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

PRINTED: 03/06/2013
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
	185300		02/21/2013

NAME OF PROVIDER OR SUPPLIER
SUMMERFIELD HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1877 FARNSLEY RD.
LOUISVILLE, KY 40216

(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 standard health survey was initiated on 02/19/13 and concluded on 02/21/13 and a Life Safety Code survey initiated on 02/19/13 and concluded on 02/20/13 with deficiencies cited at the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	F000 This plan of correction is prepared and executed because it is required by the provisions of State and Federal law and not because Summerfield Health and Rehabilitation Center agrees with the citations noted on the pages of this Statement of Deficiencies.	
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156	F156 #1 On March 13, a framed posting detailing how to apply for Medicaid and Medicare and request a refund for covered services previously paid for was hung. Additional postings, detailing rights in a Medicare/Medicaid certified facility were hung on March 15, 2013. #2 The facility administrator reviewed the requirements of this regulation and then inspected the facility's lobby postings, description of services/survey results binder, and admissions documents to identify any other omissions in the distribution of required information. The postings, binder, and admissions documents were updated as needed on March 15, 2013. #3 To ensure this information distribution remains a part of the facility postings and admissions process, a copy of the requirements of F-156 were reviewed	03/16/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE X Ken Foot | TITLE Administrator X | (X6) DATE 3-15-13 X

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 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156	F156 Continued from page 1 by the Directors of Admissions and Housekeeping on March 15, 2013. The Administrator created a checklist of the information the facility is required to provide. The Admissions and Housekeeping directors will use the checklist to verify the facility continues to provide the information required by this regulation. #4 The Directors of Housekeeping and Admissions will complete the checklist each month for the next 3 months and then quarterly for the remainder of the year to verify the required distributions are entrenched into facility practice. They will present the checklists to the QA Committee so that compliance or need for additional system modifications can be determined.	

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F 156	Continued From page 2 The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to prominently display written information on how to apply for and use Medicare and Medicaid benefits. The findings include: The facility did not provide a policy for required postings.	F 156		

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F 156	Continued From page 3 Observations made of the facility, on 02/19/13 at 9:48 AM, revealed no posting for the residents to read on how to apply for and use their Medicare and Medicaid services. Interview with the Director of Nursing (DON), on 02/20/13 at 12:38 PM, revealed she was not aware there should be a posting on the wall for how to apply for Medicare and Medicaid services. Interview with the Administrator, on 02/20/13 at 9:30 AM, revealed he was not aware there needed to be a posting for how to apply for Medicaid and Medicare services.	F 156		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the Resident Rights booklet, it was determined the facility failed to ensure staff announced themselves prior to entering resident rooms for one (1) of the twenty-four (24) sampled residents and one (1) of the eight (8) unsampled residents. Resident #10 and Unsampled Resident A voiced concerns upon interview and observations of five (5) rooms on two (2) units, rooms 510, 601, 602, 603, and 604 revealed staff entering those rooms unannounced. The findings include:	F 241	F241 #1 Residents #10, un-sampled resident A, and the residents in rooms 510, 601, 602, 603, and 604 will be interviewed by the Social Services assistant to ensure they express no fear, anxiety, anger or other evidence of a loss of self esteem as a result of any non compliance with this requirement. Identified concerns requiring Social Services follow up or care plan revisions will be documented in the residents' record. #2 The Social Services assistant will review the grievance file, Ombudsman reports, and Resident Council minutes for the past 3 months to identify any other residents who could have been affected by this same deficient practice or any other issue related to resident dignity or recognition of the residents' individuality.	04/03/2013

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F 241	Continued From page 4	F 241	F241 Continued from page 4	
	Review of the facility's information provided to the resident upon admission titled Your Rights as a Resident in a Nursing Facility, undated revealed the resident had the right to a dignified existence, self determination and communication with persons and services inside the facility. The right to personal privacy, which included personal care. The facility must promote care for the resident in a manner and in an environment that maintained or enhanced their dignity and with respect in full recognition of the resident's individuality and included privacy during treatment and with care to the resident's personnel needs.		Identified concerns requiring Social Services follow up or care plan revisions will be documented in the residents' record.	
	Observations of staff entering residents rooms without knocking were noted, on 02/19/13 at 12:15 PM, on the 600 hall of the Green Unit during the tray pass, nursing staff were observed entering Rooms 601, 602, 603 and 604 without knocking or asking permission to enter the rooms.		#3 On April 2, 2013, the facility's Ombudsman will provide re-education for all staff related to resident dignity and recognition of the residents' individuality and what it means to ensure and protect it. Following this training, all associates completed a post test to ensure understanding of the training concepts was achieved. Additionally, the issue of resident dignity will be highlighted as part of Resident Rights training provided during new associate orientation and then annually. To ensure residents are aware of their right to receive care in a manner that maintains or enhances their dignity and individuality, the facility Director of Activities will review this right during the next resident council meeting and then every 3 months thereafter for the remainder of the year.	
	Observation of the 500 hall on the Green Unit, on 02/20/13 at 10:14 AM, revealed two (2) entries into Room 510 by LPN #1 without knocking or asking permission to enter the room.			
	Interview with Unsampled Resident A, on 02/19/13 at 9:00 AM, revealed staff barely knocked on the door before entering the room if they knocked at all. The resident stated staff knocked on the door as they entered and did not wait for permission to enter.		#4 To ensure compliance has been achieved, for the next 3 months the Social Services Director and Assistant will, in conjunction with the completion of the scheduled RAI assessments and interviews, ask each resident,	
	Interview with Resident #10, on 02/20/13 at 9:30 AM, revealed staff do not really knock on the door, they just come on in, especially with meals			

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F 241	Continued From page 5 and medicine. Interview with Certified Nurse Aides (CNA) #3 and #2, on 02/19/13 at 3:10 PM, revealed they were trained to knock prior to entering a resident's room. They stated they did not realize they failed to knock. They stated they were delivering meal trays and had their hands full. They stated the residents did have the right to privacy and they should have knocked. Interview with LPN #3, on 02/20/13 at 3:30 PM revealed staff was trained to knock and wait for permission before entering a resident's room. She stated knocking as you enter the room was not acceptable and violated the resident's privacy. She indicated the nurse supervised the staff; however, she had not noticed any concerns and probably was not paying attention because she was busy. Interview with the Director of Nursing, on 02/21/13 at 2:15 PM, revealed staff was trained; however, this concern had not been a focus. She stated the residents had the right to privacy.	F 241	F241 Continued from page 5 or responsible party if indicated, if he or she is being treated with dignity and respect. Any noted concerns will be addressed through the facility's grievance reporting process which includes a QA review. For the remainder of the year, the Director of Social Services will review all grievances, Ombudsman reports, and Resident Council minutes to monitor ongoing compliance issues in this area. Any negative findings will be presented at the quarterly QA committee meetings so a revision to this plan of correction can be implemented and ongoing compliance achieved.	
F 248 SS=D	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 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 observations, interviews, record	F 248	F248 #1 A significant change assessment was completed for #7 on February 28, 2012. The resident's activity care plan was revised at this time and now reflects the resident's current condition and interests. On March 8, 2013 the Director of Activities reassessed Resident #19's activity patterns and preferences and updated the activity care plan to reflect the resident's current status.	04/2/ 2013

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F 248	Continued From page 6 reviews and review of the facility's policies, it was determined the facility failed to provide an ongoing activities program for two (2) of twenty-four (24) sampled residents and eight (8) unsampled residents (Residents #7 and #19). The facility failed to provide 1:1 activities for Residents #7 and #19 as care planned. The findings include: Review of the facility's policy regarding One to One Activities, undated, revealed one to one activities would be provided to residents based on assessment and need. Residents requiring one to one would receive one (1) fifteen minute visit from activities staff once a week. 1. Observations of Resident #7, on 02/19/13 at 11:00 AM, 12:30 PM, 2:15 PM, 3:30 PM and 4:15 PM, and on 02/20/13 at 8:00 AM, 10:15 AM, 2:10 PM and 3:20 PM, revealed the resident was in bed, awake, tossing back and forth in bed, talking in a weak voice and confused. The resident tried to communicate at each observation; however was unsuccessful. The resident had a tube feeding infusing and wore a gown. Review of the clinical record for Resident #7 revealed the facility admitted the resident with diagnoses of Cerebral Vascular Accident, Dementia with Behavior Disturbance, and Weakness. The facility completed a quarterly Minimum Data Set (MDS) assessment for the resident on 12/11/12 which revealed the resident had a severe cognitive impairment and required extensive assistance for all care needs. The resident was not eating well and had trouble concentrating. There were no documented	F 248	F248 Continued from page 6 #2 By April 1st, the Director of Activities will review the activity assessments and care plans for all other residents to ensure the plans are accurate and reflect the activity patterns and current wishes of the residents. Special emphasis will be given to those residents for whom the facility's group activities are not of interest or appropriate based on the resident's wishes or condition. #3 On March 14, 2013, the Corporate Activities Consultant provided reeducation for the Activities Staff. The re-education addressed the requirements of this regulation and care planning while emphasizing one to one programming and documentation requirements. To verify comprehension of the training materials, post tests were completed by all Activity staff. Following this education, the Activity department practice for both one to one programming and documentation were revised. To improve communication, documentation compliance, and understanding of the residents' activity plan, the department's log books have been restructured to include current resident interests/preferences sheets for quick reference.	

