

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

PRINTED: 06/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  06/07/2013
NAME OF PROVIDER OR SUPPLIER  ROSEDALE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4250 GLENN AVENUE COVINGTON, KY 41015		
(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

A Recertification Survey was conducted 06/04/14 through 06/07/13, with a deficiency cited. The highest Scope/Severity was an "E".

F 323 483.25(h) FREE OF ACCIDENT  
SS=E HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, and review of the facility's policies, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as possible, as evidenced by the accessibility of chemicals and razors in two (2) unlocked linen closets in the shower rooms on the Millers Crossing Unit. The linen closets contained shaving cream, mouth wash, alcohol hand sanitizer, lotion, antifungal foot powder and a package of "Sani-cloths". In addition, whirlpool tub disinfectant was stored on top of a soiled linen cart.

The findings include:

A review of the facility's policy, "Resident Safety", dated 01/18/12, revealed to create the safest environment possible for the resident within

F 000

PLAN OF CORRECTION:

The filing of the Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This plan of correction is filed as evidence of the facility's intent to comply with the requirements of participation to provide quality resident care.

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F323 483.25(h) FREE OF ACCIDENT HAZARDS / SUPERVISION/DEVICES

Rosedale Manor is committed to ensuring that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

With regards to the accessibility of chemicals and razors in two (2) unlocked linen closets in shower rooms on Miller's Crossing, upon becoming aware of the issue, the doors were immediately locked by the maintenance director. The doors were in proper repair, but the door knob was not in the locked position.

With regards to the whirlpool disinfectant cleaner sitting on top of the soiled linen cart, the chemical

7/19/13

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JUN 28 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sara Krollman TITLE: Administrator (X6) DATE: 6/28/13

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 323 Continued From page 1

reasonable limitations, the procedure was to lock the multi use chemicals in a locked closet in the shower room, when not in use. Further review of the facility's policy, "Supplies & Equipment", dated 06/01/08 revealed personal supplies for resident use such as mouthwash, shaving cream, etc., were kept in locked storage areas in the neighborhoods.

Additional review of the facility's policy "Medication Storage in the Facility", undated, revealed medication rooms, carts and medication supplies were to be locked. Potentially harmful substances were to be stored in a locked area.

Observation of the unlocked woman's shower room, on Millers Crossing Unit, on 06/06/13 at 10:25 AM, revealed one (1) gallon of Classic Whirlpool Disinfectant Cleaner unsecured on top of the soiled linen cart. Observation further revealed the linen closet was open and unlocked with the following products assessable to residents: two (2) bottles of McKesson lotions, eight point five ounces (8.5) each, six (6) cans of McKesson Shaving Cream, two (2) bottles of McKesson mouth wash, one (1) bottle of alcohol hand sanitizer, one (1) prescription container of antifungal powder, and one (1) package of "Sani cloths". Further observation, on 06/06/13 at 10:50 AM, of mens shower room on Millers Crossing Unit revealed, one (1) zeasorb antifungal powder, five (5) cans of shaving cream, three (3) alcohol hand sanitizers and three (3) razors, in an unlocked linen closet.

Review of the manufacturer's Material Safety Data Sheet (MSDS) for Classic Whirlpool Disinfectant Cleaner, revealed the chemical to

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was immediately removed and locked up by the nurse manager.

On 6/6/13, an audit was completed by the nurse managers, maintenance personnel, dietary supervisors and housekeeping personnel to insure that all chemicals were properly secured facility wide. No other issues with chemical storage were noted.

On 6/6/13, all staff on Miller's Crossing was immediately educated by the nurse manager on the proper storage of chemicals and razors and that the locked closets in the shower rooms must remain locked at all times.

Beginning 6/6/13, daily monitoring of the locked storage rooms in the showers has been completed. No further issues have been noted with these doors.

As of 7/8/13, all staff will be inserviced by the nurse manager, staff development, nursing supervisor, department supervisor, or department director regarding the Policies and Procedures on "Resident Safety", "Supplies & Equipment", and "Medication Storage in the Facility" (to specifically include the proper storage of chemicals, razors, and

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cause eye irritation and skin irritation and can be harmful if swallowed or if spray mist is inhaled. The MSDS for Performance Skin Care Lotion revealed, it is harmful if swallowed. The MSDS for McKesson Shaving Cream revealed accidental ingestion of product necessitate medical attention. The MSDS for McKesson mouth wash revealed health hazard of do not swallow. The MSDS for Sani-cloth revealed it caused irreversible eye damage, harmful if absorbed through the skin. The MSDS for hand sanitizer noted to call physician or poison control immediately and toxic outcome if ingested. Zeasorb drug classification from Physician's Desk Reference (PDR) Nurses Drug Handbook 2008 edition, stated Zeasorb was an antifungal and was a topical, not used for ingestion.

