

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

PRINTED: 02/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185112	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/26/2012
NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE JACKSON, KY 41335	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 164 SS=D	<p>A standard health survey was conducted on 01/24-26/12. Deficient practice was identified with the highest scope and severity at "D" level.</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 164	<p>THIS PLAN OF CORRECTION CONSTITUTES MY WRITTEN ALLEGATION OF COMPLIANCE FOR THE DEFICIENCIES CITED. HOWEVER, SUBMISSION OF THE PLAN CORRECTION IS NOT AN ADMISSION THAT A DEFICIENCY EXISTS OR THAT ONE WAS CITED CORRECTLY. THIS PLAN OF CORRECTION IS SUBMITTED TO MEET REQUIREMENTS ESTABLISHED BY STATE AND FEDERAL LAWS.</p> <p>Resident #8 was the only person identified as being affected by privacy issues during medication pass. The nurse making the med pass was inserviced on these deficient practices in 01/25/12 by nursing Supervisor.</p> <p>No other resident was identified as being affected by this deficient practice.</p>	

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

Phillip L. ...

TITLE

Administrator

(X6) DATE

2-17-12

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

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NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339
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F 164	<p>Continued From page 1</p> <p>Based on observation, interview, and review of the facility policy, the facility failed to provide personal privacy for one of eighteen sampled residents (Resident #8). Observations of the medication pass on 01/24/12, at 5:10 PM, revealed the nurse failed to close the door of the resident's room or pull the privacy curtain enough to provide privacy for the resident during administration of medication via a gastric tube and, as a result, the resident's abdomen was exposed and visible from the hallway. In addition, the facility failed to ensure residents' health information was maintained in a private and confidential manner. Observations of the 01/24/12 medication administration pass at 5:10 PM, revealed the Medication Administration Record (MAR) for Resident #8 was left open on the medication cart in the hallway and, as a result, the resident's personal health information on the MAR was exposed to the public and other residents.</p> <p>The findings include:</p> <p>A review of the facility's policy for medication administration guidelines (dated 03/03/08) revealed the nurse and/or the Certified Medication Aide (CMA) was always to "Provide privacy, cover the MAR, close doors and pull curtains as necessary."</p> <p>Observations of the medication administration pass on 01/24/12, from 5:10 PM through 5:45 PM, revealed Licensed Practical Nurse (LPN) #1 administered two medications via gastric tube to Resident #8. During the administration of the prepared medications, the resident's door was open, the privacy curtain was not pulled closed</p>	F 164	<p>An abbreviated med pass inservice was performed on 01/25/12 by nursing Supervisor. On 02/21/12 a mandatory inservice will be conducted by the pharmacy for all Nurses and c.m.a.'s . This inservice will include personal privacy/ dignity and Confidentiality of records. 100% of new nursing personnel will be observed bi-monthly by nursing supervisor. Pharmacy will randomly do unannounced observations on new nursing employees as requested. (see attached forms #A)</p> <p>Pharmacy and D.O.N./Designee each will conduct monthly med pass audits to ensure compliance is met.</p> <p>The Q.A. Committee will be notified if there is a need.</p>	02/21/12
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NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41338	
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F 164	Continued From page 2 and, as a result, the resident's abdomen was exposed and in view of the hallway. In addition, the MAR was left open and the health information for Resident #8 was exposed to the public and other residents. Interview with LPN #1 on 01/24/12, at 5:40 PM, revealed the nurse knew to close the resident's door and to pull the privacy curtain closed to prevent Resident #8 from being exposed to the hallway. The nurse also knew to close the MAR to prevent health information from being exposed to the public and other residents. The LPN stated, "I was nervous and forgot to close the door and pull the curtain enough, and I forgot to close the MAR." Interview with the Director of Nursing (DON) on 01/24/12, at 5:45 PM, revealed all nurses have been trained to close doors, pull privacy curtains closed, and to cover the MAR during a medication pass. The DON stated observations of the medication pass were conducted quarterly by the pharmacy staff and no discrepancies had been identified with medication passes or privacy issues.	F 164		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by:	F 253		
			SEE PAGE 4	

