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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 09/17/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185327		09/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF SPENCER COUNTY	625 TAYLORSVILLE RD TAYLORSVILLE, KY 40071

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F 000	INITIAL COMMENTS A standard recertification survey was initiated on 09/03/13 and concluded on 09/05/13 with a Life Safety Code survey conducted on 09/04/13 with the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would recommended for imposition.	F 000	This plan of correction is submitted per requirement by State but does not constitute admission by the provider of any fact or conclusion set forth in this statement of deficiency.	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the survey result binder, it was determined the facility failed to have survey results accessible to the residents. The survey binder was placed behind a picture, on a table in the front lobby. No posting was observed stating the survey results would be made available. The abbreviated survey of May 2013 that determined IJ existed was not included in the survey result book. In addition, after 6 PM, the door leading to the front lobby was locked and residents did not have access to the survey result binder.	F 167	F167 1. On 09/05/2013 the survey binder was removed from behind the picture on the table in the front lobby by the Administrator. On 09/05/2013 a posting notification to make survey results available was put up in the entrance to the lobby by the Business Office Manager. On 09/05/2013 the Administrator placed the abbreviated IJ survey from May 2013 in the survey book. On 09/22/2013 the survey book was moved to the resident lounge Area so that they may have access to at all times. 2. An Observation of the Survey book was made on 09/23/2013 at 7:30 a.m by the Administrator, noted no concerns with the survey book accessibility to the residents. 3. On 09/22/2013, the Administrator reviewed the tag F167 483.10 for education, Right to Survey Results-readily accessible to ensure the center was in compliance with the regulation.	10/18/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: X Administrator X — (X6) DATE: 9/23/2013

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 167	Continued From page 1 The findings include: Observations of the survey book in the front lobby, on 09/04/13 at 4:00 PM and 09/05/13 at 9:00 AM, revealed the survey binder was behind a picture frame. Further observations revealed there was no poster stating the survey results would be made available. Record review of the survey binder, on 09/05/13 at 9:10 AM, revealed the abbreviated survey on May 2013 that determined IJ existed was not included in the survey result book. Interview with the Front Lobby Secretary, on 09/03/13 at 3:30 PM, revealed there was no code to enter when entering the front door to the lobby. But after 6 PM the doors were locked and staff had to enter a code to get into the front door of the lobby. Residents were unable to access the front lobby without assistance from staff. Interview with the Administrator, on 09/05/13 at 2:15 PM, revealed he was responsible to ensure the survey binder was up-to-date with the current survey results placed in the binder. The Administrator stated he did not notice there was no sign stating the survey results would be made available and the survey results. He revealed he had only been at the facility for a month and had not noticed that the survey result binder had been placed behind a picture frame not accessible to the residents.	F 167	4. The Administrator will make observations once a week for 12 weeks to ensure that the survey results remain available to the residents, accessible to the residents, and that the notice of availability remains posted. Results will be reviewed by the Quality Assurance Committee, consisting of the Administrator, Staff Development Coordinator, Director of Nursing, Social Services Director, Activities Director, MDS Coordinator, Unit Manager, and Medical Director (at least quarterly) on a monthly basis until the team concludes the issue is resolved. If at any time concerns are identified A Quality Assurance Committee meeting will be called by the Administrator or Director of Nursing to analyze and implement further measures dependent upon the root cause to ensure on going compliance.	
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with	F 248		

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F 248	Continued From page 2 the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy titled Activities, it was determined the facility failed to provide an ongoing activity program to meet the identified interests for seven (7) of twenty-four (24) sampled residents, Residents # 4, 7, 10, 13, 19, 20 and 24. The findings include: Review of the facility's policy titled Activities, effective 12/2010, revealed the facility would provide an activity program that was appropriate to meet the needs and interests of each resident. The program would encourage self-care, resumption of normal activities, maintenance of optimal self functioning and contact with the environment. The policy stated a member of the facility staff would be assigned the responsibility of developing, documenting and maintaining an activity program for each resident. The policy continued by stating the development of each resident's daily activity plan would include consideration of individual interests and would include a variety of activities both inside and outside the facility. 1. Review of the medical record for Resident #4 revealed the resident had been admitted to the	F 248		