Interview with Licensed Practical Nurse (LPN) #3, on 06/06/13 at 10:45 AM, revealed the linen closet door should have be locked because residents had access to the unlocked shower room and a resident could possibly get to the supplies.

Interview with Nurse Manager #1, on 06/06/13 at 10:39 AM, revealed the doors to the linen closets in the shower rooms should be locked.

Interview with the Director of Nursing (DON), on 06/07/13 at 1:55 PM, revealed she was not aware the linen closet doors were not locked. The whirlpool disinfectant should have been locked up. If a resident could get in the shower room unsupervised, they could get into the chemicals.

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medications and the required locking of the doors that store those items).

The Policies and Procedures on Resident Safety, Supplies & Equipment, and Medication Storage in the Facility were reviewed by the Director of Nursing on 06/24/13 and were found to be appropriate. It was noted that additional education on those policies and procedures were necessary.

Daily monitoring of the locked doors in the shower rooms will continue through 6/27/13. Weekly monitoring will occur for the next 5 weeks. Monthly monitoring will then continue for 4 months.

This facility has QA/PI meetings monthly. Audits concerning chemical storage will be reviewed at the regular QA/PI meetings and, as necessary, at any subsequent special meeting called during the review period to insure ongoing compliance.

Compliance with chemical storage will be reviewed and analyzed at each QA/PI meeting during the review period and based upon analysis, subsequent plans of correction will be developed and implemented as necessary.

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K 000 INITIAL COMMENTS

K 000 PLAN OF CORRECTION:

CFR: 42 CFR 483.70(a)  
BUILDING: 01  
PLAN APPROVAL: 1990  
SURVEY UNDER: 2000 Existing  
FACILITY TYPE: SNF/NF  
TYPE OF STRUCTURE: Three (3) stories, Type II (222)  
SMOKE COMPARTMENTS: Seventeen (17) smoke compartments  
FIRE ALARM: Complete fire alarm system with smoke detectors  
SPRINKLER SYSTEM: Complete automatic wet sprinkler system.  
GENERATOR: Type II generator. Fuel source is diesel.  
A standard Life Safety Code survey was conducted on 06/05/13. Rosedale Manor was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for two hundred ten (210) beds with a census of one hundred ninety-five (195) 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 Fire)

The filing of the Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This plan of correction is filed as evidence of the facility's intent to comply with the requirements of participation to provide quality resident care.

RECEIVED  
JUN 28 2013  
BY: \_\_\_\_\_

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

TITLE

(X6) DATE

*Roda Knollman*

Administrator

6/28/13

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

Deficiencies were cited with the highest deficiency identified at "F" level.

K 020 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=D

Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure exit enclosures were maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of three (3) stairwells.

The findings include:

Observation, on 06/05/2013 at 1:34 PM, revealed the center stairwell wall was penetrated with wiring for a video camera. Stairwell walls are only allowed to be penetrated by specific items. The observation was confirmed with the Assistant Administrator.

Interview, on 06/05/2013 at 1:34 PM, with the Assistant Administrator revealed the video camera had been installed original to the building and he was unaware the penetration for the video camera wires was not allowed.

K 000 NFPA 101 LIFE SAFETY CODE STANDARD

Rosedale Manor is committed to ensuring that the stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour.

While the video camera and the attached wiring observed on 6/5/2013 in the center stairwell has been in existence since the building was originally constructed, it was removed on 6/10/2013 by the Environmental Services Director. The penetration for the wiring of the camera was then sealed using approved fire barrier material designed specific for this purpose.

An audit was completed by the Assistant Administrator on 6/10/2013 of all seven (7) stairwells in the facility to ensure that there were no additional cameras or other similar equipment penetrating the stairwell walls that were not specifically identified as allowable per the NFPA standard.

Education was provided to the maintenance department on 6/10/2013 by the Environmental

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K-020 Continued From page 2

Reference: NFPA 101 (2000 edition)  
7.1.3.2.1 Where this Code requires an exit to be separated from other parts of the building, the separating construction shall meet the requirements of Section 8.2 and the following.

(a) \*The separation shall have not less than a 1-hour fire resistance rating where the exit connects three stories or less.

(b) \*The separation shall have not less than a 2-hour fire resistance rating where the exit connects four or more stories.

The separation shall be constructed of an assembly of noncombustible or limited-combustible materials and shall be supported by construction having not less than a 2-hour fire resistance rating.

Exception No. 1: In existing non-high-rise buildings, existing exit stair enclosures shall have not less than a 1-hour fire resistance rating.

Exception No. 2: In existing buildings protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, existing exit stair enclosures shall have not less than a 1-hour fire resistance rating.

Exception No. 3: One-hour enclosures in accordance with 28.2.2.1.2, 29.2.2.1.2, 30.2.2.1.2, and 31.2.2.1.2 shall be permitted as an alternative.

(c) Openings in the separation shall be protected by fire

K-020

Services Director and the Administrator regarding the removal of the equipment and the NFPA standards regarding stairwells so that equipment is not installed in the future.

