

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

PRINTED: 04/05/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ APR 2012 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/22/2012
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 6TH ST. LA CENTER, KY 42056
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>An annual recertification survey was conducted on 03/20/12 through 03/22/12 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S of an "E."</p> <p>F 225 SS=D 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported</p>	F 000	<p>"The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws."</p> <p>F 225 The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and the other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <ol style="list-style-type: none"> Resident(s) affected by alleged deficient practice: <ul style="list-style-type: none"> Resident #17 no longer resides at the facility. Residents #10 and #11 were both assessed by a licensed nurse and found to have no signs or symptoms of injury. Residents with potential to be affected by alleged deficient practice: <ul style="list-style-type: none"> All facility incident reports for the past 3 months, will be reviewed by the Administrator / Nurse Management team by 04/27/2012, to ensure incidents of unknown origin had been investigated. Resident Council minutes for the past 3 months will be reviewed by the Administrator by 04/27/2012, to 	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dinger Atkins</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>04-11-12</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1</p> <p>to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedures, it was determined the facility failed to report complaints involving a Certified Nurse Aide (CNA) #1, who was reported to be verbally and physically rough with two residents (#10 and #11), in the selected sample of fifteen residents, and with one resident (#17), not in the selected sample.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure "Incident Management Policy," revised 2008, revealed incidents which result from alleged physical injury and/or verbal abuse, elopement, or incidents which result in physical injury and require medical treatment outside the facility will be immediately reported to the Director of Nursing (DON) or designee and the Executive Director. A review of the facility's policy/procedure "Abuse and/or Neglect Investigation," revised 02/09, revealed if the accused individual is an employee, they will be placed on suspension, pending results of the investigation.</p> <p>A review of the Inservice records, dated April 2011 through June 2011, revealed both CNA #1 and</p>	F 225	<p>ensure any reports of abuse or neglect had been investigated.</p> <p>3. Systems to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> Administrator provided education to all Department Directors on April 10, 2012 on facility policy related to reporting and investigating allegations of abuse. Administrator provided the following education: Beginning 03/27/2012, staff inserviced on facility policy and procedures related to reporting and investigation of allegations of abuse and neglect. Education to include providing safety for residents, documenting any incidents, and initiating investigations. Education will be completed for all staff by 04/27/2012. Upon any reports of allegation of abuse or neglect, Administrator or designee will immediately initiate safety measure for any resident involved as well as an investigation. Administrator provided education on abuse and neglect prevention and reporting to resident council on April 10, 2012. Education will be completed monthly by Administrator or designee. All noted education will be completed at General Orientation, quarterly, and as needed. <p>4. Monitoring to ensure alleged deficient practice does not recur:</p>	

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F 225	<p>Continued From page 2</p> <p>CNA #2 were inserviced on the Abuse/Neglect policies.</p> <p>A record review revealed the facility admitted Resident #17 on 07/19/09 with diagnoses to include Senile Dementia, Paranoid State and Malaise and Fatigue. There was no evidence of any incidents, abuse or neglect found in the record. A review of the significant change Minimum Data Set (MDS) assessment, dated 03/02/12, revealed Resident #17 was severely cognitively impaired and all care needs and decisions were made by the staff. He/she was bedfast, incontinent of bowel and bladder, and required the total assistance of two staff members with bed mobility. The resident was on comfort measures since 08/05/11, and expired at the facility on 03/09/12.</p> <p>A record review revealed the facility admitted Resident #10 on 07/31/08 with diagnoses to include Alzheimer's Dementia, Insomnia and Osteoporosis. Further review revealed the resident was totally dependent on staff for all care needs and decisions. There was no evidence of any incidents, abuse or neglect found in the record.</p> <p>A record review revealed the facility admitted Resident #11 on 09/21/07 with diagnoses to include Alzheimer's Disease and Peripheral Vascular Disease. Further review revealed the resident was severely cognitively impaired and was totally dependent on staff for all care needs. There was no evidence of any incidents, abuse or neglect found in the record.</p> <p>An interview with CNA #2, on 03/20/12 at 3:20</p>	F 225	<ul style="list-style-type: none"> • 24 hour report sheets and incident reports will be reviewed daily by Administrative team, Monday-Friday, and by Nurse Unit Manager on Saturday-Sunday. Administrator or designee will be responsible to ensure procedures are implemented and investigations are completed and documented for any potential allegations of abuse. • Resident Council minutes will be reviewed monthly by the Administrator for any allegations of abuse or neglect that may not have been reported. • Results of all investigations will be reported to Regional Vice President or Regional Director of Clinical Services to ensure policy and procedure was followed and a thorough investigation has been completed. • A log of all reportable incidents will be maintained by the Administrator. Audit will be completed monthly x 3 months of log to ensure complete investigation has been done. • Results of audits will be brought to the monthly Performance Improvement Committee to determine the need for further monitoring and updating the plan as needed. Appropriate action plans will be reviewed and revised as needed. 	04/30/12