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F 248	Continued From page 7 behaviors. The resident received anti-anxiety and anti-depressant medications. The resident developed dysphagia in January 2013 and a gastric tube was inserted and the resident no longer was allowed food or drink by mouth. The resident had hospitalizations from 01/09/13 until 01/14/13 and 01/16/13 until 01/22/13. Review of the comprehensive care plan dated 12/11/12 revealed the resident had limited time out of bed per choice. Documentation to determine the reason the resident chose not to be out of bed was not located. The facility care planned for the resident to participate in music, dancing, religious group activities and going outside. The facility care planned to offer the resident a newspaper. Review of the activity documentation for December 2012 revealed the resident had a pet visit on 12/11/12 and the resident's participation in activities had consisted mostly of one to one visits during the past quarter. The resident no longer desired to keep up with the news or to go outside. No other activity documentation for December 2012 was provided. Review of activity documentation for January 2013 revealed the resident had a room visit from activities on 01/28/13 to discuss football. 2. Observations of Resident #19, on 02/20/13 at 5:00 PM revealed the resident was in bed positioned on his/her back. Continued observations, on 02/21/13 at 8:20 AM, 9:05 AM and 9:50 AM revealed the resident remained in bed with no music and no books.	F 248	F248 Continued from page 7 The log books will be maintained in a central location accessible at all times by activity staff. #4 Each month of the next quarter, the Activity Director will send 5 activity assessments and care plans to the Corporate Activities consultant for review. The reviews will be used to confirm care plans, reflective of the residents' need for activity department servicing, are being written or they will be used to reeducate the Director of Activities on assessing activity needs and care plan development. The Corporate Activities consultant will conduct no less than quarterly visits to review the overall performance of the Activities department. The QA committee will review the written reports from these quarterly visits to determine if compliance is being maintained or the need for additional training or staff change is necessary.	

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F 248	Continued From page 8 Review of the clinical record for Resident #19 revealed the facility readmitted the resident on 01/23/13 with diagnoses of Anxiety, Depression, and Insomnia. Review of the care plan revealed the facility was to provide pet visits, music, church, news and books. However, review of the activity documentation for January 2013 revealed the facility documented communion on 01/08/13 and 01/15/13 as well as a one on one visit that occurred on 01/24/13 to talk. Interview with Resident #19, on 02/21/13 at 2:00 PM, revealed the resident did not get out of bed per choice due to incontinence and did not like using the lift to get up. The resident stated visits by activities were mostly to talk. The resident indicated an interest in books; however, was too weak to hold a book. The resident stated audio books would be nice if they were short. The resident stated communion was offered; however, there were no spiritual visits from any clergy. Interview with the Activity Director, on 02/20/13 at 11:50 AM, revealed Resident #7 was bedfast and required one to one activities. She stated the resident would not get out of bed since the hospitalizations in January 2013 and she had not talked with the resident to determine the reasons for the resident refusing to get up. She stated the logs for the resident's attendance at activities were not available and were locked in a file and she did not have a key. She stated the care plan should reflect the resident's current status and the resident no longer was able to read the newspaper and refused to get up for group activities. She indicated a new assessment of the resident's needs had not been completed and	F 248		

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F 248	Continued From page 9 new interventions reflecting the changes in the resident were not implemented.	F 248		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to determine a significant change had occurred for one (1) of twenty-four (24) sampled residents and eight (8) unsampled residents (Resident #7). Resident #7 declined cognitively developed an unstable condition and was placed on anti-anxiety and anti-depressant medications after admission to the facility. The findings include: The facility used the Resident Assessment	F 274	F274 #1 A significant change assessment and interdisciplinary review for number 7 was completed on February 28, 2013. Care plan revisions were made as indicated. #2 By April 1, 2013, MDS staff and Director of Nursing will review all other residents' physical and mental conditions to determine if the resident's current status is consistent with the most recently completed comprehensive assessment and then subsequent quarterly MDS assessments. If there is noted decline or improvement, the resident will be evaluated for a significant change assessment. #3 On March 11, 2013, the facility's corporate nurse consultant provided re-education for the DON, interdisciplinary care team and all nurses who complete the resident assessment. The education focused on the requirements for completing a significant change and provided strategies for capturing the information needed to identify when a significant change is needed.	04/02/2013

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F 274	Continued From page 10 Instrument (RAI) Manual as the policy for completion of Minimum Data Set (MDS) assessments. The definition of a significant change included a decline in the resident's decision-making skills, development of an unstable condition and/or emergence of a sad or anxious mood as a problem. Observation of Resident #7, on 02/19/13 at 11:00 AM, revealed the resident was awake and alert. The resident was moving about in the bed and turning side to side restlessly. The resident was able to state their name and was confused as to time and place. A tube feeding was infusing via a gastric tube. Review of the clinical record for Resident #7 revealed the facility admitted the resident with diagnoses of Dementia with Behavior Disturbance, Left Sided Hemiparesis and Cerebral Vascular Accident. The facility completed an admission MDS assessment for the resident on 03/20/12 which indicated the resident had a Brief Interview for Mental Status (BIMS) of eleven (11) with the highest possible score of fifteen (15) being the most cognitively intact. The resident was able to eat and drink normally. Review of the quarterly MDS assessment completed by the facility for Resident #7 on 06/10/12 revealed the resident's BIMS had dropped to a nine (9) and an anti-depressant had been ordered by the physician. The resident had also lost five (5) pounds. Review of the next quarterly MDS assessment completed by the facility for Resident #7 was	F 274	F274 Continued from page 10 Following this education, this group completed a training post test to confirm comprehension of the material. Going forward, this education will be repeated for any newly hired MDS staff and as needed based on results of QA audits, by the MDS Coordinator. #4 The DON will review 10% of all assessments completed each week for the next 4 weeks and then 25% of all assessments completed monthly for the following 2 months to determine that significant changes are being completed as indicated. Following this initial quarter of reviews, the DON will review 10% of all MDS assessments completed quarterly and will report findings to the QA meeting so that compliance can be confirmed or need for additional re-education or systemic changes is identified.	

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F 274	Continued From page 11 dated 09/10/12. The MDS revealed the resident's BIMS had dropped to a four (4). The resident continued to receive the anti-depressant and an anti-anxiety medication had been ordered. The resident had lost six (6) more pounds. On 12/11/12 the facility completed a quarterly MDS assessment for Resident #7 which revealed the resident's BIMS score had dropped to a three (3). The resident continued on the anti-anxiety and anti-depressant medication. The clinical record indicated Resident #7 had two (2) hospital stays in January 2013 for Seizures and for a new diagnosis of Dysphagia which required the placement of a feeding tube. The physician documented the resident could receive nothing by mouth. Review of the comprehensive care plan for Resident #7 revealed the interdisciplinary team last revised the care plan on 12/11/12. Interview with Certified Nurse Aide (CNA) #3, on 02/20/13 at 2:30 PM, revealed Resident #7 required total care over the last few months and was very confused. She stated the resident could no longer eat or drink and had a feeding tube. She stated the resident refused to get out of bed and was often restless. Interview with the MDS Coordinator, on 02/21/13 at 3:20 PM, revealed she obtained information on changes in residents from several sources. She stated she attended a morning meeting where resident changes were discussed based on new physician orders, nursing's 24 hour report, CNA care records and incidents. She stated she	F 274		