The Environmental Services Director will ensure on-going compliance by having the environmental services team complete monthly audits for the next year.

Compliance with stairwell penetration will be reviewed and analyzed at each QA/PI meeting during the review period and based upon analysis, subsequent plans of correction will be developed and implemented as necessary. The facility has QA/PI meetings monthly.

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K 020

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K 020

door assemblies equipped with door closers complying with 7.2.1.8.

(d) Openings in exit enclosures shall be limited to those necessary for access to the enclosure from normally occupied spaces and corridors and for egress from the enclosure.

Exception No. 1: Openings in exit passageways in covered mall buildings as provided in Chapters 36 and 37 shall be permitted.

Exception No. 2: In buildings of Type I or Type II construction, existing fire-protection rated doors shall be permitted to interstitial spaces provided that such space meets the following criteria:

(a) The space is used solely for distribution of pipes, ducts, and conduits.

(b) The space contains no storage.

(c) The space is separated from the exit enclosure in accordance with 8.2.3.

(e) Penetrations into and openings through an exit enclosure assembly shall be prohibited except for the following:

- (1) Electrical conduit serving the stairway
- (2) Required exit doors
- (3) Ductwork and equipment necessary for independent stair pressurization
- (4) Water or steam piping necessary for the heating or cooling of the exit enclosure

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K 020 Continued From page 4  
(5) Sprinkler piping  
(6) Standpipes  
Exception No. 1: Existing penetrations protected in accordance with 8.2.3.2.4 shall be permitted.  
Exception No. 2: Penetrations for fire alarm circuits shall be permitted within enclosures where fire alarm circuits are installed in metal conduit and penetrations are protected in accordance with 8.2.3.2.4.  
(f) Penetrations or communicating openings shall be prohibited between adjacent exit enclosures.

K 025 SS=F NFPA 101 LIFE SAFETY CODE STANDARD  
Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure smoke barriers were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect nine (9) of seventeen (17) smoke compartments, one

K 020 NFPA 101 LIFE SAFETY CODE STANDARD

Rosedale Manor is committed to ensuring smoke barriers are constructed to provide at least a one hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

With regards to the nine smoke compartments observed on 6/5/13 with data wires and conduit piping not sealed, the environmental services team began sealing those penetrations with approved fire barrier material designed specific for this purpose. All nine smoke compartments will have all penetrations sealed by 7/19/2013.

The Environmental Services Director, Asst. Administrator and Administrator will complete an audit following the completion of the above work, but no later than

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hundred fifty-eight (158) residents, staff and visitors. The facility is licensed for two hundred ten (210) beds and the census was one hundred ninety-five (195) on the day of the survey.

The findings include:

Observation, on 06/05/13 between 10:30 AM and 12:30 PM, revealed smoke barriers at 2 South Left Hall, 2 South Middle Hall, 2 South Right Hall had penetrations not sealed around conduit piping and data wires penetrated the walls.

2 North Left Hall, 2 North Middle Hall and 2 North Right Hall smoke barriers had penetrations around conduit and data wires not sealed.

1 North Left Hall, 1 North Middle Hall, 1 North Right Hall had penetrations of data wires and conduit not sealed to prevent the passage of smoke.

Interview, on 06/05/13 at 12:30 PM, with the Maintenance Director revealed he was unaware of the amount of penetrations observed during the survey.

Interview, on 06/05/13 at 3:15 PM, with the Administrator revealed the facility would get the penetrations corrected.

Reference: NFPA 101 (2000 edition)  
8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as

K 025 7/19/2013 to ensure that all the smoke penetrations have been sealed and that no other penetrations exist in any of the 17 smoke compartments.

Education was provided to the environmental service team on 6/10/2013 by the Administrator and Environmental Service Director regarding the NFPA standards regarding penetrations of smoke barriers and the audits to be performed by the team in the future.

The environmental services team will complete an audit of the smoke compartments after any work that has been performed in the facility by a vendor that would have the potential to penetrate a smoke barrier. This will be completed within 24 hours.

The Environmental Services Director will ensure on-going compliance by having the environmental services team complete monthly audits for the next year.

Compliance with smoke barriers/penetrations will be reviewed and analyzed at each QA/PI meeting during the review period and based upon analysis, subsequent plans of correction will be developed and implemented as necessary. The facility has QA/PI meetings monthly.

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follows:

- (1) The space between the penetrating item and the smoke partition shall meet one of the following conditions:
  - a. It shall be filled with a material that is capable of limiting the transfer of smoke.
  - b. It shall be protected by an approved device that is designed for the specific purpose.
- (2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions:
  - a. It shall be filled with a material that is capable of limiting the transfer of smoke.
  - b. It shall be protected by an approved device that is designed for the specific purpose.
- (3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions:
  - a. It shall be made on either side of the smoke partitions.
  - b. It shall be made by an approved device that is designed for the specific purpose.