Mepilex dressing.</p> <p>Continued observation revealed the nurse changed gloves and removed the soiled dressings to the two Pressure Ulcers to the right buttock, changed gloves, cleansed the areas with wound cleanser, and applied Aquacel with Versiva. She then proceeded to change gloves and cleanse the two Pressure Ulcers to the left buttock with wound cleanser and applied Aquacel with Versiva. Further observation revealed she</p>	F 441	<p>Identification of Other Residents All residents have the potential to be affected by this practice. Residents with physician ordered dressing changes will be observed during a dressing change to monitor compliance with infection control standards; this was completed by 12-21-10 by the RN Staff Development Coordinator. Physicians' orders; such as labs and antibiotics are reviewed in the Clinical Meeting daily by the nurse management staff, including the Director of Nursing or designee, the Unit Coordinator, and the MDS Coordinator. Infections are tracked, trended and monitored through the facility's Quality Assurance Committee, the facility's Infection tracking, trending and monitoring was reviewed at the Quality Assurance Committee Meeting on 12-15-10 with the Director of Nursing, Medical Director, Administrator, QA Nurse, Medical Records Coordinators, both Social Service Directors and Pharmacy in attendance.</p>	

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F 441	<p>Continued From page 9</p> <p>removed the soiled dressing from the Pressure Ulcer on the coccyx, changed gloves, cleansed the area with wound cleanser and applied Aguacel with Versiva.</p> <p>Although the nurse performed wound care to multiple wound sites, there was no evidence she washed her hands between wound sites.</p> <p>Interview on 11/18/10 at 3:30 PM with LPN #5 revealed she normally did not wash her hands between wound sites; however, she did change her gloves between each wound site.</p> <p>Interview on 11/18/10 at 3:36 PM with the Assistant Director of Nursing (ADON), revealed staff should wash hands and change gloves between wound sites when performing dressing changes.</p> <p>2. Observation of the Medication Pass on 11/16/10 at 5:15 PM revealed Licensed Practical Nurse (LPN) #2 dropped a pill on top of the medication cart. The nurse poked up the pill with her bare hands and administered it to an unsampled resident.</p> <p>Interview with LPN #2 on 11/16/10 at 5:20 PM revealed she knew she should have discarded the dropped pill and obtained another one. She stated "I was nervous".</p>	F 441	<p>Systemic Changes</p> <p>In-servicing is currently being completed with the Licensed Nurses on the facility's infection control policy. In-service includes preventing and controlling the spread of infection by utilizing infection control practices during routine daily care of the residents, proper hand hygiene, and gloving. In-service includes the facility's Infection Control Program and process of investigating and monitoring infections to prevent the spread of illness. Licensed Nurses are being evaluated on infection control knowledge by skills competencies on proper hand washing and wound dressing changes.</p> <p>The in-services and skills competencies are being conducted by the RN Staff Development Coordinator/Assistant Director of Nursing (SDC/ADON) and trained Nursing Supervisors beginning on 12-1-10. In-servicing and skills competencies will be completed by 12-21-10. This in-service is included in the new hire orientation. The SDC/ADON coordinates and conducts orientation for newly hired employees.</p> <p>Monitoring</p> <p>Licensed Nurses will be audited quarterly by observation utilizing a skills competency checklist for wound dressing changes and hand hygiene. The results of these competencies will be submitted to the monthly Quality Assurance Committee for review, evaluation and recommendations.</p>	12-22-2010

Systemic Changes

The facility changed the contract with the Respiratory Company to clean and maintain the concentrators on a weekly basis instead of bi-weekly on 11-26-10. The facility's Quality Assurance Nurse will continue auditing the special needs equipment and services as prior to the survey, but now this audit has been updated to include the oxygen concentrators and oxygen concentrator filters for cleanliness and making sure the equipment is working properly and submitting the audits to the Director of Nursing for review.

Monitoring

The Director of Nursing will submit findings to the Quality Assurance Committee Meetings Monthly for review and recommendations.