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F 274	Continued From page 12 talked to CNAs and nurses and personally visited the resident. She stated the resident met the definition of significant decline in status and an MDS should have already been completed in order to develop a new care plan. Interview with the Director of Nursing, on 02/21/13 at 3:40 PM, revealed her expectation was for the MDS Coordinator to track residents' conditions and complete MDS assessments as indicated. She stated she was the supervisor for the MDS Coordinator and she had not ensured the MDS completion was correct or timely.	F 274		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the manufacture's operations manual for the Low Air Loss Mattress, it was determined the facility failed to follow the comprehensive plan of care for one (1) of the twenty-four (24)sampled residents and eight (8) unsampled residents, Resident #8 for application of the heel protection boots and use of the low air loss mattress. The findings include:	F 282	F282 #1 Resident #8 no longer resides in the facility. No further corrective action is warranted. #2 The wound nurse completed re-evaluations on all residents utilizing pressure relieving devices and powered support surfaces on March 15,2013. This review verified the use of such devices/mattresses is still appropriate for the residents' plan of care and the devices were physically available for use and properly functioning. The wound nurse reviewed the care plans and CNA assignment sheets to verify they identified of residents' need for usage of pressure relieving devices. The comprehensive care plans and CNA assignment sheets for all residents will be reviewed by the DON, and interdisciplinary team to ensure they are reflective of the services being provided,	04/02/2013

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F 282	Continued From page 13 Review of the manufacturer's manual detailing recommendations for use of the Low Air Loss Mattress Replacement System revealed to keep the control unit turned on while the resident was on the mattress and do a hand check test to ensure the appropriate settings. Review of Resident #8's clinical record revealed the facility admitted the resident on 01/30/13 with Pressure Ulcers to the sacral area and the left heel. The facility assessed the resident on the Minimum Data Set on 02/06/13 as requiring a two person assist for bed mobility and transfers. Review of the comprehensive plan of care revealed an intervention for pressure reduction boots and a low air loss mattress. Observation of Resident #8, on 02/19/13 at 12:26 PM, revealed the heel protection boots were sitting on the isolation can by the wardrobe at the foot of the bed. The heel protection boots were not placed on the resident until the dressing change was completed by the nurse on 02/19/13 at 2:45 PM. Interview with Certified Nursing Assistant (CNA) #2, on 02/19/13 at 2:54 PM, revealed she was aware the heel protection boots were to be on at all times while in bed. The CNA revealed the boots were removed that morning when the resident went to therapy and had not been reapplied upon return. The CNA revealed she was aware of the purpose of the boot and revealed a potential to have increase or worsening pressure areas to the resident's heels. The CNA revealed she obtained information regarding the care of residents from the CNA sheet.	F 282	F282 Continued from page 13 especially specialized assistive devices, and they match the aide assignment sheets. This review, and any identified care plan/assignment sheet revisions, will be completed by April 1, 2013. #3 By April 1, 2013, the Director of Nursing will complete re-education for all nursing staff related to providing services in accordance with each resident's written plan of care. To verify comprehension of the material, each staff member completed a post test derived from the training content. The Director of Staff Development will educate all newly hired staff during orientation and all nursing staff annually. The wound nurse has created a pressure relieving device tracking list. The wound nurse will be responsible for keeping the list current. As part of weekly wound rounds, the wound nurse will confirm the devices are available for use, functioning, and noted on the residents' care plan and CNA assignment sheet. This list will be distributed weekly to the Unit Managers and Director of nursing to increase focus on the use of pressure relieving devices during management rounds.	

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F 282	Continued From page 14 Review of the CNA sheet revealed it did not have information regarding the use of the heel protection boots. Interview with Licensed Practical Nurse (LPN) #1, on 02/19/13 at 3:38 PM, revealed heel protection boots should be on anytime the resident was in bed. The LPN revealed she did not know how long they had been off and had not been monitoring to ensure their placement. The LPN revealed the purpose of the boot was to protect from pressure and prevent worsening of the heel wound. The LPN revealed both the CNA and nurses were responsible to monitor for the placement of the boots. The LPN revealed the CNA assignment sheet had each residents care needs. The LPN revealed the Unit Supervisor was responsible to make the CNA sheets; however, anyone could add resident needs. The LPN revealed she did not know the pressure boots were not listed on the CNA sheet. Observation of Resident #8, on 02/20/13 at 11:15 AM, revealed the resident was in their room lying in the bed with the air mattress not turned on and deflated. Observation, on 02/20/13 at 2:00 PM, revealed the bed remained deflated and turned off. Interview with CNA #1, on 02/20/13 at 2:00 PM, revealed she returned the resident to bed after therapy and fed them lunch at 11:00 AM and never noticed the bed was deflated and turned off. Upon inspection the CNA revealed the low air loss mattress was unplugged from the wall. The CNA revealed she did not know much about the air mattress and did not know what the potential	F 282	F282 Continued from page 14 The Unit managers will formally use the device tracking list to complete a second weekly review of device usage. Corrective action will be initiated as needed. A report of the findings, and any necessary corrective actions, will be made to the Director of Nursing. By April 1, 2013, all nursing staff will receive, via written memo from the Director of Nursing, instruction in the use of powered pressure relieving mattresses. The Nurses will document the setting and function of the mattresses every shift on the TAR. #4 In additions to the weekly wound round checks, each week for the next quarter the Unit Managers will use the pressure relieving device tracking list to ensure the pressure relieving devices are available for use, functioning, noted on the resident's care plan and CNA assignment sheets, and being properly documented on the TAR. For the remaining quarters of the year, the Unit Managers will use the tracking list monthly. Weekly and monthly reports will be submitted to the Director of Nursing who will make a report of the findings during the quarterly QA committee meetings so compliance, or need for additional systemic modifications can be identified.	

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F 282	Continued From page 15 was for not having it plugged in and turned on. Interview with LPN #2, on 02/20/13 at 2:05 PM, revealed she had just given the resident an injection and did not notice the mattress being deflated, unplugged or turned off. The LPN revealed she was aware it was to be on and at what setting, but did not notice it was deflated. The LPN revealed a potential for increased or worsening pressure ulcers. Interview with Staff Development, on 02/21/13 at 4:15 PM, revealed the facility did do audits to ensure all assisted devices were being used, but had not provided training on the use of heel protectors or the mattresses. Interview with the Director of Nursing (DON), on 02/21/13 at 5:00 PM, revealed she did monitor for use of assisted devices and did random checks on the residents to ensure everything was in place. The DON revealed she could not remember if training had been provided. The DON revealed the interventions on the plan of care were developed to protect the residents skin and all nursing staff should be monitoring to ensure it was being followed.	F 282		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 #1 The oven and mixer were cleaned on February 22, 2013. The CNA who failed to follow proper technique when assisting residents with finger foods, was re-educated by the Director of Staff Development on March 12, 2013. Based on return demonstration of correct food handling techniques, the reeducation appears to have been effective.	04/02/2013

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F 371	Continued From page 16 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 one (1) of one (1) kitchen oven and one (1) of one (1) kitchen mixer were clean and sanitary. In addition a Certified Nursing Assistant was observed touching food with bare hands for one (1) of the twenty-four (24) sampled residents and eight (8) unsampled residents. Resident #8. The findings include: Reviews of the facility's policy regarding Environmental Sanitation/Infection Control: Cleaning of Ovens and Mixers, dated 2006, revealed ovens were to be kept clean and free of spills and grease. The policy stated cleaning should occur daily when spills occur and weekly of both the interior and exterior of the oven. The mixer should be cleaned and sanitized daily with all splatters wiped up immediately. 1. Observation of the kitchen during initial tour, on 02/19/13 at 7:50 AM, revealed the mixer was found covered with plastic; however, upon inspection white colored particles and splatters were noted on the motor and the back of the mixer. Further observation revealed the bottom of the interior aspect of the oven was covered with a build-up of a black colored hard substance. Interview with the Cook, on 02/19/13 at 7:50 AM, revealed both the mixer and the oven appeared	F 371	F371 Continued from page 16 #2 On February 21, 2013, the kitchen manager reviewed the previous quarters' sanitation audits, conducted by the consultant dietician, as well as the previous month's cleaning schedule to identify any other lapses in the facility's systems to store, prepare, distribute, and serve food under sanitary conditions. Any identified concerns were addressed at this time. The Director of Nursing and Unit Managers observed breakfast, lunch and dinner meals on February 22, 26, and March 14, 2013 to identify other nursing staff who may be in need of reeducation related to bare handed serving of food. No facility residents have been diagnosed with a food born related illnesses. #3 On February 21. 2013, the kitchen manager amended the cleaning schedule to increase the frequency of both the oven and mixer cleaning. In addition, the kitchen manager will now be signing off on the cleaning schedule so if scheduled cleaning for a piece of equipment or area gets deferred, the manager gets it rescheduled to ensure sanitation standards are being maintained.	