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F 225	Continued From page 3 PM, revealed she was involved in identifying abuse and neglect and reported several times to the licensed staff; however, nothing was done until a family member voiced a complaint and a report was made. Further interview with CNA #2, on 03/21/12 at 1:25 PM, revealed she was a preceptor for CNA #1 during CNA #1's orientation process. During provision of care for Resident #17 and an attempt to turn the resident in the bed, CNA #2 stated that CNA #1 was observed to "grab the draw sheet and banged [his/her] head against the wall while turning [him/her]." CNA #2 reported this incident to Registered Nurse (RN) #2. CNA #2 stated CNA #1 was allowed to finish the shift and it appeared that "nothing was done." CNA #2 revealed she told the Housekeeping Supervisor about the incident, who told CNA #2 to report it to the Administrator. However, CNA #2 stated she did not report the incident to the Administrator, because after a couple of nights, CNA #1 seemed to "be better," so she thought someone had spoken to her. An interview with CNA #2, on 03/21/12 at 2:05 PM, revealed that CNA #1 was "rough" with two more residents (#10 and #11) as well. CNA #2 stated that CNA #1 did not explain to Resident #10 that she would be turning him/her in the bed; CNA #1 turned the resident abruptly and startled the resident. CNA #2 stated she "took over" at that point and CNA #1 left the room. CNA #2 finished turning/repositioning Resident #10 and then went to Resident #11's room. She revealed, upon her arrival to Resident #11's room, CNA #1 had "pushed [him/her] over" in the bed. After this episode, CNA #2 reported to Licensed Practical Nurse (LPN) #3, that CNA #1 was "too rough with the residents." CNA #2 stated LPN #3 notified the Director of Nursing (DON) and left a	F 225		

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F 225	<p>Continued From page 4 message, and also left a note on the DON's door.</p> <p>An interview with LPN #3, on 03/21/12 at 10:50 AM, and at 3:18 PM, revealed CNA #2 did not report to her about anyone being rough with any of the residents. LPN #3 stated "if she did report, I would have removed the CNA and there would have been an investigation." She revealed she did not notify the DON or place a note on the DON's office door. She stated she would have notified the DON immediately and removed the CNA from care if a report had been made.</p> <p>An interview with the Housekeeping Supervisor, on 03/21/12 at 2:53 PM, revealed CNA #2 "texted" her, and mentioned that a CNA spoke harshly to one of the residents. She stated she told CNA #2 to report it to her supervisor.</p> <p>An interview with RN #2, on 03/21/12 at 4:34 PM, revealed she left employment in May 2012, and had never worked with either of the CNAs (#1 or #2). She did not recall a report about a CNA "being rough" with the residents.</p> <p>An interview with the DON, on 03/22/12 at 9:15 AM, revealed she did not recall a note being left on her door, or a message left on her answering machine regarding CNA #1. She stated there was only one complaint regarding CNA #1, and that was made by another resident's family member.</p> <p>An interview with CNA #2, on 03/21/12 at 2:22 PM revealed "I should have told another supervisor or the Administrator."</p> <p>An interview with the Administrator, on 03/21/12</p>	F 225		

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F 225	Continued From page 5 at 3:07 PM and at 3:35 PM, revealed there were no reports made to her regarding CNA #1 about roughness, harsh talk or abuse of residents, until a family member complained, on 06/15/11. The resident in question required assistance of one person and [he/she] could pivot on one foot at that time. When CNA #1 assisted the resident to the rocker recliner, the seat fell forward and caused the resident to rock backwards, and the family complained. An interview, on 03/21/12 at 1:10 PM and at 1:51 PM, with two family members, felt the incident was handled well by the Administrator and had no concerns. Further interview, at 3:42 PM, revealed after another falls incident involving CNA #1, on 06/17/11, the CNA was suspended, and then terminated on 06/21/11 due to poor work performance.	F 225		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to ensure services provided or arranged by the facility met professional standards of quality for one resident (#18), not in the selected sample, related to the failure to accurately transcribe the physician's orders to the monthly Medication Administration Records (MARs). Findings include:	F 281	F 281 The services provided or arranged by the facility must meet professional standards of quality. 1. Resident(s) affected by alleged deficient practice. <ul style="list-style-type: none"> Physician responsible for Resident #18 was contacted 03/21/12 to make clarification for Lasix dosage and frequency. Clarification order written for 03/01/12, indicated resident #18 had received accurate dosing. 2. Residents with potential to be affected by alleged deficient practice. <ul style="list-style-type: none"> 100% audit completed by Nursing Management on 03/22/12-03/23/12. Audit done to ensure accuracy of all physician order sheets as compared to Medication Administration Records/MD orders. Any discrepancies identified, MD was notified and clarification orders written. 3. Systems to ensure alleged deficient practice does not recur: <ul style="list-style-type: none"> DON or Staff Development Coordinator initiated education to nurses on the proper procedure of monthly recaps. Education will be completed on 4/27/12. Monthly reviews will be validated through reviewing resident's chart, 	