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F 248	Continued From page 3 facility on 11/17/09 and readmitted 05/30/13 with diagnoses to include: Above the Knee Amputation, Chronic Pain, Atrial Fibrillation, Osteoarthritis, Gout and Depressive Disorder. The facility assessed Resident #4 on 04/15/13 as a thirteen (13) on a scale of zero (0) to fifteen (15), using the Brief Interview for Mental Status (BIMS) tool in determining cognition. In addition, the facility identified, while Resident #4 was a resident in the facility, having books, newspapers and magazines to read were very important to him/her, as well as listening to the music he/she liked. The facility identified Resident #4 found going outside to get fresh air when the weather was good was also very important to him/her. Continued record review for Resident #4 revealed the care plan identified the resident at risk for decreased socialization due to the diagnoses of Chronic Pain Syndrome, an Above the Knee Amputation on the right and Gout. The care plan identified Resident #4 enjoyed books, music, news, groups and going outside, weather permitting. The goal on the care plan for the identified concerns was the resident would have no decrease in individual activities. The approaches did not include the individual identified activities noted as important to the Resident #4. There was no daily activity plan for Resident #4 to review. Observation, on 09/03/13 at 5:55 PM, revealed Resident #4 sitting in his/her room watching television. Observation, on 09/04/13 at 9:40 AM, 10:47 AM, 11:54 AM and 12:15 PM, revealed Resident #4 sitting in his/her room with the television on.	F 248	F 248 1.An updated Quality of Life Lifestyle Review was completed for Resident #4 on 09/20/2013 by the Activity Director. This includes what is important to the resident. Resident #4 activity plan was updated with individualized approaches to daily activities on 09/23/2013 by the Activity Director. Resident #4 will be offered assistance with activity interests by the Activity Department and this will be documented on the Daily Participation log by the Activities Department. An updated Quality of Life Review was completed by the Activity Director for Resident #10 on 09/23/2013 to reflect the residents current activity needs. An activity plan was updated with individualized approaches to daily activities on 09/23/2013 by the Activities Director. Resident will be offered activities related to individualized interests, and this will be tracked on the Daily Participation log by the Activities Department. Resident #19 had an activity plan created based on an initial Quality of Life Lifestyle	10/18/2013

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F 248	Continued From page 4 Observation, on 09/05/13 at 11:00 AM, revealed Resident #4 sitting in his/her room in a wheelchair. Church was in progress at the time. The resident remained in the room. Interview, on 09/05/13 at 8:05 AM, with Resident #4 revealed there was "not much" activity for him/her to engage in. Resident #4 revealed he/she had not felt like doing much, but did like to read. However, Resident #4 stated he/she had not been offered anything to do in terms of activities; no books, no newspapers, no one on one. Resident #4 revealed he/she was not offered to go sit outside in good weather. 2. Review of the medical record for Resident #10 revealed an admit date of 04/07/13 with diagnoses of Dementia with Behaviors, Cerebral Vascular Accident, Hypertension, Osteoporosis, Cognitive Communication Deficit and Diabetes. Resident #10 had been assessed by the facility with a BIMS score of fourteen (14) on 04/24/13. The facility identified Resident #10 felt books, music, animals and going outside as weather permits were important to the resident. There was no daily activity plan for Resident #10 to review. Observation, on 09/03/13 at 5:58 PM, of Resident #10 in his/her room revealed the resident in bed, awake, calling out for water. The television was on. Observation, on 09/04/13 at 9:44 AM, revealed Resident #10 in his/her room sitting in a wheelchair with the television on. Observations at 10:45 AM, 11:48 AM and 3:55 PM revealed the resident sleeping in bed.	F 248	review which was completed for resident #19 on 09/23/2013 by the Activity Director. Resident #24 was a closed record. Resident #7 care plan approach was updated to reflect the residents' identified interests by Activity Director on 09/23/2013. On 09/22/2013 resident was given a radio to play music in her room. Resident remains on a 1:1 program as well. Resident #13 was given a radio on 09/22/2013. An updated 1:1 review was completed for Resident #13 on 09/23/2013 by the Activities Director. Resident #13 will remain on 1:1 program 3 times weekly and this will be tracked by 1:1 activity participation log by the Activity Department. 1:1 visits for the month will be current by 09/27/2013. Resident #20 no longer resides at the facility and has a closed record. ~~2.An audit of all residents'~~ activity interests will be updated by completing individual Quality of Life Lifestyle reviews, updating the activity care plans, reviewing 1:1 programs and Daily Participation logs for all residents in the center to assess current needs. This will be completed by the Activity Director, Unit Manager, Social Services,	