12-22-2010

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K 000	INITIAL COMMENTS	K 000	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.	
K 062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the sprinkler system was maintained according to NFPA standards. This deficient practice had the potential to affect seven (7) of seven (7) smoke compartments, staff and all the residents. The facility has the capacity for 118 beds with a census of 89 the day of survey.</p> <p>The findings include:</p> <p>During an observation on November 17, 2010, at 11:50 a.m., with the Director of Maintenance (DOM), two (2) sprinkler heads located in the attic area, in front of the dining hall, were noted to be covered with blown in insulation. This would have kept the sprinkler heads from reacting as intended.</p> <p>An interview with the DOM on November 17,</p>	K 062	<p>RECEIVED DEC 15 2010</p> <p>K 062</p> <p><u>Corrective Actions for Targeted Residents:</u> There were no specific residents identified as affected by this practice. Maintenance audited and cleaned all sprinkler heads in the building on 11/18/10. A Full flow trip test was performed by Koorsen Fire and Security on 11/23/10.</p> <p><u>Identification of Other Residents with Potential to Be Affected:</u> All residents have a potential to be affected by this practice.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Aren Phillips</i>	TITLE <i>Administrator</i>	(X6) DATE <i>12/9/10</i>
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 062	<p>Continued From page 1</p> <p>2010, at 11:50 a.m., revealed the insulation was added back in the summer and the DOM was not aware the insulation was on the sprinkler heads. Insulation on the sprinkler heads was observed in three (3) more attic areas during the survey.</p> <p>A record review on November 17, 2010, at 1:00 a.m., revealed a full flow trip test was conducted on March 6, 2007. This test ensures the sprinkler system is operating as intended. An interview with the DOM on November 17, 2010, at 1:00 a.m., revealed the DOM was not aware this test is required every three (3) years.</p> <p>Reference: NFPA 25 (1998 edition)</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>9-1* General. This chapter shall provide the minimum requirements for the routine inspection, testing, and maintenance of valves, valve components, and trim. Table 9-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance.</p> <p>Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance</p> <table border="0"> <tr> <td>Trip test</td> <td>Annually</td> </tr> <tr> <td>Full flow trip test</td> <td>3 years</td> </tr> </table> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	Trip test	Annually	Full flow trip test	3 years	K 062	<p><u>Systemic Changes:</u> Facility added all sprinkler heads in the attic onto their Monthly Sprinkler Check form on 12/7/10 to ensure all are cleaned and maintained. The Facility updated the Fire and Safety Inspection form that is utilized for tracking of all Fire System Inspections by the Safety Committee on 12/7/10 to include Full flow trip test inspection every 3 yrs. The Safety Team was in-serviced on 12/9/10 regarding these updated forms along with completing a Monthly Fire Safety Equipment Checklist to be utilized in checking sprinkler heads during their monthly safety rounds.</p> <p><u>Monitoring:</u> The Administrator will conduct periodic audits on Monthly Sprinkler Check form completed by Maintenance to ensure all Sprinkler heads are being cleaned. The Safety Team will complete a Monthly Fire Safety Equipment Checklist during monthly rounds throughout the building, and attic to ensure all Sprinkler heads are free from debris. The Safety Team will review all inspections of the Fire System and when they are due on a monthly basis. Any issues will be brought to the Quality Assurance Committee for three months for monitoring.</p>	12-22-2010
Trip test	Annually							
Full flow trip test	3 years							
K 076	NFPA 101 LIFE SAFETY CODE STANDARD	K 076						

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K 076 SS=D	<p>Continued From page 2</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that oxygen cylinders were stored according to NFPA standards. This deficient practice had the potential to affected one (1) of seven (7) smoke compartments, staff and approximately twenty (20) residents. The facility has the capacity for 118 beds with a census of 89 the day of survey</p> <p>The findings include:</p> <p>During the Life Safety Code tour on November 17, 2010, at 10:25 a.m., with the Director of Maintenance (DOM), twenty-five (25) "E" size oxygen cylinder tanks were observed to be stored in the oxygen storage room. These tanks were within five (5) feet of combustible storage. Oxygen cylinders while in storage and in quantities greater than 300 cu. feet must be kept five (5) feet from combustibles.</p>	K 076	<p>K 076</p> <p><u>Corrective Actions for Targeted Residents:</u> There were no specific residents identified as affected by this practice. Facility divided E Tanks into two different sides of the building (two different smoke compartments) so not to exceed 12 E tanks or 300cu. feet in these areas on 12-7-10.</p> <p><u>Identification of Other Residents with Potential to Be Affected:</u> All residents have a potential to be affected by this practice. Facility is compliant with K076.</p> <p><u>Systemic Changes:</u> The Safety Team was in-serviced on the placement of the O2 tanks on 12-09-10. Facility Contract Oxygen Company was informed of this change on 12-08-10 by the Administrator. In-servicing of all staff began on 12-9-10 and will be completed by 12-21-10.</p> <p><u>Monitoring:</u> The Central Supply Clerk will conduct weekly audits to ensure facility does not exceed more than 12 e-tanks in both designated areas. The Safety Team will conduct monthly rounds to ensure oxygen is stored accordingly. Any issues will be brought to the Quality Assurance Committee for 3 months for monitoring.</p>	12-22-2010

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K 076	<p>Continued From page 3</p> <p>An interview revealed the Director of Maintenance, at the time of the observation, revealed the DOM was not aware of this requirement. Quantities 300 cu. ft. (12 E sized cylinders) and less may follow the requirements of S&C-07-10.</p> <p>Reference: S&C-07-10</p> <p>Up to 300 cu ft (12 E sized cylinders) of nonflammable medical gas can be located outside of an enclosure (per smoke compartment) at locations open to the corridor such as at a nurse 's station or in a corridor of a healthcare facility.</p> <p>This amount of nonflammable medical gas per smoke compartment is not considered a hazard if the containers are properly secured, such as in a rack to prevent them from tipping over or being damaged. In this case the medical gas is considered an "operational supply" and not storage. If the cylinders are placed in a corridor they should be placed so as not to obstruct the use of the corridor. This amount of medical gas is in addition to those cylinders contained in "crash carts" and in use on wheelchairs or gurneys.</p> <p>The term "PRN" means "as needed." An individual cylinder placed in a patient room for immediate use by a patient is not required to be stored in an enclosure and is considered in use. It should be secured to prevent tipping or damage to the cylinder. If the resident does not need the use of oxygen for an extended period of time, such as several days, then the medical gas container should be removed from the room and properly secured in an approved storage room.</p> <p>Reference: NFPA 99 1999 edition</p>	K 076		