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F 281	<p>Continued From page 6</p> <p>A review of the facility's policy/procedure, "Monthly Recaps," undated, revealed "each month the newly printed physician's orders and administration records are reviewed by nursing staff and compared to the current month's orders and administration records to ensure accuracy." This would include comparing the newly printed physician's orders and current physician's orders for updated orders, discontinued orders, new orders, and comparing the MARs to the newly printed MARs, and then comparing the MARs to the physician's orders for accuracy.</p> <p>A record review revealed the facility admitted Resident #18 on 12/28/11 with diagnoses to include Diabetes and History of Gastric By-Pass Surgery.</p> <p>A review of the physician's order, dated 02/22/12, revealed Lasix 20 milligrams (mg) by mouth (po) twice a day; however, this order was not transcribed over to the current monthly orders for March 2012. A review of the physician's orders, dated March 2012, revealed no evidence of an order for Lasix.</p> <p>An observation of a medication pass, on 03/21/12 at 9:25 AM, revealed Licensed Practical Nurse (LPN) #1 administered Lasix 20 mg po to Resident #18.</p> <p>An interview with LPN #1, on 03/21/12 at 9:45 AM, revealed the 02/22/12 physician's order for Lasix 20 mg was not transcribed to the current monthly physician's orders and MARs. The licensed nurse who compared the monthly MAR and the physician's order "probably did not go back and verify the telephone orders."</p>	F 281	<p>medication in cart, and validation/notification through pharmacy, before making changes, noting the strength, dosage, and times of medication before administration.</p> <p>4. Monitoring to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> DON or designee will audit 6 recaps per month x 3 months, then 3 recaps per month x 2 months to ensure accuracy. DON or designee will audit 10 charts with new orders/week matching MD orders, telephone orders, medication in cart, and note any discrepancy for 4 weeks x 1 month, then monthly x 3 months. Nursing Administration will provide on-going education as indicated for non-compliance. Results of audits will be brought to the monthly Performance Improvement committee to determine the need for further monitoring and updated the plan as needed. Appropriate actions plans will be reviewed and revised as needed. 	04/30/12

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F 281	Continued From page 7 An interview with Registered Nurse (RN) #1, on 03/21/12 at 10:00 AM, revealed the licensed nurses compared each monthly MAR, instead of comparing the MAR to the current physician's order. She was unaware if the physician was contacted to ensure whether or not he still wanted the resident to be on Lasix. An interview with the Director of Nursing (DON), on 03/21/12 at 10:05 AM, revealed the procedure for checking monthly orders was to compare the MARs to the most current physician's orders. This had been reviewed many times with the staff, and she was unsure why this occurred. If there was a conflict regarding the physician's orders, the physician should be notified and the order should be clarified.	F 281		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure one	F 315	F 315 483.23 (d) No Catheter, Prevent UTI, restore Bladder 1. Resident(s) affected by alleged deficient practice: • Resident #3 no longer resides at the facility. 2. Residents with potential to be affected by alleged deficient practice: • All residents requiring foley catheter will be reviewed by DON or designee to ensure no signs or symptoms of UTI exist. MD notification will be made and treatment plans developed as necessary. Completion date: 04/27/12. • All residents benefit from proper procedure for peri care. 3. Systems to ensure alleged deficient practice does not recur: • Nursing administration initiated education on proper Peri-Care / Catheter Care procedures with skills check-off. Emphasis on proper glove changes and hand washing. Completion date: 04/27/12. • Ongoing education will be provided in Nursing General Orientation, annually as skills check-off, and more often as indicated by Nursing Administration. 4. Monitoring to ensure alleged deficient practice does not recur:	