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F 248	Continued From page 5 Interview, on 09/05/13 at 8:15 AM, with Resident #10 revealed he/she liked to go to Bingo. Resident #10 stated he/she liked flowers and going outside, that he/she was a cattle farmer when younger. Resident #10 revealed he/she was not taken outside. 3. Review of the medical record for Resident #19 revealed an admit date of 08/29/13 with diagnoses of Transient Ischemic Attack, Cerebral Vascular Accident, Hypertension and Cerebral Degeneration. There was no initial admit care plan to address activities. There was no daily activity plan for Resident #19. Resident #19 had not yet been assessed for his/her cognitive status. Interview, on 09/05/13 at 4:37 PM, with the Activities Director revealed she had not created either an initial care plan or standard care plan for Resident #19. Resident #19 was admitted 08/29/13. 4. Review of the closed medical record for Resident #24 revealed an admit date of 08/06/13 and a discharge date of 08/28/13. The diagnoses listed for Resident #24 were Hypertension, Peripheral Vascular Disease, Coronary Artery Disease and Diabetes. The care plan for Resident #24 identified a potential risk for decreased socialization due to the diagnoses of Chest Pain, Hypertension, Diabetes and Coronary Artery Disease. In addition, the facility identified Resident #24 enjoyed having books, magazines and newspapers to read, listening to music and going outside when the weather was nice. However, there were no interventions or approaches to provide the identified interests. There was not an activity assessment present	F 248	MDS, Assistant Director of Nursing, Director of Nursing, Social Services Assistant, and Restorative Nurse by 09/27/2013. 3.The Activity Director was re-educated by the Administrator on 09/23/2013 on Documentation requirements, policy and procedure for Activity Programming and ensuring that all the activity needs for each residents have been met by reviewing their activity interests and assisting residents with those activity interests. Activity Director also educated on providing necessary items such as radios, books, magazines to residents who need assistance with their activity pursuits. Activity Director also educated on developing outings for residents who are less cognitive and offering the residents interested in going outside weather permitting to engage in this activity. 4.The Administrator or Director of Nursing will review resident initial or updated documentation and activity plans weekly for 12 weeks with each admission and OBRA assessment to ensure activities are of current interest, individualized and approaches are effective. Results will be reviewed by the	

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F 248	Continued From page 6 within the Minimum Data Set (MDS) assessment. There was no daily activity plan for Resident #24. Interview, on 09/05/13 at 4:10 PM, with the Activities Director revealed she was not familiar with the facility Activities policy. She stated she understood the activity program that was to be developed and maintained for each individual resident was the activities calendar. She revealed there was no individualized plan for individual residents. It was also revealed that residents with less cognition or greater individual needs were not taken out of the facility or offered the same number of field trips residents with higher functioning or a higher cognitive status were offered. 5. Review of the clinical record for Resident #7 revealed the facility admitted the resident on 06/10/13 with diagnoses of Legally Blind, a Stroke with right sided Paralysis, and Contractures. The facility assessed the resident using the Minimum Data Set (MDS), on 06/17/13, as having a Brief Interview for Mental Status (BIMS) score of nine (9) indicating the resident was moderately impaired. Review of the resident's comprehensive plan of care revealed a potential risk for decrease in socialization related to the diagnosis of being legally blind. The care plan revealed an interest in music, listening to television, being read to, social visits, and religious services. However, the care plan approach did not include an intervention that incorporated the resident's identified interests. Observation of Resident #7, on 09/04/13 at 10:48 AM, 1:30 PM, 3:00 PM, and on 09/05/13 at 8:40	F 248	Quality Assurance Committee, consisting of the Administrator, Staff Development Coordinator, Director of Nursing, Social Services Director, Activities Director, MDS Coordinator, Unit Manager, and Medical Director (at least quarterly) on a monthly basis until the team concludes the issue is resolved. If at any time concerns are identified A Quality Assurance Committee meeting will be called by the Administrator or Director of Nursing to analyze and implement further measures dependent upon the root cause to ensure on going compliance.	