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F 371	Continued From page 17 dirty. The Cook revealed the mixer should be cleaned after each use and then covered with plastic indicating it was ready for use. The Cook revealed the oven was assigned to the evening cook for cleaning and was placed on a cleaning schedule posted on the door to the dry storage area. The Cook revealed the oven was scheduled for cleaning on Saturdays. Review of the cleaning schedule revealed the oven had not been initialed, indicating it was cleaned, for the two (2) weeks prior to survey. Interview with the Dietary Manager, on 02/21/13 at 2:30 PM, revealed dirty kitchen equipment had a potential for cross contamination of the food. The Dietary Manager revealed she did monitor the condition of the kitchen equipment and did notice the oven was not cleaned as assigned over the weekend, but did not notice it had not been cleaned for 2 weeks. The Dietary Manager revealed she had not yet investigated as to why the oven and mixer was not cleaned per policy and as assigned. 2. Observation of Resident #8 being fed lunch by Certified Nursing Assistant (CNA) #2, on 02/19/13 at 12:26 PM, revealed the CNA picking up the resident's french fries with her bare hands and feeding them to the resident. Interview with CNA #2, on 02/19/13 at 2:54 PM, revealed she normally handed finger foods to the resident and then let them feed themselves. The CNA revealed she was trained not to use her bare hands and knew she was not supposed to use bare handed contact with food due to a potential for cross contamination. The CNA	F 371	F371 Continued from page 17 Additionally, on March 18, 2013, the facility's consultant dietician will provide in-service training to all dietary staff. The content of the in-service will include review of the facility policies related to storing, preparing, distributing, and serving food under sanitary conditions. The in-service will emphasize the importance of following the cleaning schedule. Following this training, all associates completed a post test to ensure understanding of the training concepts was achieved. By April 1, 2013, the Director of Nursing will provide re-education related to the proper handling of resident trays for all nursing staff who assist with resident meals. Such education will continue to be part of new hire orientation. Annual CNA competency check offs will confirm proper food handling techniques are being utilized. To reduce the likelihood of bare handed touching or food, the kitchen manager will ensure food service gloves are available in the dining room and nursing units for use by the nursing staff. #4 The dietary manager will make weekly observations of kitchen sanitation.	

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F 371	Continued From page 18 revealed it was a habit and tried to be mindful of how she fed the residents. Interview with the Green Unit Manager (UM), on 02/21/13 at 1:55 PM, revealed he started three (3) weeks prior to survey and was still learning issues with the unit that required monitoring. The UM revealed he had not noticed bare handed touching of food, but revealed all staff should not be using bare hands due to cross contamination and the CNA should have used a fork to assist the resident with feeding. Interview with Staff Development, on 02/21/13 at 4:15 PM, revealed the facility educated all staff during orientation to not use their bare hands to feed residents. Staff Development stated an inservice was last completed in May 2012. Staff Development further stated he had not noticed this as a problem and revealed he did monitor for bare handed touching of food. Interview with the Director of Nursing (DON), on 02/21/13 at 5:00 PM, revealed training was completed for all staff on bare handed touching of food and preventing cross contamination. The DON revealed she did randomly make rounds and observe dining and did not identify bare handed touching of food as an issue.	F 371	F371 Continued from page 18 These observations will be recorded for the next quarter to ensure sanitation standards are being maintained. The consultant dietician will continue monthly sanitation audits. This will include review of the cleaning schedule to confirm it is being followed and sanitary conditions are being maintained. These reports will be presented to the QA committee so compliance or need for additional system revisions can be determined. In addition to routine observations made during management rounds, the Director of Nursing and Unit Managers will complete focused observations of 3 meals of week for the next quarter and then once a week for the remainder of the year to evaluate staff performance. The Director of Nursing will report the finding from these observations to the QA committee so compliance can be confirmed or need for further systemic change identified.	
F 441 SS=E	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.	F 441	F441 #1 Resident #8 no longer resides in the facility.	04/02/2013

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F 441	Continued From page 19 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to use proper hand hygiene during a dressing change for Resident #3, failed to use sanitary technique for Resident	F 441	F441 Continued from page 19 The Unit Managers have been monitoring resident #3 and #12 for indication of a negative outcome resulting from this alleged deficient practice. No additional corrective action has been needed. LPN #1 and #11 have been verbally coached by the Director of Nursing and Unit Manager concerning their failure to provide care in a manner consistent with accepted infection control practices. #2 The Director of Nursing and Medical Director will review the facility's infection reports, generated through surveillance of lab/culture results and antibiotic usage and weekly wound reports to identify any other residents who could have been affected by this alleged deficient practice. Physician notification will occur for any resident identified. #3 By April 1, 2013, the Director of Nursing will provide re-education for the licensed staff related to the facility's infection control policies. The re-education will emphasize hand hygiene and dressing changes to include both sterile and wet to dry techniques.	

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F 441	Continued From page 20 #8, failed to properly close a urinary drainage port and prevent the port from touching the floor for Resident #12 and failed to assure soiled briefs and linens were not left on the floor for three (3) of twenty-four (24) sampled residents and eight (8) unsampled residents. The findings include: 1. Review of the facility's policy regarding Hand Hygiene, dated 11/01/12, revealed moving from a contaminated body site to a clean body site during resident care was a situation that required hand hygiene. Review of the facility's policy regarding Dressings, date 02/01/12, revealed the procedure when removing a soiled dressing was to pull glove over the soiled dressing, discard the soiled dressing in a biohazard bag and to wash and dry hands thoroughly before reapplying gloves. Observation of a dressing change for Resident #3 on 02/19/13 at 4:00 PM, revealed Licensed Practical Nurse (LPN) #11 did not remove her soiled gloves after removing the soiled dressing from Resident #3's buttock wound. LPN #11 applied the new dressing wearing the soiled gloves and then touched the resident's hand. Interview with LPN#11, on 02/19/13 at 4:30 PM, revealed she was trained to wash her hands and reapply clean gloves when going from a dirty to a clean area during any resident care. LPN #11 commented she did not know why she did not follow the policy and this could create an infection for the resident.	F 441	F441 Continued from page 20 This re-education also included a review of infection control practices related to catheter care and meal service/ food handling. A post test will be used to demonstrate competency of the training material. The Director of Nursing will provide re-education for the CNAs related to hand hygiene, proper handling of linens and briefs, catheter care, and infection control practices related to meal/food service handling. A post test will be used to demonstrate competency of the training material. Infection control will continue to be a part of the new hire orientation and required annual in-service training. On March 13, 2013 the Director of Nursing revised the facility's indwelling catheter policy so it now identifies proper placement of the urinary drainage port. #4 To ensure proper infection control practices are being implemented, the Unit Managers, Director of Staff Development, and Director of Nursing will observe every nurse perform a dressing change, at least twice, over the next four weeks.	

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	185300		02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 21 Interview with the Wound Care Nurse LPN #14, on 02/20/13, revealed the staff was trained to remove soiled gloves, wash their hands and reapply clean gloves whenever going from a dirty to clean area during resident care. LPN #14 commented this could spread bacteria. 2. Review of the facility's policy regarding Indwelling Urinary Catheter, not dated, revealed it did not include proper placement of the urinary drainage port. Review of the facility's policy regarding Dressings, dated 02/01/13, revealed a process to provide guidelines for the application of a clean dressing and handling of contaminated dressing in a sanitary manner by pulling glove over dressing and discard into plastic or biohazard bag. Observation of Resident #8, on 02/19/13 at 12:26 PM, revealed Certified Nursing Assistant (CNA) #2 sitting at the resident's bedside feeding the resident lunch. The drainage port to the urinary drainage bag was out of the holder and lying on the floor. Observation of Resident #12, on 02/19/13 at 2:05 PM and on 02/20/13 at 10:25 AM, revealed a soiled brief and a pile of bed linen on the floor saturated with a yellow colored substance. Interview with CNA #2, on 02/19/13 at 2:54 PM, revealed she did not notice the urinary drainage spout being on the floor till she emptied the	F 441	F441 Continued from page 21 The Director of Staff Development and Unit Managers will, for the remainder of the year, continue these observations so that every nurse is observed again at least once a quarter to ensure proper infection control practice is being followed. The Director of Staff Development and Unit Managers will make documented observations of the CNA handling of linens and briefs weekly for the next 12 weeks and then monthly for the remainder of the year. The sample size for these observations will be 10. The ADON will compile the results of these observations and report the findings to the QA Committee so compliance or need for additional systematic change may be determined.	