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F 315	<p>Continued From page 8</p> <p>resident (#3), in the selected sample of fifteen residents, received appropriate treatment and services to prevent a urinary tract infection (UTI). During observation of catheter care, on 03/21/12, Certified Nurse Aide (CNA) #3 completed Resident #3's perineal care, and then proceeded to provide catheter care to Resident #3 without changing her gloves or washing her hands.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Personal Hygiene Care for the Female Resident," undated, revealed, "Always proceed from the least contaminated area to the most contaminated area. Separate labia and wash urethral area first wiping downward from front to back. If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about three (3) inches."</p> <p>A record review revealed the facility admitted Resident #3 on 07/18/11 with diagnoses to include Circulatory Disease, Hypertension, Urethral Strictures and Acute Renal Failure. A review of the quarterly Minimum Data Set (MDS), dated 02/28/12, revealed the resident required extensive assistance with Activities of Daily Living (ADLs) and had an indwelling catheter.</p> <p>An observation of catheter care, on 03/21/12 at 11:22 AM, revealed CNA #3 provided perineal care, with stool noted on the disposable wipe after the wipe was used. Catheter care was immediately completed, spreading the labia area and cleaning the catheter tubing, utilizing the same gloves used for perineal care.</p>	F 315	<ul style="list-style-type: none"> • DON or designee will audit proper procedure for completion of foley catheter care 3 x per week, for 1 month, then 1 x per week for 1 month, then 2 per month for 3 months. • Results of the audits will be brought to the monthly Performance Improvement Committee to determine the need for further monitoring and updating the plan as needed. Appropriate action plans will be reviewed and revised as needed. 	04/30/12

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F 315

Continued From page 9
An interview with CNA #3, on 03/22/12 at 1:30 PM, revealed she should have changed her gloves and washed her hands in between the provision of perineal care and catheter care.

F 315

F371 The facility must (1)Procure food considered satisfactory by Federal, State, or Local authorities; and (2)Store, prepare, distribute and serve food under sanitary conditions.

F 371
SS=E

An interview with the Director of Nursing (DON), on 03/22/12 at 9:17 AM, revealed she expected the staff to change gloves between the provision of perineal care and catheter care.

483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

F 371

1. Residents affected by alleged deficient practice.
 - Dietary services manager provided immediate education to the dietary staff members for proper storage.
 - Area over range will be cleaned and painted to remove rust. Completion by 04/27/12.
2. Residents with potential to be affected by alleged deficient practice:
 - All residents benefit from sanitary food storage and preparation. No residents were affected by alleged deficient practice.
3. Systems to ensure alleged deficient practice does not recur:
 - Registered Dietitian to provide inservice to Dietary Manager and dietary staff on proper storage of food containers, as well as cleaning procedures for food preparation and service areas.
 - Drying rack for bonnets and bases was ordered by facility on 04/10/12, pending delivery.
4. Monitoring to ensure alleged deficient practice does not recur:
 - Weekly sanitation audits will be conducted by the dietary manager, with a monthly audit being completed by the Consultant RD. Audit will include visual

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and review of the facility's census and condition form, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions related to an accumulation of rust-colored substances on the back area of the range hood and the pipes over the range burners. Additionally, there was standing water in the bottom of plates and bonnets which were stored near the food debré sprayer and the dirty dish area.

A review of the facility's Census and Condition

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 6TH ST. LA CENTER, KY 42056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 371	<p>Continued From page 10</p> <p>form, dated 03/22/12, revealed the census was 61. It was determined 59 of 61 residents were served food that was stored and prepared in the facility's kitchen.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. An observation of the cooking surfaces, on 03/20/12 at 10:50 AM, revealed a build-up of a rust-colored substances on the back wall of the range hood and the pipes directly over the range burners. <p>An interview with the Dietary Manager, on 03/22/12 at 12:15 PM, revealed the rust-colored surfaces were inspected by the company that serviced the range hood and they did not mention this being a problem. However, the Dietary Manager was unaware of whose responsibility it was to clean the rusted area of the range hood, or when the hood and pipes were last cleaned.</p> <ol style="list-style-type: none"> 2. An observation of the kitchen and food service areas, on 03/22/12 at 12:15 PM, revealed approximately 55 plate bottoms and bonnets, were stored on the stainless steel counter next to the dirty dish area and the opening to the dining room. Out of the 55 bonnets and bottoms, approximately 20 had standing water noted on the inside and were stacked inside each other with no way for the water to drain out. Approximately 12 inches from the bonnets and bottoms were trays and dirty dishes stacked from the noon meal. <p>An interview with the Dietary Manager, on 03/22/12 at 12:20 PM, revealed the kitchen storage space was very limited and there was no</p>	F 371	<p>observation of storage of food service items as well as cleanliness of areas over range. On-going.</p> <ul style="list-style-type: none"> • Results of the audits will be brought to the monthly Performance Improvement Committee to determine the need for further monitoring and updating the plan as needed. Appropriate action plans will be reviewed and revised as needed. <p>04/30/12</p>