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NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	<p>Continued From page 3</p> <p>Based on observation, interview, and review of facility policy, it was determined the facility failed to ensure effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Observations throughout the facility revealed six geri-chairs with torn and frayed armrests, sharp, cracked tile in the women's shower room on the Team 3 hallway, and inadequate ventilation in the resident smoke room.</p> <p>The findings include:</p> <p>A review of the facility policy entitled Maintenance Policy (not dated) revealed the goal for the facility's maintenance program was to ensure the building and surroundings were safe, sanitary, and operational at all times. The policy also revealed a log of needed repairs was kept at each nursing station and maintenance staff was to check the log each morning and make needed repairs.</p> <p>Observations of the facility from 01/24/12 through 01/26/12, revealed the following areas were in need of maintenance services:</p> <ul style="list-style-type: none"> -Six geri-chairs with torn, frayed armrests in use by residents or available for resident use. -Sharp, cracked tiles around the drain in the women's shower on the Team 3 Hallway. -The dining room was observed to have a strong smoke smell as a result of inadequate ventilation in the residents' "smoke" room. <p>The resident group interview on 01/25/12, at 9:00 AM, revealed complaints of a smoke smell in the dining room from the smoke room.</p>	F 253	<p>No specific resident was identified as being affected by failure to comply with housekeeping and maintenance services. The six geri-chairs with needed repairs will be repaired or replaced by 02/21/12. The women's shower on Team III had the cracked tile repaired on 02/03/12. Adequate ventilation in the resident smoke room will be corrected by 02/21/12 with the repair of Smokeeater. The door leading from the dining area has been repaired to curtail smoke entering the dining area.</p> <p>Any resident could be affected if the building is not maintained in a sanitary orderly manner. A thorough inspection was made by the maintenance supervisor and administrator on 01/31/12 and 02/01/12.</p>	

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F 253	Continued From page 4 Interview with Registered Nurse (RN) #1 on 01/26/12, at 1:45 PM, and with Licensed Practical Nurse (LPN) #2 on 01/26/12, at 1:55 PM, revealed the process for reporting maintenance issues was to write the issue on the log on the clipboard that was kept at each nursing station and reviewed daily by the Maintenance Supervisor. An interview with the Maintenance Supervisor (MS) during the environmental tour on 01/26/12, at 2:00 PM, revealed he frequently made rounds throughout the facility to look for maintenance issues and stated he relied on staff to identify and document identified concerns on request forms located at the nurses' stations. The MS also stated he was unaware of the issues identified during the environmental tour and had not received any complaints about a smoke smell in the dining room.	F 253	Housekeeping and maintenance employees were inserviced on 02/12/12 and 02/13/12 by the Administrator. The subject was the process and responsibility for timely reporting and maintaining the building to meet requirements under F253. Housekeeping and maintenance staff will do daily monitoring as they perform their duties. Nursing Supervisor/designee will do monthly environmental rounds. The Administrator/designee will do a complete building inspection quarterly. The QA committee will be consulted as needed.	02/21/12
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431	No resident was found to be affected by this deficient practice. The unlabeled medication was properly disposed of by nursing staff on 01/26/12.	

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F 431	<p>Continued From page 5 applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of the facility's recommendation for storage of medications, it was determined the facility failed to label, date, and store all drugs and biologicals in accordance with currently accepted professional principles. One multi-dose vial of Aplisol (tuberculin skin test solution) had been opened and was available for use; however, the medication was not dated to indicate the date the bottle was opened.</p> <p>The findings include: A review of the facility's Storage Recommendations (revision date of 10/06/11) revealed all Multiple-Dose Vials for injection</p>	F 431	<p>Any resident could be affected by not following pharmacy services guideline. 100% of vials were checked by nursing supervisor to ensure they were labeled on 01/26/2012.</p> <p>Pharmacy personnel will conduct a Mandatory inservice on 02/21/12 To ensure these standards are met. All nurses and C.M.A.'s will attend.</p> <p>Monitoring will be performed by D.O.N./designee and by pharmacy Personnel monthly. Q.A. committee will be notified if there is a need.</p>	02/21/12	

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F 431	Continued From page 6 (non-insulin) were to be dated when opened and any unused portion of the product was to be discarded after 28 days, or in accordance with the manufacturer's recommendations. Observation on 01/26/12, at 12:15 PM, of the facility's medication refrigerator revealed a 1-milliliter vial of Aplisol (tuberculin skin test solution) that had been opened and remained available for use. Further observation revealed staff had failed to document the date the vial was opened. Interview on 01/26/12, at 12:15 PM, with RN #1 revealed all multi-dose vials should be dated when opened and stated she was unsure who had opened the vial and why it was not dated. Interview on 01/26/12, at 12:25 PM, with Certified Medication Aide #1 revealed all multi-dose medications should be initialed by the person that opened the vial/bottle and dated when opened.	F 431		
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	F 441	Resident #8 suffered no adverse effects. No other resident was identified as being affected by this deficient practice.	