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F 248	Continued From page 7 AM, 2:30 PM, and 5:15 PM, revealed the resident was alone in the room, lying in bed, with no visitors, music or television. Interview with Resident #7, on 09/05/13 at 5:15 PM, revealed the resident did enjoy music, but nothing was ever offered to be able to listen to music in his/her room. The resident further revealed that television noise was often too much because everyone had them on at the same time. Interview with the Activities Director, on 09/05/13 at 5:40 PM, revealed the resident rarely came out of his/her room due to a fear of being left behind. When asked what type of activities the resident enjoyed, the Activities Director revealed a love of music, but did not know whether or not the resident had a radio or any type of device to play music in his/her room. The Activities Director revealed the resident was a candidate for sensory activities but was not receiving them. The Activities Director revealed the resident was receiving social visits from a volunteer twice a week to meet the needs of the resident. 6. Review of the clinical record for Resident #13 revealed the facility admitted the resident on 02/18/13 with diagnoses of Dementia with Behavioral Disorder, Alzheimer's Disease, Hypertension, Abnormal Gait, Generalized Pain and Muscle Weakness. The admission assessment dated 02/25/13 revealed the resident required extensive assistance for ambulation and locomotion. Review of the activity notes, dated 05/23/13 revealed the resident prefered to stay in their room and the activity department would offer 1:1 visitation. A note dated 08/22/13 revealed the resident refused group activities, but family visited.	F 248		

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F 248	Continued From page 8 Interview with the Activity Director, on 09/05/13 at 4:10 PM, revealed the resident refuses to attend group activities and prefers to stay in room. She stated the resident was assessed to like music (radio) and watch television (news). She stated 1:1 visits were provided weekly. Review of the activity participation log for July 2013 revealed the the resident participated in watching TV/radio daily and socialized daily. The Activity Director stated she would document whenever family visited or staff went in and talked with the resident to show socialization of the resident. The other activities documented for July 2013 were Bible study/religious one time a week. The activity department provided 1:1 stimulation activity (15 min) four (4) times that month. Review of the August 2013 activity participation log revealed the same as for July 2013 except Bingo was documented two times that month with 1:1 visits on July 7, 9, and 18 th. Review of the September 2013 participation log revealed no 1:1 visits were documented by the end of the survey on 09/05/13. Observation of Resident #13, on 09/03/13 at 5:56 PM revealed the resident was in their room eating dinner. The television was on. On 09/04/13, observations at 8:20 AM, 9:40 AM, 10:35 AM, 11:27 AM, 12:16 PM, 3:15 PM, and 4:25 PM revealed the resident was in their room either in bed sleeping or up in a chair eating meals. Observations revealed the television was on, but the resident was not watching. No radio was found in the room and no type of music was provided. An activity called "Calm Waters" was provided in the dining room each day at 4:00 PM; however, the resident was in bed sleeping and	F 248		