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F 371	Continued From page 11 other place to stack the bonnets and bottoms. The Dietary Manager was aware of the need to store the materials away from the dirty dish area and in a way to promote drainage, yet did not have the available space or materials to do this.	F 371	F 441 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.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	1. Resident(s) affected by alleged deficient practice: <ul style="list-style-type: none"> Resident #3 no longer resides at the facility. 2. Residents with potential to be affected by alleged deficient practice: <ul style="list-style-type: none"> All residents requiring foley catheter will be reviewed by DON or designee to ensure no signs or symptoms of UTI exist. MD notification will be made and treatment plans developed as necessary. Completion date: 04/27/12. All residents benefit from proper procedure for peri care. 3. Systems to ensure alleged deficient practice does not recur: <ul style="list-style-type: none"> Nursing administration initiated education on proper Peri-Care / Catheter Care procedures with skills check-off. Emphasis on proper glove changes and hand washing. Completion date: 04/27/12. Ongoing education will be provided in Nursing General Orientation, annually as skills check-off, and more often as indicated by Nursing Administration. 4. Monitoring to ensure alleged deficient practice does not recur:	

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F 441	<p>Continued From page 12</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to help prevent the development and transmission of disease and infection, for one resident (#3), in the selected sample of fifteen residents. During observation of catheter care, on 03/21/12, Certified Nurse Aide (CNA) #3 completed Resident #3's perineal care, and then proceeded to provide catheter care to Resident #3 without changing her gloves or washing her hands.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Personal Hygiene Care for the Female Resident," undated, revealed, "Always proceed from the least contaminated area to the most contaminated area. Separate labia and wash urethral area first wiping downward from front to back. If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about three (3) inches."</p> <p>A record review revealed the facility admitted Resident #3 on 07/18/11 with diagnoses to include Circulatory Disease, Hypertension, Urethral Strictures and Acute Renal Failure. A</p>	F 441	<ul style="list-style-type: none"> DON or designee will audit proper procedure for completion of foley catheter care 3 x per week, for 1 month, then 1 x per week for 1 month, then 2 per month for 3 months. Results of the audits will be brought to the monthly Performance Improvement Committee to determine the need for further monitoring and updating the plan as needed. Appropriate action plans will be reviewed and revised as needed. 	04/30/12

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F 441	<p>Continued From page 13</p> <p>review of the quarterly Minimum Data Set (MDS), dated 02/28/12, revealed the resident required extensive assistance with Activities of Daily Living (ADLs) and had an indwelling catheter.</p> <p>An observation of catheter care, on 03/21/12 at 11:22 AM, revealed CNA #3 provided perineal care, with stool noted on the disposable wipe after the wipe was used. Catheter care was immediately completed, spreading the labia area and cleaning the catheter tubing, utilizing the same gloves used for perineal care.</p> <p>An interview with CNA #3, on 03/22/12 at 1:30 PM, revealed she should have changed her gloves and washed her hands in between the provision of perineal care and catheter care.</p> <p>An interview with the Director of Nursing (DON), on 03/22/12 at 9:17 AM, revealed she expected the staff to change gloves between the provision of perineal care and catheter care.</p>	F 441		

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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: 1967</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (000)</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 03/22/12. Life Care Center of Lacerter was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for seventy (70) beds and the census was sixty one (61) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>“The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws.”</p> <p>K 027 Door openings in the smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core.</p> <ol style="list-style-type: none"> The cross-corridor doors located next to room 212, will be repaired by a contracted company to ensure they close properly. Hardware for doors was ordered 04/03/12. All other facility doors were evaluated by the Maintenance Department for proper closure, no other problems were identified. The Maintenance Department was inserviced by the Administrator to monitor doors for proper closure on 04/10/2012. The Maintenance Department will audit doors to ensure that the smoke doors close properly and appropriate smoke barrier is maintained weekly x 4 weeks then monthly x 2 months. Results of the audit will be reviewed by the Performance Improvement (PI) committee to determine need for further monitoring. Completion Date: 05/01/2012 	05/01/12
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Singer Atkins</i>	TITLE Executive Director	(X6) DATE 06/12/12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1	K 000			
K 027 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</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 two (2) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for seventy (70) beds and the census was sixty one (61) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 03/22/12 at 12:50 PM, with the Administrator and Maintenance Director revealed the cross-corridor doors located next to room 212, would not close completely when tested,</p>	K 027			