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F 441	<p>Continued From page 7 actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility policy, the facility failed to ensure an effective infection control program was maintained for one of eighteen sampled residents (Resident #8). Observation of the medication administration on 01/24/12, revealed the nurse touched a medication with ungloved hands prior to administration of medications to Resident #8.</p> <p>The findings include: A review of the facility policy for Administration of</p>	F 441	<p>Pharmacy personnel will conduct an in-service on infection control standards pertaining to med pass on 02/21/12. An abbreviated med pass in-service was initiated by supervisors on 01/25/12. All new nursing personnel will be observed bi-monthly during med pass by nursing supervisor/designee for compliance. Pharmacy will also do unannounced observations upon request from facility. (See Forms B)</p> <p>Monthly medication pass monitoring will be conducted by D.O.N./designee and by pharmacy personnel.</p> <p>Q.A. committee will be consulted for input when necessary.</p>	02/21/12

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F 441	Continued From page 8 Medication Guidelines (dated 03/03/08) revealed nurses and/or Certified Medication Aides (CMA) were never to touch a pill or capsule unless they wore gloves. Observation of the medication administration pass on 01/24/12, at 5:10 PM, revealed Licensed Practical Nurse (LPN) #1 removed a Loratab (narcotic analgesic) capsule from the container and placed the medication into her ungloved hand. The LPN transferred the capsule into her other ungloved hand and then placed the medication into the medication cup. The LPN then crushed the medication and administered the medication to Resident #8 via a gastric tube. Interview with LPN #1 on 01/24/12, at 5:40 PM, revealed the LPN knew not to touch medication with ungloved hands but stated she was nervous and forgot. Interview with the Director of Nursing (DON) on 01/24/12, at 5:45 PM, revealed the nurses/CMAs were never to touch medications with ungloved hands. The DON stated the pharmacy staff observed medication passes every quarter and had not identified any discrepancies with the medication administration.	F 441		
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	F 468	No resident was identified as being affected by loose handrails. The rails identified as Being loose near room #'s 102,109,120, and 147 were secured on 01/27/12.	

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F 468	<p>Continued From page 9</p> <p>failed to ensure corridors were equipped with firmly secured handrails. Six handrails were observed to be loose from the walls of the hallways.</p> <p>The findings include:</p> <p>A review of the facility policy entitled Maintenance Policy (not dated) revealed the goal for the facility's maintenance program was to ensure the building and surroundings were safe, sanitary, and operational at all times. The policy also revealed a log of needed repairs was kept at each nursing station and maintenance staff was to check the log each morning and make needed repairs. The Maintenance Supervisor denied having a policy related to handrail repair/maintenance.</p> <p>Observations conducted of the facility's hallways on 01/24/12, at 5:55 PM, revealed loose handrails located outside resident rooms 102, 109, 120, and 147, by the resident telephone, and outside the Assistant Director of Nursing's office.</p> <p>Interview on 01/26/12, at 2:00 PM, with the Maintenance Supervisor revealed facility staff was to notify Maintenance of needed repairs and was to document items that needed repair on a maintenance form attached to a clipboard kept at the nurses' station. The Maintenance Supervisor stated he was unaware the handrails were loose. He stated he makes walking rounds to check the facility for maintenance issues but does not have a schedule for checking for loose handrails.</p>	F 468	<p>Any resident could be affected if the facility is not maintained properly. All rails were checked by maintenance employees on 01/27/12.</p> <p>Housekeepers and maintenance Employees were in-serviced on 02/12/12 and 02/13/12 by the Administrator to educate them in providing a safe interior by timely identification, correction, and maintenance of necessary repairs.</p> <p>Daily monitoring for needed repairs will be done by housekeeping and maintenance employees as they perform their duties. Nursing Supervisor/ Designee will do monthly environmental rounds. Administrator will do quarterly building inspections for compliance. QA committee will assist when necessary.</p>	02/13/2012	