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F 248	Continued From page 9 did not attend. Continued interview with the Activity Director, on 09/05/13 at 4:10 PM, revealed the resident was to receive 1:1 visits three (3) times a week for fifteen (15) minutes; however, in July the resident only received 1:1 visits for four of the thirty-one days and in September 2013, no documented 1:1 visits. 7. Review of the clinical record for Resident #20 revealed the facility admitted the resident on 08/13/13 with diagnoses of Malignant Neoplasm to brain and spine, Fracture to C-2, Closed Spinal Cord Injury, Dysphagia, Urinary Tract Infection, and Failure to Thrive. Review of the Quality of Life lifestyle review, dated 08/20/13 revealed the resident enjoyed aromatherapy, current events, and liked to be read to. The resident was placed on 1:1 visits. Review of the activity participation log for September 2013 revealed only one 1:1 visit was provided for five days and television and socialization daily. Observation of Resident # 20, on 09/05/13 at 1:40 PM, revealed the resident laying in bed with eyes closed. The television was not on and no other form of music was provided. Interview with the Activity Director, on 09/05/13 at 4:10 PM, revealed the resident did not get out of bed and 1:1 visits were provided with hand massage, family visits, and reading of poetry. The 1:1 visits (except for family visits) were for 15 minutes. However, only one auditory stimulation activity was provided in September 2013. The facility did not provide the August 2013	F 248		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185327		09/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF SPENCER COUNTY	626 TAYLORSVILLE RD TAYLORSVILLE, KY 40071

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F 248	Continued From page 10 participation log as requested.	F 248		
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have an effective pest control system to prevent multiple flies throughout the facility, on residents' food, and failed to monitor the blowers meant to deter the flies from coming into the building were turned off allowing the flies to enter the building. The findings include: Interview with the Resident Council, on 09/03/13 at 4:00 PM, revealed multiple residents voiced a concern regarding flies in the building. Interview with Certified Nursing Assistant (CNA) #1, on 09/05/13 at 9:27 AM, revealed some days the flies were more a problem than other days. CNA #1 stated she felt the flies came into the building when the residents went outside to the courtyard to smoke. Observation, on 09/04/13 at 11:30 AM, revealed a fly flying around on the 200 hall. Observation of the Dining Room, on 09/04/13 at	F 469	F469 1. On 09/05/2013 the Maintenance Director plugged the air curtains back in on 100,200 and 300 hall, the location of where residents' go out to smoke. The Maintenance Director also purchased additional fly traps posted outside of the service area of the kitchen to help with keeping the flies from getting into the building on 09/05/2013. 2. An observation by the Administrator on 09/22/2013 on 100,200,300 hall noted the air curtain working and no flies observed. An observation by the Administrator on 09/22/2013 after meal time and no flies observed. The Maintenance Director installed switches to the air curtains on 09/20/2013 to ensure they could not be shut off. It was determined that there was not an air curtain on the rear service door in the employee break room area which was next to the kitchen and dining room which could contribute to flies entering the building. An air curtain was purchased and will be installed by the Maintenance Director or Assistant Maintenance Director by 09/27/2013. 3. Re-education was provided to the Maintenance Director on	10/18/2013

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 469	Continued From page 11 12:30 PM, revealed a fly flying around residents' food. Observation of the kitchen during tray line, on 09/04/13 at 11:20 AM, revealed flies flying around the steam table and being waved away multiple times by the food server. Observation of the air curtain on the 100, 200 and 300 hall, on 09/05/13 at 10:10 AM, revealed the air curtain was not working. Observation of the air curtain on the 100, 200 and 300 hall, on 09/05/13 at 2:13 PM, revealed the air curtain was not working. Interview with the Maintenance Director, on 09/05/13 at 2:13 PM, revealed he was not aware the air curtain was not working. He stated we paint each week and the maintenance department usually turned off the air curtain at that time and they probably forgot to turn it back on. Interview with the Administrator, on 09/05/13 at 2:15 PM, revealed he had noticed the flies. He knew that maintenance was working on the fly problem, but was not aware the air curtain had been turned off. This would have helped prevent flies from coming into the building.	F 469	maintaining an effective pest control program on 09/23/2013 by the Administrator. 4. The Maintenance Director or the Maintenance Assistant will perform walking rounds 5 times a week for 12 weeks in the center to ensure our current pest control program is effective. The center will also follow up with the residents during the Resident Council meeting monthly. Results will be reviewed by the Quality Assurance Committee, consisting of the Maintenance Director, Staff Development Coordinator, Administrator, Director of Nursing, Social Services Director, Activities Director, MDS Coordinator, Unit Manager, and Medical Director (at least quarterly) on a monthly basis until the team concludes the issue is resolved. If at any time concerns are identified A Quality Assurance Committee meeting will be called by the Administrator or Director of Nursing to analyze and implement further measures dependent upon the root cause to ensure on going compliance.	