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K 076	<p>Continued From page 4</p> <p>8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³)</p> <p>(A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry.</p> <p>(B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor.</p> <p>(C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following:</p> <p>(1) A minimum distance of 6.1 m (20 ft)</p> <p>(2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems</p> <p>(3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.</p> <p>8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p>	K 076		
K 144 SS=F		K 144		

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K 144	<p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Based on an interview, the facility failed to maintain the generator set by NFPA standards. This deficient practice had the potential to affected seven (7) of seven (7) smoke compartments, staff and eighty nine (89) residents. The facility has the capacity for 118 beds with a census of 89 the day of survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on November 17, 2010 at 10:15 a.m., an interview with the Director of Maintenance (DOM) at the generator transfer switch revealed the DOM was not aware the generator transfer switch was required to be tested monthly. Monthly testing ensures this switch remains operational. There was no documented evidence the facility provided monthly testing as required.</p> <p>Reference: NFPA 110 1999 edition</p> <p>6-4:5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 144	<p>K 144</p> <p><u>Corrective Actions for Targeted Residents:</u> There were no specific residents identified as affected by this practice. The Maintenance Department was in-serviced on 11-18-10 on regarding how to manually start the generator by the transfer switch on 11-18-10 by the Manufacturer of the generator. The Maintenance Department manually started the generator via the transfer switch on 11-18-10 without incident.</p> <p><u>Identification of Other Residents with Potential to Be Affected:</u> All residents have a potential to be affected by this practice.</p> <p><u>Systemic Changes:</u> The Maintenance Department has added the manual start of generator via the transfer switch onto their monthly audit form to ensure this is completed. The Safety Team was in-serviced regarding the transfer switch being tested monthly and on the updated audit sheet for tracking the testing of the Transfer Switch. The Maintenance Director will be responsible for ensuring this test is completed monthly.</p> <p><u>Monitoring:</u> The Maintenance Director will bring audit sheets to the Monthly Safety Committee Meeting for review. Any issues will be brought to Quality Assurance Committee for three months for monitoring.</p>	12-22-10
K 147	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		

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K 147 SS=D	<p>Continued From page 6</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, the facility failed to ensure electrical power strips were being used in an approved manner. This deficient practice had the potential to affected two (2) of seven (7) smoke compartments, staff and three (3) residents. The facility has the capacity for 118 beds with a census of 89 the day of survey</p> <p>The findings include:</p> <p>During the Life Safety Code tour on November 17, 2010 at 11:00 a.m., with the Director of Maintenance (DOM), a nebulizer and electrical bed cord was observed to be plugged into a multi outlet adapter (power strip) in resident room number 20. Generally power strips with surge protection may be used for resident television, computers, radios etc., on an as needed basis, but not to be used with medical equipment to help prevent against electrical shock.</p> <p>An interview on November 17, 2010 at 11:00 a.m., with the DOM revealed the DOM was aware that power strips should not be used with medical equipment. During the survey resident room numbers 31 and 51 were also observed to be using medical equipment with power strips.</p> <p>Reference; NFPA 99 1999 edition</p>	K 147	<p>K 147</p> <p><u>Corrective Actions for Targeted Residents:</u> There were three specific residents identified as affected by this practice. Facility Maintenance Staff removed Medical Equipment that was plugged into power strip in rooms 20, 31 and 51 on 11/18/10 and plugged into appropriate receptacles. The facility Maintenance staff audited all rooms to ensure no medical equipment was plugged into power strips in all other resident rooms on 11/18/10.</p> <p><u>Identification of Other Residents with Potential to Be Affected:</u> All residents have a potential to be affected by this practice.</p> <p><u>Systemic Changes:</u> All staff will be in-serviced regarding the use of power strips beginning 12/8/10-12/21/10. The Facility Maintenance Staff Conducted an audit on 11/18/10 regarding which rooms needed additional receptacles to avoid the need for power strips, extension cords, etc. The Maintenance Staff will install additional receptacles in rooms 20, 31 and 51 and any identified needed rooms by 12/21/10. The Safety Team was in-serviced on 12/9/10 on this requirement along with their responsibility of reporting any issues found during their monthly room rounds.</p>	

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K 147	Continued From page 7 3-3.2.1.2 D 2. 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	<u>Monitoring:</u> The Maintenance Staff will be responsible for doing monthly audits of rooms to ensure enough receptacles are available to keep from using power strips, etc. for Medical Equipment. The Safety Team will complete Monthly room rounds and will report any rooms found to need additional receptacles to Maintenance. Any issues will be brought to the Quality Assurance Committee for three months for monitoring.	12-22-2010