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K 027	Continued From page 2 leaving a gap of approximately one-half of an inch or greater between the pair of doors and would not resist the passage of smoke. Interview, 03/22/12 at 12:50 PM, with the Administrator and Maintenance Director revealed they were unaware the doors would not close all the way leaving a gap between the doors in the closed position and acknowledged the doors would not resist the passage of smoke in the event of an emergency. Reference: NFPA 101 (2000 edition)	K 027	K 029 One hour fire rated construction or an approved automatic fire extinguisher system 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.	
K 029 SS=D	8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. 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	K 029	<ol style="list-style-type: none"> Private contractor will be hired to evaluate structural plans and need for addition of door to separate dry storage area. Maintenance inspected all other doors to ensure they function and close properly by 04/10/12. The Maintenance Department was inserviced on the requirements of Protection of Hazards in accordance with NFPA standards by the Administrator on 04/10/12. The Maintenance Department will audit doors to ensure that the self closing devices are in working order weekly for 4 weeks then monthly x 2. Results of audits will be reviewed by the PI committee to determine need for further monitoring. Date Completed: 06/20/2012 	<p><i>Handwritten notes:</i> Call per phone conversation w/ G.P. 06/14/12 Changes to date Contract signed 05/04/12 6/20/12</p>

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K 029	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for seventy (70) beds and the census was sixty one (61) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 03/22/12 at 1:00 PM, with the Administrator and Maintenance Director revealed the dry storage area did not have a door that would resist the passage of smoke with a self closing device.</p> <p>Interview, on 03/22/12 at 1:00 PM, with the Administrator and Maintenance Director revealed they were not aware the area needed to have a door with a self closing device.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>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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K 029	Continued From page 4 from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029	K 038 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1.19.2.1 1. Proper signage for delayed egress doors was purchased and posted on doors at the end of 100 hall and front door, completed 04/05/12. 2. All other delayed egress doors were checked to ensure proper signage. 3. Maintenance Department was educated by Administrator on need for proper signage on exit doors, completed 04/10/12. 4. Maintenance Department will audit doors monthly x 4 months, to ensure proper signage. Results of audit will be reviewed by PI committee. 5. Completion Date: 04/05/12	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		4/15/12

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K 038	<p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for seventy (70) beds and the census was sixty one (61) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 03/22/12 between 9:19 AM and 10:00 AM, with the Administrator and Maintenance Director revealed the delayed egress doors located at each end of the 100 hall and the front door, did not have the required signage stating the door was equipped with a fifteen (15) second delay before opening.</p> <p>Interview, on 03/22/12 between 9:19 AM and 10:00 AM, with the Administrator and Maintenance Director revealed they were aware the delayed egress signage was to be on the exit doors but stated that the signs had been removed.</p> <p>Reference:</p> <p>NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving</p>	K 038		
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 5TH ST. LA CENTER, KY 42056
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 038	<p>Continued From page 6</p> <p>low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the</p>	K 038		
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K 038	<p>Continued From page 7</p> <p>door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.</p> <p>7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors.</p>	K 038		

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K 038	Continued From page 8 Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.	K 038	K 047 Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 1. Exit and directional signage for 200 hall and rehab/laundry area will be evaluated and corrected by a contracted company. 2. All facility exit signage will be evaluated by contracted company to ensure compliance. 3. The Maintenance Department was inserviced by the Administrator on 04/10/12 on the standard for signage. 4. Exit and directional signage will be monitored monthly by Maintenance Director or designee, during planned fire drills. Any issues will be reported to the PI committee for recommendations. 5. Completion Date: 05/14/12		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for seventy (70) beds and the census was sixty one (61) on the day of the survey.	K 047		5/14/12	

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 6TH ST. LA CENTER, KY 42056		
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K 047	Continued From page 9 The findings include: Observation, on 03/22/12 between 9:19 AM and 1:00 PM, with the Administrator and Maintenance Director revealed egress paths to exits from the conference room toward the 200 hall, the area next to rehab and laundry, were not identified with directional and exit signage. Further observation showed the exit signs were only on one side of the smoke doors on the 200 hall. Interview, 03/22/12 between 9:19 AM and 1:00 PM, with the Administrator and Maintenance Director revealed they were unaware the signage was not complete. The Administrator agreed the signage could be confusing in the event of an emergency. Reference: NFPA 101 (2000 edition) 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.	K 047	K 054 All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 1. Documentation was received from contract company showing the facility to be in compliance with this standard. Testing was completed 12/10/2010, with next date due 12/2012. 2. Testing will be completed by contracted company within regulations. 3. Maintenance Director inserviced by Administrator on 04/10/12 on proper documentation of scheduled maintenance. 4. Scheduled maintenance will be completed in accordance with facility Preventive Maintenance program. Any discrepancies reported to Administrator. 5. Completion Date: 04/10/2012		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3	K 054		04/10/12	

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K 054	<p>Continued From page 10</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure smoke detectors were inspected and tested in accordance with NFPA Standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for seventy (70) beds and the census was sixty one (61) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 03/22/12 at 9:56 AM, with the Administrator and Maintenance Director revealed no documentation of a Smoke Detector Sensitivity Test being performed on the fire alarm smoke detectors within the last two years. Smoke detectors must be tested according to NFPA 72 (1999 edition) to ensure their reliability.</p> <p>Interview, on 03/22/12 at 9:56 AM, with the Administrator and Maintenance Director revealed he was unaware the facility did not have a current sensitivity test on the fire alarm smoke detectors. The Maintenance Director also called the company that does the testing and they confirmed that the testing is outside of 2 years.</p> <p>Reference: NFPA 72 (1999 edition)</p> <p>7-3.2.1* Detector sensitivity shall be checked within 1 year after</p>	K 054			