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F 441	Continued From page 22 drainage bag at the end of her shift. The CNA revealed the drainage was last emptied by the previous shift at 6:00 AM. The CNA revealed the spout on the floor was a potential problem for infection control and should have been more mindful as the resident had a recent urinary tract infection. The CNA confirmed placing a soiled brief on the floor, the CNA revealed it was put there while she was changing Resident #12. The CNA revealed she had been told not to place soiled briefs and linens on the floor due to problems with infections. Interview with CNA #1, on 02/20/13 at 2:00 PM, revealed she did place a soiled brief on the floor after changing Resident #12 and revealed she had been trained not to do this and it was an infection problem. The CNA revealed she had not placed the trash can within reach while providing care. Observation of a dressing change for Resident #8 with Licensed Practical Nurse (LPN) #1, on 02/19/13 at 2:14 PM, revealed the nurse opened a bottle of normal saline and placed the lid to the bottle face down, directly on the overbed table. The LPN then reapplied the lid to the bottle. The same bottle of normal saline was used again for cleaning of a wound on the resident's heel. A clean dressing was applied to the heel wound, but then removed and the LPN placed the contaminated dressing on the overbed table. A clean dressing was then prepped and prepared directly on the surface of the overbed table and then applied to the wound. The dressing change items were collected once completed and the overbed table was not cleaned after the dressing change was completed.	F 441		

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F 441	Continued From page 23 Interview with LPN #1, on 02/19/13 at 3:38 PM, revealed she had been trained on wounds and dressing change techniques. The LPN revealed placing the lid back on the bottle of normal saline contaminated the lid and the bottle of solution once it was reapplied. The LPN revealed placing the soiled dressing on the overbed table and placing the clean dressing on the table was a potential for infection control. The LPN revealed the dressing from the table was not clean and should not have been applied to the resident's wound. Interview with Staff Development, on 02/21/13 at 4:15 PM, revealed an inservice on dressing change technique, which included a skills check off was completed upon hire and annually there after. Staff Development further stated the Director of Nursing (DON) would notify him when a concern had been identified and required more inservice. Staff Development revealed the described technique posed a risk for infections. He stated the audits had been completed to monitor technique and handwashing. He had noticed a problem with soiled briefs and linens being placed on the floor and did provide an inservice and notified the Unit Managers to monitor for that practice. Staff Development stated placing the soiled items on the floor created problems with infections and also contributed to the odors in the facility. Interview with the DON, on 02/21/13 at 5:00 PM, revealed poor dressing change technique created a potential for infections. The DON revealed she was not monitoring for actual dressing change technique or for proper disposal of briefs and	F 441		

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F 441	Continued From page 24 revealed a potential problem for improper technique and soiled linens on the floor was the spread of infections and odors.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to assure resident equipment was not stored on overhead lights, failed to assure all bathrooms had emergency call cords and failed to assure the facility was free of odors throughout the facility for one (1) of twenty-four (24) sampled residents and eight (8) unsampled residents. Unsampled Resident C and two (2) of two (2) public bathrooms. The findings include: 1. The facility did not provide a policy for storage of resident equipment. Observation during the environmental tour, on 02/20/13 at 10:50 AM, revealed a splint leg reacher was stored on the resident's overhead light.	F 465	F465 #1 The splint and reacher were removed from the over bed light in unsampled resident C's room on February 22, 2013. Storeroom locksets, which remain locked at all times, were installed on the common area restrooms on March 7, 2013. The linens and brief were removed from #12's room the day of this observation. On March 14, 2013, the soiled utility rooms were cleaned, including the sink hoppers and rolling brief containers. At this time, the Director of Nursing confirmed that all rolling brief containers had lids and that routine emptying of the containers is part of the CNA orientation and shift assignments. #2 To identify other potential areas where the facility was not compliant in providing a safe, functional, sanitary, and comfortable environment for residents, staff, and the public, the Administrator, Director of Maintenance, and Director of Housekeeping will complete an inspection of resident rooms, common areas, and service areas on March 19, 2013.	04/02/2013

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F 465	Continued From page 25 Interview with Unsampled Resident C, on 02/21/13 at 9:20 AM, revealed he did not place the leg reacher on the light fixture. Unsampled Resident C further stated he had been looking for the reacher for a while now. Interview with Certified Nursing Assistant (CNA) #3, on 02/21/13 at 9:20 AM, revealed the therapy staff used the splint leg reacher to help Unsampled Resident C put on his/her shoes. CNA #3 stated she did not put the splint leg reacher on the resident's overhead light. Interview with Licensed Practical Nurse (LPN) #3, on 02/21/13 at 10:55 AM, revealed staff was not supposed to store items on the light fixture because it was a fire hazard. Interview with Director of Nursing (DON), on 03/21/13 at 3:56 PM, revealed no items should be stored above the overhead light as it could be a hazard. Interview with the Maintenance Director, on 02/21/13 at 9:05 AM, revealed he was not aware staff was storing items on the light fixture. The Maintenance Director further stated staff was not to do that. 2. The facility did not provide a policy regarding emergency call cords in public bathrooms. Observations of two (2) of two (2) public bathrooms located in the front lobby, which was open to residents, on 02/19/13 at 9:48 AM, revealed no emergency pull cords available. Interview with the Maintenance Director, on	F 465	F465 Continued from page 25 In addition, these parties reviewed the findings from the past quarter's monthly maintenance overviews conducted by the facility's Regional Director of Facilities Management, maintenance job logs, QA room inspection checklists, grievance logs, and resident council concerns. Identified concerns have been scheduled for cleaning, repair or replacement. These will be completed by April 1, 2013. #3 On March 22, 2013, the Administrator distributed a memo to all staff detailing the requirements of this regulation and assigning responsibility to all staff for keeping the facility in compliance. The memo reviewed the procedure for reporting/requesting housekeeping or maintenance services and it empowered all associates to resolve issues that could lead to non compliance. The Director of Nursing assigned responsibility for confirming the condition of the soiled utility rooms remains acceptable to the Unit Managers and desk nurse shift supervisors.	

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F 465	Continued From page 26 02/21/13 at 9:05 AM, revealed he was not aware the two (2) bathrooms which stayed open to the public needed a pull cord. Interview with the DON, on 02/21/13 at 3:56 PM, revealed she was not aware there should be pull cords in the front lobby bathrooms. She stated someone could have an injury and the staff would not know it. 3. Review of the facility's Housekeeping/Laundry Department Policy, not dated, revealed the facility would provide a clean, safe and sanitary environment for the residents. To keep the building and facilities of Summerfield Manor clean and orderly. Observation during initial tour, on 02/19/13 at 8:00 AM, revealed the smelled of urine and stool permeated the entire building on all units. Observation of the Blue unit, on 02/20/13 at 3:10 PM, revealed odors of stool. A strong smell was noted in the corridor between the shower room and the soiled utility area, located at the entrance to the 200 hall. A large white plastic rolling garbage container was also noted with multiple plastic clear bags inside the garbage container. Upon further inspection of the clear bags, revealed visible white briefs inside, with a brown, smeared substance. The clear bags were noted to be stacked higher than the garbage container. In addition, there was no lid on the garbage container to contain the multiple bags of garbage. Observation of the Soiled Utility Room, on 02/21/13 at 2:55 PM, revealed the hopper had a brown water substance that prevented	F 465	F465 Continued from page 26 The Director of Staff development will explain the facility's obligation to provide a safe, functional, sanitary, and comfortable environment during new hire orientation and annually thereafter in conjunction with ongoing Resident Rights re-education. #4 On a monthly basis, the Safety Committee will review the results of the safety checklist and the "Are you ready for Company," checklist. Both tools evaluate the condition of the physical plant and resident environment including overbed light storage, nurse call system function, and facility odors. Identified concerns will be reported to the QA committee to that compliance or need for additional systemic change may be determined.	