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	185327		R 10/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/18/13 as alleged.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1985, 1992 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type III (000) SMOKE COMPARTMENTS: Nine (9) smoke compartments FIRE ALARM: Complete fire alarm system with smoke detectors SPRINKLER SYSTEM: Complete automatic dry sprinkler system. GENERATOR: Type II generator. Fuel source is propane. A standard Life Safety Code survey was initiated on 09/03/13 and concluded on 09/04/13. Signature Healthcare of Spencer County was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility has one hundred twenty (120) certified beds with a census of one hundred sixteen (116) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

X — X Administrator X 9/23/2013

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 Fire)	K 000		
	Deficiencies were cited with the highest deficiency identified at "F" level.			
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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the egress was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, residents, staff, and visitors. The facility is certified for one hundred twenty (120) beds with a census of one hundred sixteen (116) on the day of the survey. The facility failed to ensure the means of egress were free of obstructions and impediments. The findings include: Observation, on 09/04/13 at 9:22 AM, with the Maintenance Director revealed a counter top projecting 7 ½" out from the wall located at the Receptionist Office.	K 038	K038 1. The counter top was removed on 09/05/2013 by the Maintenance Assistant. 2. An observation of the center on 09/23/2013 by the Maintenance Director revealed that all other egress' were maintained in accordance with NFPA standards. 3. Maintenance Director was re-educated by Administrator on NFPA 101 Life Safety Code Standard (2000 edition) section 7.1.10.1, 7.5.1.,7.7.1,and 7.3.2 on 09/23/2013.	10/18/2013

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K 038	Continued From page 2 Interview, on 09/04/13 at 9:22 AM, with the Maintenance Director revealed he was not aware of the requirement. Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times. 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. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23. 7.3.2* Measurement of Means of Egress. The width of means of egress shall be measured in the clear at the narrowest point of the exit component under consideration.	K 038	4. The Maintenance Director will perform walking rounds weekly for 12 weeks to ensure all egress' were maintained in accordance with NFPA standards. Results will be reviewed by the Quality Assurance Committee, consisting of the Maintenance Director, Staff Development Coordinator, Administrator, Director of Nursing, Social Services Director, Activities Director, MDS Coordinator, Unit Manager, and Medical Director (at least quarterly) on a monthly basis until the team concludes the issue is resolved. If at any time concerns are identified A Quality Assurance Committee meeting will be called by the Administrator or Director of Nursing to analyze and implement further measures dependent upon the root cause to ensure on going compliance.	

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	185327	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/04/2013

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K 038	Continued From page 3 Exception: Projections not more than 31/2 in. (8.9 cm) on each side shall be permitted at 38 in. (96 cm) and below. Reference: S&C-12-21-LSC	K 038		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview the facility did not meet the requirements for illumination of means of egress in accordance with NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty (120) beds with a census of one hundred sixteen (116) on the day of the survey. The facility failed to provide required illumination outside an exit for discharge. The findings include: Observation, on 09/04/13 at 9:34 AM, with the Maintenance Director revealed the exit located in the Main Dining Room did not have a light fixture installed outside to provide the required illumination for exit discharge. Interview, on 09/04/13 at 9:34 AM, with the Maintenance Director revealed he was not aware	K 045	K045 1. On 09/06/2013 the Maintenance Director installed a two bulb light fixture located at the exit for the Main Dining Room. 2. An observation on 09/23/2013 revealed the fixture located at the exit for the Main Dining Room installed and functioning properly. 3. The Maintenance Director was re-educated on 09/23/2013 by the Administrator on NFPA 101 Life Safety Code Standard Reference S&C-12-21-LSC. 4. The Maintenance Director or Maintenance Assistant will perform walking rounds weekly for twelve weeks to ensure that any means of egress in the center is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. Results will be	10/18/2013