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01/24/2012

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NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339	Division of Health Care Southern Enforcement Branch
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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1985 SURVEY UNDER: 2000 existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 111 (000) SMOKE COMPARTMENTS: Six COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Type II natural gas generator A life safety code survey was initiated and concluded on 01/24/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	THIS PLAN OF CORRECTION CONSTITUTES MY WRITTEN ALLEGATION OF COMPLIANCE FOR THE DEFICIENCIES CITED. HOWEVER, SUBMISSION OF THE PLAN CORRECTION IS NOT AN ADMISSION THAT A DEFICIENCY EXISTS OR THAT ONE WAS CITED CORRECTLY. THIS PLAN OF CORRECTION IS SUBMITTED TO MEET REQUIREMENTS ESTABLISHED BY STATE AND FEDERAL LAWS.	
K 018 SS:F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than	K 018	SEE PAGE 2 OF 11	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Phillip J. Futral* TITLE: *Administrator* (X6) DATE: 2-17-12

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution has taken appropriate safeguards to 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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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185112	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/24/2012
NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339	
(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 018	<p>Continued From page 1</p> <p>required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/2 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridor doors were maintained according to NFPA standards. This deficient practice affected three of six smoke compartments, staff, and approximately seventy-five residents. The facility has the capacity for 120 beds with a census of 82 on the day of the survey.</p> <p>During the Life Safety Code tour on 01/24/12, at 11:45 AM, with the Director of Maintenance (DOM), a corridor door to resident room 127 would not latch. Corridor doors must close and latch to help resist the passage of smoke in a fire.</p>	K 018	<p>The doors to rooms 127, 121 and 129 had the latches adjusted on 01/27/12 and now work properly. Decorations on rooms 102, 108 and 126 had decorations removed on 01/27/12.</p> <p>All resident room doors were checked for proper closure by maintenance employees on 01/30/12.</p> <p>The Administrator conducted an in-service for housekeeping and maintenance employees on 02/12/12 and 02/13/12, NFPA101 Life Safety Code was discussed the subject was proper door closure and doors being free of obstructions.</p> <p>Housekeeping and maintenance will monitor daily as they complete their job duties. DON/Designee will do monthly environmental rounds for compliance. Administrator will do a thorough building inspection quarterly. QA committee will be consulted as needed.</p>	02/03/12

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K 018	Continued From page 2 situation. During the survey resident rooms 121 and 129 would not latch. Resident rooms 102, 108, and 126 would not close and latch due to unapproved decorations hung over the door. Decorations must be fire resistive. An interview on 01/24/12, at 11:45 AM, with the DOM revealed the doors were checked on a monthly basis to ensure they closed correctly. The DOM stated he could not keep up with the unapproved decorations put on the doors because he is not notified when the decorations are put on the doors. Reference: NFPA 101 (2000 Edition). 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors. 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. Exception: Combustible decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present. 10.3.6 Fire-retardant coatings shall be maintained to retain the effectiveness of the treatment under service conditions encountered in actual use.	K 018	The doors to rooms 127, 121 and 129 had the latches adjusted on 01/27/12 and now work properly. Door decorations on rooms 102, 108 and 126 were removed on 01/27/12. All resident room doors were checked for proper closure by maintenance employees on 01/30/12. The Administrator conducted an in-service for housekeeping and maintenance employees on 02/12/12 and 02/13/12, NFPA101 Life Safety Code was discussed to include proper door closure and doors being free of obstructions. Housekeeping and maintenance will monitor daily as they complete their job duties. DON/Designee will do monthly environmental rounds for compliance. Administrator will do a thorough building inspection quarterly. QA committee will be consulted as needed.	02/03/12
K 029	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		