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F 465	Continued From page 27 observation of the bottom of the hopper and smelled of feces. Interview with Resident #3's family member, on 02/20/13 at 11:00 AM, revealed he/she had noted odors in the hallways upon entering the building. Interview with the Housekeeping Manager, on 02/21/13 at 9:25 AM, revealed the housekeepers were not responsible for the garbage, that it was the CNA staff who were responsible to remove the garbage. Continued interview with the Housekeeping Manager, on 02/21/13 at 10:55 AM, revealed she was not aware the garbage cans had no lids. Interview with CNA #4, on 02/21/13 at 9:55 AM, revealed she had not noticed any smells. CNA #4 stated the CNA's were to never allow the garbage cans to overflow. CNA's were assigned to remove garbage twice a shift. Interview with LPN #4, on 02/21/13 at 9:45 AM, revealed the CNA's were assigned to remove the garbage twice a shift and when the garbage cans were full there was an odor. LPN #4 stated she had smelled odor's before at the nurses station. Interview with the Manager of the Blue Unit, on 02/21/13 at 3:45 PM, revealed she did not smell odors when she walked into the building. she had smelled odors when she walked past a room that had a resident getting a brief changed. No one had complained about the smells, just little isolated issues, like a mother stating someone had an accident. No one had ever reported to her that the garbage container in the soiled utility room was missing a lid.	F 465		

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

PRINTED: 03/06/2013
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
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F 465	Continued From page 28 Interview with the DON, on 02/21/13 at 3:56 PM, revealed the CNA's were to tie off the clear bags when they completed their brief changes and then removed the garbage twice a day. Usually the Unit Manager monitored the garbage cans and they had not had any complaints from the families. Observation of Resident #12, on 02/19/13 at 2:05 PM and 02/20/13 at 10:25 AM, revealed a soiled brief and a pile of bed linen on the floor saturated with a yellow colored substance. Interview with Staff Development, on 02/21/13 at 4:15 PM, revealed he had noticed a problem with soiled briefs and linens being placed on the floor, and provided an inservice to the staff member and notified the Unit Managers to monitor for that practice. The Staff Development stated placing the soiled items on the floor contributed to the odors in the facility. Interview with the DON, on 02/21/13 at 5:00 PM, revealed she was not monitoring for proper disposal of briefs and revealed a potential problem for odors	F 465		

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

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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
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1979, 1998 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: one (1) story, Type V (111) SMOKE COMPARTMENTS: twelve (12) 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 diesel. A standard Life Safety Code survey was initiated on 02/19/13 and concluded on 02/20/13. Summerfield Health and Rehab Center was found to be not in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire). The facility is certified for one hundred sixty-five (165) beds with a census of one hundred fourty-nine (149) on the day of the survey.	K 000	KOOO This plan of correction is prepared and executed because it is required by the provisions of State and Federal law and not because Summerfield Health and Rehabilitation Center agrees with the citations noted on the pages of this Statement of Deficiencies.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
X Levi Foot	X Administrator	X 3-15-13

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 The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 025 SS=E	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 observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect six (6) of twelve (12) smoke compartments, residents, staff and visitors. The facility is certified for one hundred sixty five (165) beds with a census of one hundred forty nine (149) on the day of the survey. The findings include:	K 025	K025 #1 The facility maintenance department, using fire rated materials, will seal all smoke wall penetrations referenced with this citation. The completion date for this project is April ~~6~~, 5 2013. #2 On April 1, 2013, the facility Maintenance Director and Regional Director of Facilities Management (RDFM) will complete a visual inspection of all smoke barriers. The tour will identify remaining penetrations or previous repairs with non fire rated materials. Repairs to these areas, using fire rated materials, will be completed by the Maintenance Director or Senior Maintenance assistant on April ~~6~~, 5 2013. #3 On April 1, 2013, the Regional Director of Facilities Management (RDFM) reviewed the requirement of this regulation with the Director or Maintenance and Maintenance Assistants.	4-6-13 ~~04/07/~~ 2013 per Kevin Forte Adm key PB 3-22-13

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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 025	Continued From page 2 Observations, on 02/19/13 between 1:00 PM and 2:00 PM, with the Maintenance Director revealed the smoke barriers, extending above the ceiling had penetrations of pipes and the use of unrated material. The penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. The locations of the penetrations are as follows: 1) 100 Hall by the nurses' station had unrated foam used to seal penetrations. 2) 100 Hall by the Center Hall had penetrations around the main sprinkler pipe. 3) 500 Hall by the Center Hall had penetrations around the main sprinkler pipe. 4) 700 Hall had penetrations by wires and the use of unrated foam to seal penetrations. Interview, on 02/19/13 between 1:00 PM and 2:00 PM, with the Maintenance Director revealed he was not aware of the penetrations or the use of the unrated foam. Interview, on 02/20/13 at 2:00 PM, with the Administrator revealed he was aware of the requirements for smoke barriers but not aware of the penetrations or the use of unrated foam. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as	K 025	K025 Continued from page 2 At this time, the RDFM and Maintenance Director added a monthly inspection of smoke barriers to TELS, the facility's preventive maintenance system. The Director of Maintenance, or Senior Maintenance Assistant, will document the inspection results, and any necessary repairs using fire rated materials, in the TELS system. In addition, the RDFM has worked with the Director of Maintenance to develop a new procedure for signing in/signing out contractors and reviewing their finished work prior to departure to ensure smoke wall penetrations have been properly sealed using rated materials. #4 To ensure compliance has been achieved and is being maintained, each month for the next 3 months and then quarterly for the rest of the year, the Director of Maintenance will report the results of the monthly inspections to the facility safety committee. If ongoing compliance with this requirement is in doubt, the Safety Committee will refer the issue to the full QA committee for resolution. In addition, the RDFM will review TELS compliance on a monthly basis.	

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	185300		02/20/2013

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K 025	Continued From page 3 follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025	K025 Continued from page 3 Any deferred scheduled preventive maintenance or LSC required service will be reported to the Administrator who will bring the identified concerns to the QA committee for resolution.	
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 exits were maintained in accordance with NFPA standards. The deficiency had the potential to	K 038	K038 #1 The Blue Unit courtyard exit gate was hung to swing with the direction of egress travel. This was completed on March 15, 2013. #2 On March 15, 2012, the Administrator and Director of Maintenance reviewed the facility's fire evacuation plan to identify all fire plan exit doors and courtyard gates and completed a visual inspection of each exit door and courtyard gate to confirm they functioned without impediment and they swung in the direction of egress travel.	4-6-13 ~~04/07/~~ 2013 per Kevin Frith 2 by PB 3-20-13

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K 038	Continued From page 4 affect one (1) of twelve (12) smoke compartments, residents, staff, and visitors. The facility has one hundred sixty five (165) certified beds with a census of one hundred forty nine (149) on the day of the survey. The findings include: Observation, on 02/19/13 at 4:50 PM, with the Maintenance Director revealed a gate outside the Dining Room exit that did not swing in the direction of egress located in the Blue Courtyard. Interview, on 02/19/13 at 4:50 PM, with the Maintenance Director revealed he was not aware the gate was swinging the wrong way. Interview, on 02/20/13 at 2:00 PM, with the Administrator revealed he was not aware the gate was swinging the wrong way. 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	K 038	K038 Continued from page 4 This inspection was documented in the facility's Life Safety binder. #3 On April 1, 2013, the Regional Director of Facilities Management (RDFM) reviewed the requirement of this regulation with the Director or Maintenance and Maintenance Assistants. At this time, the RDFM and Maintenance Director expanded the weekly inspection of all fire exits, currently required by TELS, the facility's preventive maintenance system, to include an inspection of all courtyard exit gates. The Director of Maintenance, or Senior Maintenance Assistant, will document the inspection results, and any necessary repairs, in the TELS system. #4 To ensure compliance has been achieved and is being maintained, each month for the next 3 months and then quarterly for the rest of the year, the Director of Maintenance will report the results of the weekly inspections to the facility safety committee. If ongoing compliance with this requirement is in doubt, the Safety Committee will refer the issue to the full QA committee for resolution.	