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K 045	Continued From page 4 the exit did not have the required illumination for egress lighting. Reference NFPA 101 (2000 edition) 19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8. Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in 7.7 DISCHARGE FROM EXITS 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. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2.	K 045	reviewed by the Quality Assurance Committee, consisting of the Maintenance Director, Staff Development Coordinatior, Administrator, Director of Nursing, Social Services Director, Activities Director, MDS Coordinator, Unit Manager, and Medical Director (at least quarterly) on a monthly basis until the team concludes the issue is resolved. If at any time concerns are identified A Quality Assurance Committee meeting will be called by the Administrator or Director of Nursing to analyze and implement further measures dependent upon the root cause to ensure on going compliance.	
	Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23. 7.7.2 Not more than 50 percent of the required number of exits, and not more than 50 percent of the required egress capacity, shall be permitted to discharge through areas on the level of exit discharge, provided that the criteria of 7.7.2(1)			

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K 045	Continued From page 5 through (3) are met: (1) Such discharge shall lead to a free and unobstructed way to the exterior of the building, and such way is readily visible and identifiable from the point of discharge from the exit. (2) The level of discharge shall be protected throughout by an approved, automatic sprinkler system in accordance with Section 9.7, or the portion of the level of discharge used for this purpose shall be protected by an approved, automatic sprinkler system in accordance with Section 9.7 and shall be separated from the nonsprinklered portion of the floor by a fire resistance rating meeting the requirements for the enclosure of exits (see 7.1.3.2.1). Exception: The requirement of 7.7.2(2) shall not apply where the discharge area is a vestibule or foyer meeting all of the following: (a) The depth from the exterior of the building shall not be more than 10 ft (3 m) and the length shall not be more than 30 ft (9.1 m). (b) The foyer shall be separated from the remainder of the level of discharge by construction providing protection not less than the equivalent of wired glass in steel frames. (c) The foyer shall serve only as means of egress and shall include an exit directly to the outside. (3) The entire area on the level of discharge shall be separated from areas below by construction having a fire resistance rating not less than that required for the exit enclosure. Exception No. 1: Levels below the level of discharge shall be permitted to be open to the level of discharge in an atrium in accordance with 8.2.5.6. Exception No. 2: One hundred percent of the exits shall be permitted to discharge through areas on the level of exit discharge as provided in	K 045		

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K 045	Continued From page 6 Chapters 22 and 23. Exception No. 3: In existing buildings, the 50 percent limit on egress capacity shall not apply if the 50 percent limit on the required number of exits is met. 7.7.3 The exit discharge shall be arranged and marked to make clear the direction of egress to a public way. Stairs shall be arranged so as to make clear the direction of egress to a public way. Stairs that continue more than one-half story beyond the level of exit discharge shall be interrupted at the level of exit discharge by partitions, doors, or other effective means. 7.7.4 Doors, stairs, ramps, corridors, exit passageways, bridges, balconies, escalators, moving walks, and other components of an exit discharge shall comply with the detailed requirements of this chapter for such components. 7.7.5 Signs. (See 7.2.2.5.4 and 7.2.2.5.5.) 7.7.6 Where approved by the authority having jurisdiction, exits shall be permitted to discharge to roofs or other sections of the building or an adjoining building where the following criteria are met: (1) The roof construction has a fire resistance rating not less than that required for the exit enclosure. (2) There is a continuous and safe means of egress from the roof. 7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided	K 045		

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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
K 045	Continued From page 7 in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low	K 045		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185327		09/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF SPENCER COUNTY	625 TAYLORSVILLE RD TAYLORSVILLE, KY 40071