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K 054	<p>Continued From page 11 installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer ' s calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</p>	K 054		
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K 054	Continued From page 12 Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced. Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.	K 054	K 056 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 portion 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.	
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 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	K 056	<ol style="list-style-type: none"> 1. Sprinkler system was evaluated by contracted professional on 04/09/12. One quick action sprinkler head was identified on the front porch, with 4 in the front lobby. Evaluation of the other areas of the facility found only standard response sprinkler heads. Sprinkler heads of different styles were found, but all had the same action characteristics. 2. Sprinkler heads for the front porch as well as the entire compartment contained in the front lobby will be scheduled for replacement by a contracted professional. 3. Maintenance Department and Administrator toured facility with contracted professional on 04/09/12 to review every sprinkler head in facility. Education on types of sprinkler heads was provided at that time. 4. Inspection of sprinkler system including sprinkler heads will be conducted quarterly by contracted company. Issues will be reported to Administrator for correction. 5. Completion Date: 04/20/2012 	4/20/12

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K 056	Continued From page 13 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 four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for seventy (70) beds and the census was sixty one (61) on the day of the survey. The findings include: Observation, on 03/22/12 between 9:19 AM and 1:00 PM, with the Administrator and Maintenance Director revealed a standard response sprinkler head and a quick response sprinkler head in the same compartment located throughout the facility. Further observation showed the same on the front porch. Interview, on 03/22/12 between 9:19 AM and 1:00 PM, with the Administrator and Maintenance Director 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. Reference: NFPA 13 (1999 Edition) 7-2.3.2.4 Where listed quick-response sprinklers are used	K 056		

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K 056	Continued From page 14 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.	K 056	K 062 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 1. Contracted company replaced gauge on the sprinkler riser on 04/09/12. Contracted company added a sprinkler head wrench as well as appropriate spare sprinkler heads to box on 04/09/12. Sprinkler heads on front porch were replaced 04/09/12. Sprinkler heads in dietary department and clean utility room will be replaced by contracted company. Contracted company will be consulted about closet shelves on 100 hall, replacement will be made. 2. All sprinkler heads were assessed by contracted company on 04/09/12, any additional issues were identified. 3. The Maintenance Department was inserviced on the requirements for the sprinkler head box, maintenance of sprinkler heads, and proper storage under sprinkler heads by the Administrator on 04/10/12. 4. Maintenance Director will audit the sprinkler box to ensure it contains a wrench weekly x 4 weeks then monthly x 2. Sprinkler heads will be monitored by Maintenance Director visually for any corrosion or paint with monthly preventive maintenance rounds. Sprinkler heads will also be monitored quarterly by contracted company. Closets will be monitored by department managers to ensure storage is appropriate. 5. Completion Date: 04/20/12	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		4/20/12

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K 062	<p>Continued From page 15</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for seventy (70) beds and the census was sixty one (61) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 03/22/12 between 9:19 AM and 1:00 PM, with the Administrator and Maintenance Director revealed the facility failed to provide to provide documentation that the gauge on the sprinkler riser had been calibrated within the last 5 years.</p> <p>Interview, on 03/22/12 between 9:19 AM and 1:00 PM, with the Administrator and Maintenance Director revealed they were not aware the gauges on the sprinkler riser had to be calibrated once every 5 years.</p> <p>Observation, on 03/22/12 between 9:19 AM and 1:00 PM, with the Administrator and Maintenance Director revealed there was not a sprinkler head wrench located in the box with the spare sprinkler heads.</p> <p>Interview, on 03/22/12 between 9:19 AM and 1:00 PM, with the Administrator and Maintenance Director revealed they were unaware that a sprinkler head wrench was required to be with the spare sprinkler heads.</p>	K 062		
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K 062	<p>Continued From page 16</p> <p>Observation, on 03/22/12 between 9:19 AM and 1:00 PM, with the Administrator and Maintenance Director revealed the sprinkler heads on the front porch had been corroded along with the ones in the dishwashing room. Further observation showed the sprinkler head in the clean utility room had been painted.</p> <p>Interview, on 03/22/12 between 9:19 AM and 1:00 PM, with the Administrator and Maintenance Director revealed they were unaware the sprinkler heads had corroded. Further interview about the painted sprinkler head revealed they were unaware the sprinkler head had been painted in the clean utility room.</p> <p>Observation, on 03/22/12 between 9:19 AM and 1:00 PM, with the Administrator and Maintenance Director revealed the closets on the 100 hall had a shelf installed across the top that was installed within 18 " of the sprinkler heads.</p> <p>Interview, on 03/22/12 between 9:19 AM and 1:00 PM, with the Administrator and Maintenance Director revealed they were unaware the shelves were installed to close to the sprinkler head.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing</p>	K 062		