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K 038	Continued From page 5 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. Reference: CMS S&C letter 5-38	K 038	K038 Continued from page 5 In addition, the RDFM will review TELS compliance on a monthly basis. Any deferred scheduled preventive maintenance or LSC required service will be reported to the Administrator who will bring the identified concerns to the QA committee for resolution.	
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, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect two (2) of twelve (12) smoke compartments, residents, staff and visitors. The facility is certified for one hundred sixty five (165) beds with a census of one hundred forty nine (149) on the day of the survey. The findings include:	K 045	K045 #1 By April 6, 2013, facility maintenance department will install lighting, capable of illuminating the path of egress, in both the Green and Blue unit courtyards. This lighting will be powered by an electric circuit served by the facility's emergency generator. #2 On March 15, 2013, the Administrator and Director of Maintenance reviewed the facility's fire evacuation plan to identify all fire exits and completed a visual inspection of each exit to confirm a functioning light, compliant with the requirements of this regulation, was installed at each exit. This inspection was documented in the facility's Life Safety binder.	4-6-13 04/07 2013 [illegible] by PB 3-22-13

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K 045	Continued From page 6 Observation, on 02/19/13 at 11:29 PM, with the Maintenance Director revealed two exterior exits with only one light bulb outside to light the egress path. The exits with only one light were located in the Green and Blue Resident Lounge. Interview, on 02/19/13 at 11:29 PM, with the Maintenance Director revealed he was not aware the exits did not have the required illumination for egress lighting. Interview, on 02/20/13 at 2:00 PM, with the Administrator revealed he was not aware 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. 7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided 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.	K 045	K045 Continued from page 6 #3 On April 1, 2013, the Regional Director of Facilities Management (RDFM) will review the requirement of this regulation with the Director or Maintenance and Maintenance Assistants. At this time, the RDFM and Maintenance Director will add a monthly inspection of fire exit exterior lighting to TELS, the facility's preventive maintenance system. The Director of Maintenance, or Senior Maintenance Assistant, will document the findings of these monthly inspections in the TELS system. #4 To ensure compliance has been achieved and is being maintained, each month for the next 3 months and then quarterly for the rest of the year, the Director of Maintenance will report the results of the inspections to the facility safety committee. If ongoing compliance with this requirement is in doubt, the Safety Committee will refer the issue to the full QA committee for resolution. In addition, the RDFM will review TELS compliance on a monthly basis. Any deferred scheduled preventive maintenance or LSC required service will be reported to the Administrator who will bring the identified concerns to the QA committee for resolution.	

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

PRINTED: 03/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 045	Continued From page 7 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 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.	K 045		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in	K 047	K047	4-6-13 ~~04/07/2013~~ Kevin Foots by PB 2-22-13

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K 047	Continued From page 8 accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of twelve (12) smoke compartments, residents, staff and visitors. The facility is certified for one hundred sixty five (165) beds with a census of one hundred forty nine (149) on the day of the survey. The facility failed to ensure exits were clearly recognizable with proper exit signage. The findings include: Observation, on 02/19/13 at 3:12 PM, with the Maintenance Director revealed the exit doors located in the two (2) resident lounges did not have an exit sign above the door making the path of egress clearly recognizable. Interview, on 02/19/13 at 3:12 PM, with the Maintenance Director revealed he was not aware the exits did not have proper signage. Interview, on 02/20/13 at 2:00 PM, with the Administrator revealed he was not aware the exits did not have proper signage. Reference: NFPA 101 (2000 edition)	K 047	K047 Continued from page 8 #1 Illuminated "Exit" signs were installed above the entrances to both the Green and Blue unit lounges and above both the Green and Blue unit lounges courtyard exit doors. These signs will be powered by an electric circuit served by the emergency generator. The installations were completed on March 15, 2013. #2 On March 15, 2013, the Administrator and Director of Maintenance reviewed the facility's fire evacuation plan to identify all fire exits. On March 14, 2013, the Administrator and Maintenance Director completed a visual inspection of each exit to confirm a functioning exit sign was installed at each fire exit. No additional sign installations were needed. This inspection was documented in the facility's Life Safety binder. #3 On April 1, 2013, the Regional Director of Facilities Management (RDFM) will review the requirement of this regulation with the Director or Maintenance and Maintenance Assistants. At this time, the RDFM and Maintenance Director will add a monthly inspection of fire exit signage to TELS, the facility's preventive maintenance system.	

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K 047	Continued From page 9 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.	K 047	K047 Continued from page 9 The Director of Maintenance, or Senior Maintenance Assistant, will document the findings of these monthly inspections in the TELS system. #4 To ensure compliance has been achieved and is being maintained, each month for the next 3 months and then quarterly for the rest of the year, the Director of Maintenance will report the results of the inspections to the facility safety committee. If ongoing compliance with this requirement is in doubt, the Safety Committee will refer the issue to the full QA committee for resolution. In addition, the RDFM will review TELS compliance on a monthly basis. Any deferred scheduled preventive maintenance or LSC required service will be reported to the Administrator who will bring the identified concerns to the QA committee for resolution.	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, installed in accordance with NFPA Standards. The deficiency had the potential to affect six (6) of twelve (12) smoke compartments, residents, staff and visitors. The facility is certified for one hundred sixty five (165) beds with a census of one hundred forty nine (149) on the day of the survey. The facility failed to ensure sprinkler	K 056	K056 #1 Kentuckiana Sprinkler Company has been scheduled to replace the mixed response sprinkler heads located in rooms 102, 104, 108, 204, 206, 210, 212, 405	05/12/2013

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K 056	Continued From page 10 heads installed in a compartment were of the same temperature response type, and not blocked by light fixtures. The findings include: 1. Observations, on 02/19/13 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed mixed response sprinkler heads located in rooms #102, 104, 108, 204, 206, 210, 212, 405. Further observation revealed a recalled STAR ME1 sprinkler head located in the Kitchen. Interview, on 02/19/13 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed he was not aware of the requirement for sprinkler heads being of the same response rating and not aware of the recalled sprinkler head. Interview, on 02/20/13 at 2:00 PM, with the Administrator revealed he was not aware of the installation requirements for sprinklers, or the recalled sprinkler head located in the Kitchen. 2. Observations, on 02/19/13 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed sprinkler heads that were blocked by light fixtures being mounted too close to the sprinkler head located in the Main Office, Admissions Office, Copier Room, Social Services Office, Employee Lounge, Office Manager's Office, Green Common Shower, 700 Hall Sitting, Medical Supply Office 700 Hall, Therapy Hall, Therapy Room, and Blue Oxygen Room Bathroom. Interview, on 02/19/13 between 1:00 PM and 5:00 PM, with the Maintenance Director revealed he	K 056	K056 Continued from page 10 and the recalled head located in the kitchen. For the remaining sprinkler heads being identified as being blocked by light fixtures, the blockages will be abated by replacing or moving the light fixture when feasible and by installing longer sprinkler heads when necessary. #2 On March 11, 2013, the Director of Maintenance and representative from A&M Electric toured the entire building to identify all other sprinkler heads being blocked by lighting fixtures. On March 13, the Director or Maintenance and a representative from Kentuckiana Sprinkler Company toured the entire facility to identify all other smoke compartments with mixed response, recalled, or blocked sprinkler heads. The Director of Maintenance marked the location of heads requiring corrective action on a facility blueprint. The Regional Director of Facility Management (RDFM) will complete another building tour on April 1st to confirm the accuracy of the blueprint and the identified scope of work required to bring the building into compliance with this requirement.	

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K 056	Continued From page 11 was not aware of the light fixtures being mounted too close to sprinkler heads. Interview, on 02/20/13 at 2:00 PM, with the Administrator revealed he was not aware of the installation requirements for sprinklers. Reference: NFPA 13 (1999 Edition) 7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response	K 056	K056 Continued from page 11 #3 Based on this scope of work, no later than April 3rd, work orders will be submitted authorizing A&M to order the identified lighting fixtures and authorizing Kentuckiana to begin the process of measuring the sprinkler heads to be replaced so fabrication of the new heads can begin. The lead time for lighting delivery is approximately 3 weeks with installation to begin upon receipt by the facility maintenance staff. Lighting installation will be completed in one week. The lead time for the manufacture of sprinkler heads is two to three weeks. Installation will occur upon receipt by Kentuckiana and should take approximately a week. On April 1, 2013, the Regional Director of Facilities Management (RDFM) will review the requirement of this regulation with the Administrator, Director of Maintenance and Maintenance Assistants. The Director of Maintenance will be responsible for oversight of this project.	