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K 029 SS=D	<p>Continued From page 3</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridor doors were maintained according to NFPA standards. This deficient practice affected one of six smoke compartments, staff, and approximately six residents. The facility has the capacity for 120 beds with a census of 82 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 01/24/12, at 12:40 PM, with the Director of Maintenance (DOM), storage room corridor door 159 was observed not to have a door-closing device as required. During the survey, storage rooms 157 and 160 were also observed not to have a door-closing device. Rooms that are considered to be a hazardous area are required to have a door-closing device. An interview with the DOM</p>	K 029	<p>No residents was identified under K029. Room 157, 159 and 160 will have a door closing device installed or storage items removed from the room, by 02-21-2012</p> <p>All rooms have been checked for required door closings. Any resident could be affected by failure to comply with NFPA101 Life Safety Standards.</p> <p>The administrator conducted In-services on 02-12-2012 and 02-13-2012 for housekeeping and maintenance employees. Complying with NFPA101 Life Safety Standards was one of the subjects. The maintenance department has been provided with a copy of NFPA101 Life Safety Code.</p> <p>Housekeeping and maintenance employees will monitor for compliance as they perform their daily duties. DON/Designee will monitor compliance monthly. Administrator/Designee will do a thorough building inspection quarterly. QA committee notified for input as needed.</p>	02/21/12

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K 029	Continued From page 4 on 01/24/12, at 12:40 PM, revealed the DOM was not aware which rooms are considered hazardous areas that would require a door-closing device. The DOM stated that he does not have access to life safety code requirements in the performance of his duties.	K 029		
K 038 SS=E	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 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exits and access to exits were maintained according to NFPA standards. This deficient practice affected three of six smoke compartments, staff, and approximately thirty residents. The facility has the capacity for 120 beds with a census of 82 on the day of the survey. The findings include: During the Life Safety Code tour on 01/24/12, at 11:35 AM, with the Director of Maintenance (DOM), it was observed that the personal care room door could swing into the exit access corridor without a self-closing device and failed to open to within 7 inches of the corridor wall in the fully open position. This condition could impede	K 038	No resident was identified under K038. The lock was removed on 01/24/12. All exits were checked on 01/25/12 by maintenance employees and found to be in compliance. Any resident could be affected by not complying with K038. On 02/12/12 and 02/13/12 maintenance and house-keeping employees were in-serviced on NFPA 101 Life Safety code by the administrator. Maintaining safe exits from the building was part of the in-service.	

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NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339
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K 038	<p>Continued From page 6</p> <p>egress in an emergency and requires a door-closing device to remedy the situation. During the survey, the bathroom door next to room 140, and the oxygen room and bed pan room doors were observed to have this same condition. An interview with the DOM on 01/24/12, at 11:35 AM, revealed the DOM was not aware these doors needed door-closing devices.</p> <p>On 01/24/12, at 01:25 PM, with the DOM, an exit from the dining room led to a locked gate. Exits must be accessible and maintained to the public way. An interview with the DOM on 01/24/12, at 01:25 PM, revealed the DOM was aware the gate should be accessible but was told to put the lock on the gate anyway.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.2.1.4.4* During its swing, any door in a means of egress shall leave not less than one-half of the required width of an aisle, corridor, passageway, or landing unobstructed and shall not project more than 7 in. (17.8 cm) into the required width of an aisle, corridor, passageway, or landing, when fully open. Doors shall not open directly onto a stair without a landing. The landing shall have a width not less than the width of the door. (See 7.2.1.3.)</p> <p>Exception: In existing buildings, a door providing access to a stair shall not be required to maintain any minimum unobstructed width during its swing, provided that it meets the requirement that limits projection to not more than 7 in. (17.8 cm) into the required width of a stair or landing when the door is fully open.</p>	K 038	<p>Housekeeping and maintenance employees will monitor for compliance daily as they perform their duties. Nursing supervisor/designee will observe for compliance during monthly environmental rounds. Quarterly inspections for compliance will be conducted by the administrator plus observations during random rounds.</p>	02/25/12

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NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41338
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K 038	Continued From page 6 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. 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 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that sprinkler heads were maintained as required. This deficient practice affected five of six smoke compartments, staff, and all the residents. The facility has the capacity for 120 beds with a census of 82 on the day of the survey. The findings include:	K 038		
K 062 SS=F		K 062	No resident was identified as being affected by this deficient practice. All sprinkler heads will be cleaned or replaced for compliance as of 02/21/12. Any resident could be affected if the sprinkler system did not function properly.	