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K 062	Continued From page 17 shall comply With 5-5.5.2. 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. 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.	K 062		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/22/2012
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 5TH ST. LA CENTER, KY 42056	
(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 062	Continued From page 18 Reference: NFPA 25 (1998 Edition). 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections. 10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel. Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected,	K 062		

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K 062	Continued From page 19 tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1	K 062		

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42066	
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K 062	Continued From page 20 Obstruction investigation Maintenance 5 years or as needed Chapter 10	K 062	<p>K 064 Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1.19.3.5.6, NFPA 10</p> <ol style="list-style-type: none"> Tables blocking wall mounted fire extinguisher and pull for the hood were removed. Contracted company will relocate pull for the hood and portable extinguisher to ensure standards are met. Dietary department educated by maintenance director on blocking fire extinguishers and pull box, on 04/13/12 Blockage of fire extinguisher and pull box will be monitored weekly x 4 weeks, then monthly x 3 weeks by dietary manager. Results of audit will be reported to PI committee for recommendations. Completion Date: 04/30/2012 	04/30/12
K 064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain the installation of portable fire extinguishers in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for seventy (70) beds and the census was sixty one (61) on the day of the survey.</p> <p>Findings include:</p> <p>Observations, on 03/22/12 at 11:45 AM, with the Administrator and Maintenance Director revealed the wall mounted, portable fire extinguisher in the Kitchen was blocked by a table. Further observation showed the pull for the kitchen hood suppression was also blocked by an additional table.</p> <p>Interview, on 03/22/12 at 11:45 AM, with the Administrator and Maintenance Director revealed that they were unaware the tables could not be in front on the fire extinguisher and the pull for the</p>	K 064		

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K 064	Continued From page 21 kitchen hood suppression Reference: NFPA 10 6.2.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected, manually or by electronic monitoring, at more frequent intervals when circumstances require. 6.2.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Operating instructions on nameplate legible and facing outward (4)* Safety seals and tamper indicators not broken or missing (5) Fullness determined by weighing or " hefting " (6) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (7) Pressure gauge reading or indicator in the operable range or position (8) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (9) HMIS label in plac NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by:	K 064	K 104 Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. 1. Contracted company will complete inspection of fire damper system. Inspection to be completed by 04/30/12. 2. Inspection will be completed every 4 years by license contractor. 3. Education provided to Maintenance Director on proper inspection guidelines and maintenance of documentation by Administrator on 04/10/12. 4. Completion of 4 year inspection will be monitored through preventive maintenance program with results reported to PI committee. 5. Completion Date: 04/20/12	04/20/12
K 104 SS=F		K 104		

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K 104	Continued From page 22 Based on observation and interview, it was determined the facility failed to ensure fire/smoke dampers were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for seventy (70) beds and the census was sixty one (61) on the day of the survey. The findings include: Observation, on 03/22/12 at 10:00 AM, with the Maintenance Director revealed no documentation for fire damper testing. The Fire damper is supposed to be serviced once every four years in accordance with NFPA 90A. Interview, on 03/22/12 at 10:00 AM, with the Maintenance Director, revealed that no maintenance documentation was kept on the fire/smoke dampers. Reference: NFPA 90A (1999 edition) 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 104	K 130 NFPA 101 Miscellaneous 1. Slide bolt locks have been opened on doors outside exits of 100 hall. Contracted company will replace doors with non-locking doors that meet standard. 2. Facility rounds found no other doors failing to meet this standard. 3. Education provided to Maintenance Director on standard related to maintaining doors with a means of egress by the Administrator on 04/10/12. 4. Audit of proper egress of doors will be completed by Maintenance Director weekly x 4 weeks, then monthly x 3 months. Results will be reported to PI committee for recommendations. 5. Completion Date; 06/20/2012	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130		6/20/12

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K 130	Continued From page 23 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for seventy (70) beds and the census was sixty one (61) on the day of the survey. The findings include: Observation, on 03/22/12 at 10:50 AM, with the Administrator and Maintenance Director revealed an unapproved lock (slide bolt type) was installed on the storm doors located outside the exits for the 100 hall. Interview, 03/22/12 at 10:50 AM, with the Administrator and Maintenance Director revealed they were aware of the lock installed on the door; however, they were not aware that slide bolt locks were prohibited. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130		