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K 045	Continued From page 8 lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area. Reference: NFPA 101 (2000 Edition) 19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8.	K 045		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on battery light testing record review, observation, and interview it was determined the facility failed to test emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty (120) beds with a census of one hundred sixteen (116) on the day of the survey. The facility failed to test emergency battery lighting for 90 minutes annually. The findings include: Battery light testing record review, on 09/03/13 at	K 046	K046 1. On 09/06/2013 the Maintenance Director performed a 90 minute test on the emergency lighting with no identified issues. Also on 09/06/2013 the Maintenance Director installed an emergency battery light located in the transfer switch room with no other issues identified.	10/18/2013

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K 046	Continued From page 9 3:30 PM, with the Maintenance Director revealed the facility did not have documentation for the annual testing of emergency battery lighting located in the facility. Interview, on 09/03/13 at 3:30 PM, with the Maintenance Director revealed they were not aware documentation was to be kept for emergency battery light testing. Observation, on 09/04/13 at 9:56 AM, with the Maintenance Director revealed the facility did not have an emergency battery light located in the transfer switch room. Interview, on 09/04/13 at 9:56 AM, with the Maintenance Director revealed he was not aware the transfer switch room was required to have an emergency battery light installed. Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 11/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.	K 046	2. An observation on 09/23/2013 revealed emergency light fixture in transfer switch room functioning properly and no issues with emergency lighting noted within the center. 3. The Maintenance Director was re-educated by the Administrator on 09/23/2013 on NFPA 101 Life Safety Code Standard Emergency lighting of at least 1 ½ hour duration is provided in accordance with 7.9,19.2.9.1 4. The Maintenance Director or Maintenance Assistant will perform weekly rounds for 12 weeks to ensure there are no issues with emergency lighting noted within the center. Results will be reviewed by the Quality Assurance Committee, consisting of the Maintenance Director, Staff Development Coordinator, Administrator, Director of Nursing, Social Services Director, Activities Director, MDS Coordinator, Unit	

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K 046	Continued From page 10 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046	Manager, and Medical Director (at least quarterly) on a monthly basis until the team concludes the issue is resolved. If at any time concerns are identified A Quality Assurance Committee meeting will be called by the Administrator or Director of Nursing to analyze and implement further measures dependent upon the root cause to ensure on going compliance.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076	K076 1. The oxygen tank was removed on 09/04/2013 and placed in the oxygen storage rack within the oxygen storage room by nursing staff. 2. An observation of the soiled utility room on 09/23/2013 by the Maintenance Director revealed no oxygen tanks in service areas. 3. Re-education provided to all staff by 09/27/2013 by the Staff Development	10/18/2013

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K 076	Continued From page 11 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty (120) beds with a census of one hundred sixteen (116) on the day of the survey. The facility failed to ensure oxygen tanks were secured. The findings include: Observation, on 09/04/13 at 10:30 AM, with the Maintenance Director revealed an oxygen tank sitting on the floor and not in a storage rack located in the Unit One Soiled Utility Room. Interview, on 09/04/13 at 10:30 AM, with the Nursing Staff revealed they did not know who or why the tank was left in the Soiled Utility Room. Reference: NFPA 99 (1999 edition)	K 076	Coordinator that no oxygen tanks can be stored in any other location other than the oxygen storage room in a rack. 4. The Maintenance Director will perform daily rounds 5 times a week for 12 weeks to ensure oxygen tanks are properly stored in the oxygen storage rooms. Results will be reviewed by the Quality Assurance Committee, consisting of the Administrator, Staff Development Coordinator, Maintenance Director, Director of Nursing, Social Services Director, Activities Director, MDS Coordinator, Unit Manager, and Medical Director (at least quarterly) on a monthly basis until the team concludes the issue is resolved. If at any time concerns are identified A Quality Assurance Committee meeting will be called by the Administrator or Director of Nursing to analyze and implement further measures dependent upon the root cause to ensure on going compliance.	
	8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry.			

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K 076	Continued From page 12 (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27.	K 076		
	(i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14. 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of			

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K 076	Continued From page 13 the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING	K 076		

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{K 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/18/13 as alleged.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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.