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NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339
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K 062	Continued From page 7 During the Life Safety Code survey on 01/24/12, at 11:50 AM, with the Director of Maintenance (DOM), paint was observed on sprinkler heads in the Team 2 corridor area. Not maintaining sprinkler heads can decrease their ability to react as intended. An interview with the DOM on 01/24/12, at 11:50 AM, revealed either the DOM missed cleaning the sprinkler head when it was cited last year or paint got on the sprinkler heads when the facility painted the previous month. The facility was cited for the same deficient practice on 11/09/10 and 11/03/09. During the survey, paint was observed on sprinkler heads in the Teams 1 and 3 corridor areas, dining room, and resident rooms. Reference: NFPA 25 (1998 Edition). 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.	K 062	Maintenance and housekeeping employees were in-serviced on 02/12/12 and 02/13/12 on maintaining the sprinkle system. In the future, sprinkle heads will be masked in areas being painted to prevent the problem from re-occurring. All sprinkler heads will be masked for protection during painting in the future. Monitoring for cleanliness will be done daily by maintenance and housekeeping employees as they perform their duties. The administrator will randomly monitor the system during rounds and during quarterly building inspections. the system will be checked quarterly by Landmark Sprinkler Company.	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored, and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.	K 066	No resident was identified as being affected by this deficient practice. Metal self closing container for safe ash disposal will be available by 02/21/12.	02/21/12

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K 066	<p>Continued From page 8</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoking areas were maintained according to NFPA standards. This deficient practice affected one of six smoke compartments, staff, and no residents. The facility has the capacity for 120 beds with a census of 82 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 01/24/12, at 1:15 PM, with the Director of Maintenance (DOM), a smoking area outside the facility was observed not to have a metal self-closing container into which ashtrays could be emptied. During the survey, a smoking area next to the dining area was also observed not to have a metal self-closing container. An interview with the DOM revealed the DOM was aware that</p>	K 066	<p>Any resident could be affected if Life Safety Code on smoking regulation are not met.</p> <p>Maintenance and housekeeping employees were in-serviced on 02/12/12 and 02/13/12 on proper disposal of cigarette butts and ashes.</p> <p>Nursing Supervisor/designee will do monthly monitoring for compliance during environmental rounds. Maintenance and housekeeping will monitor daily while performing their duties. Administrator will monitor during random rounds and during quarterly building inspection.</p>	02/21/12

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K 066	Continued From page 9	K 066		
K 130	smoking areas needed metal self-closing containers in which to empty ashtrays.	K 130	No resident was identified as being affected by this deficient practice. The two dryers were completely cleared of lint on 01/24/12.	
SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786		Any resident could be affected if NFPA 101 Life Safety Standard K130 is not adhered to.	
	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain gas clothes dryers by manufacturer's recommendations. This deficient practice affected one of six smoke compartments, staff, and no residents. The facility has the capacity for 120 beds with a census of 82 on the day of the survey.		In-service by the Administrator for maintenance employees was held on 02/12/12 and 02/13/12 on compliance with MFPA 101, K130. Laundry Supervisor was also in-serviced on regular cleaning of dryer on 02/12/12.	
	The findings include: During the Life Safety Code tour on 01/24/12, at 12:45 PM, with the Director of Maintenance (DOM) a large amount of lint buildup was observed on top of the lint trap in the lower compartment of two dryers. The manufacturer's daily maintenance schedule for the dryers calls for the removal of any accumulated lint from the cabinet's high limit thermostat and thermistor. Failure to do so will allow a buildup of lint in this area to act as an insulator, causing the tumbler to overheat. Both of the dryers' top front covers were observed to be propped open. An interview with the DOM and laundry staff on 01/24/12, at 12:45 PM, revealed the lint screen was cleaned daily but not the temperature probes. A member of the laundry staff stated the top panels of the dryers were propped open in order for the		Laundry employees will clean dryer daily and maintenance will do monthly cleaning.	

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K 130	Continued From page 10 burners to get enough air to operate.	K 130	Housekeeping will check dryers daily for compliance. Maintenance will check dryers weekly. Administrator will monitor for compliance during random rounds and during quarterly building inspections. QA committee will be contacted if continued problems.	02/12/12