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K 056	Continued From page 12 sprinklers shall be permitted to be used. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. Reference: NFPA 13 (1999 edition) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.	K 056	K056 Continued from page 12 He will alert the Administrator and Regional Director of Facilities Management if the project cannot be completed by May 12, 2013. The Administrator will notify the OIG Central office in Frankfort to request a temporary waiver of this requirement until the project is completed. #4 The Director of Maintenance will visually check 25% of the facility's sprinkler heads each quarter for the next year. These checks will be recorded in TELS, the facility's preventive maintenance program. The Director of Maintenance will report the results of the inspections to the facility safety committee. If ongoing compliance with this requirement is in doubt, the Safety Committee will refer the issue to the full QA committee for resolution. In addition, the RDFM will review TELS compliance on a monthly basis. Any deferred scheduled preventive maintenance or LSC required service will be reported to the Administrator who will bring the identified concerns to the QA committee for resolution.	

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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
	185300		02/20/2013

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K 056	Continued From page 13 Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP) Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B — Maximum Allowable Distance of Deflector Obstruction (in.) Less than 1 ft — 0 1 ft to less than 1 ft 6 in. — 21/2 1 ft 6 in. to less than 2 ft — 31/2 2 ft to less than 2 ft 6 in. — 51/2 2 ft 6 in. to less than 3 ft — 71/2 3 ft to less than 3 ft 6 in. — 91/2 3 ft 6 in. to less than 4 ft — 12 4 ft to less than 4 ft 6 in. — 14 4 ft 6 in. to less than 5 ft — 161/2 5 ft and greater — 18 For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).	K 056		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25,	K 062	K062	04/02/2013

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K 062	Continued From page 14 9.7.5 This STANDARD is not met as evidenced by: Based on sprinkler testing record review, and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect twelve (12) of twelve (12) smoke compartments, residents, staff and visitors. The facility is certified for one hundred sixty five (165) beds with a census of one hundred forty nine (149) on the day of the survey. The facility failed to complete the required testing for the sprinkler system. The findings Include: Sprinkler Testing Record Review, on 02/19/13 at 11:20 AM, with the Maintenance Director revealed the facility did not have documentation that the gauges on the sprinkler riser had not been calibrated or replaced within the last five years. Interview, on 02/19/13 at 11:20 AM, with the Maintenance Director revealed he was not aware of the requirement. Interview, on 02/20/13 at 2:00 PM, with the Administrator revealed he was not aware of the requirement. Reference: NFPA 13 (1999 Edition) 2-2.1.1* Sprinklers shall be inspected from the	K 062	K062 Continued from page 14 #1 On February 22, 2013, Kentuckiana Sprinkler Company replaced all the air and water pressure gauges on the facility's sprinkler riser. The date of installation was written on the gauges. The service ticket will be filed in the Life Safety binder until the next quarterly inspection when the gauge replacement will be officially documented. #2 The facility has only one riser so no further deficient practice was identified. All other required sprinkler system maintenance and inspections are up to date and documented in the facility's Life Safety binder. #3 On April 1, 2013, the Regional Director of Facilities Management (RDFM) will review the requirement of this regulation with the Director or Maintenance and Maintenance Assistants. At this time, the RDFM and Maintenance Director pre-scheduled riser gauge replacement in TELS, the facility's preventive maintenance program. A month before the gauges' installation 5 year anniversary, the program will alert the facility Director of Maintenance and RDFM of the need for required service to allow time for the contractor to be scheduled.	

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K 062	Continued From page 15 floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used. Reference: NFPA 25 (1998 Edition).	K 062	K062 Continued from page 15 #4 As part of ongoing preventive maintenance activities, the sprinkler riser water and air pressure gauges are checked weekly by either the Director of Maintenance or the Senior Assistant. Any noted problems will be referred to the sprinkler contractor for resolution. Additionally, the contractor will verify the gauges appear to remain fit for duty as part of routine quarterly inspections. The Director of Maintenance will alert the QA committee of any identified concerns with the riser gauges so a more lasting solution may be found.	

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K 062	Continued From page 16 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections. 10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel. Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance	K 062		

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K 062	Continued From page 17 Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10 Reference: NFPA 13 (1999 Edition)	K 062		

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K 062	Continued From page 18	K 062		
	5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.			
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that fire extinguishers were maintained in accordance with NFPA standards. The deficiency had the potential to affect smokers, staff, and visitors. The facility is certified for one hundred sixty five (165) beds with a census of one hundred forty nine (149) on the day of the survey. The facility failed to ensure the designated smoking areas had a fire extinguisher. The findings include: Observation, on 02/19/13 at 4:51 PM, with the Maintenance Director revealed there was no fire extinguisher located in the designated smoking areas.	K 064	K064 #1 On March 13, 2013, fire extinguishers were installed in the designated resident smoking areas. The fire extinguishers will be maintained by the facility's fire extinguisher contractor. #2 The facility has a service arrangement with a certified contractor for the maintenance of it fire extinguishers. Documentation of the required maintenance is in the facility's Life Safety binder. All extinguishers are correctly labeled, tagged, and required signage is posted. All extinguishers are visually inspected monthly by either the Director of Maintenance or Senior Maintenance assistant to verify their presence and apparent fitness for duty. The service contractor is notified immediately to resolve any apparent deficiency.	04/02/ 2013

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K 064	Continued From page 19 Interview, on 02/19/13 at 4:51 PM, with the Maintenance Director revealed he was not aware that a fire extinguisher was required to be located in the smoking areas. Interview, on 02/20/13 at 2:00 PM, with the Administrator revealed he was not aware that a fire extinguisher was required to be located in the smoking areas. Reference: NFPA 10 1999 4-3.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d)* Safety seals and tamper indicators not broken or missing (e) Fullness determined by weighing or "hefting" (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place 4-3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 4-3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. Reference: NFPA 10 (1998 edition)	K 064	K064 Continued from page 19 #3 On April 1, 2013 the facility's Regional Director of Facilities Management (RDFM) will review the requirements of this regulation with the Director of Maintenance and Assistants. As part of routing preventive maintenance and safety activities, the maintenance department will continue verifying all facility fire extinguishers remain in place and ready for use on a monthly basis. The additional extinguishers for the smoking areas were added to TELS, the facility's preventive maintenance program, by the RDFM and facility Director of Maintenance. #4 To ensure compliance has been achieved and is being maintained, each month for the next 3 months and then quarterly for the rest of the year, the Director of Maintenance will report the results of the inspections to the facility safety committee. If ongoing compliance with this requirement is in doubt, the Safety Committee will refer the issue to the full QA committee for resolution. In addition, the RDFM will review TELS compliance on a monthly basis.	

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K 064	Continued From page 20 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.	K 064	K064 Continued from page 20 Any deferred scheduled preventive maintenance or LSC required service will be reported to the Administrator who will bring the identified concerns to the QA committee for resolution.	
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. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of	K 066	K066 #1 On March 15, 2013 a fire rated, self closing receptacle for disposal of ashes and cigarette butts was placed near the smoking area in the designated resident smoking areas. #2 On March 15, 2013, the facility Administrator and Director of Maintenance inspected all of the facility designated smoking areas. These areas all have "smokers post" type self extinguishing ash and cigarette butt receptacles. The facility janitor is responsible for emptying these receptacles. On March 15, 2013, the facility provided him with a fire rated, self closing receptacle for this task. No smoking signs are posted at the facility entrances, oxygen storage areas and the facility smoking policy is presented during the admission process to ensure residents and visitors are aware of the smoking areas.	04/04/2013

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K 066	Continued From page 21 approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect smokers, staff and visitors. The facility is certified for one hundred sixty five (165) beds with a census of one hundred forty nine (149) on the day of the survey. The facility failed to ensure the smoking areas had a metal container with a self-closing lid to dump ashtrays. The findings include: Observation, on 02/19/13 at 4:51 PM, with the Maintenance Director revealed the facility failed to provide a metal container with a self-closing lid to dump the ashtrays, located in the designated smoking areas. Interview, on 02/19/13 at 4:51 PM, with the Maintenance Director revealed he was not aware of the requirement for metal containers with a self-closing lid for dumping ashtrays. Interview, on 02/20/13 at 2:00 PM, with the Administrator revealed he was not aware of the requirement for metal containers with a self-closing lid for dumping ashtrays. Reference: NFPA Standard 101 (2000 Edition). 19.7.4 Smoking (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066	K066 Continued from page 21 The nursing staff will continue to complete smoking assessments for all residents who smoke to determine their need for assistance and protective devices. #3 On April 1, 2013, the facility Regional Director of Facilities Management (RDFM) will review the requirements of this regulation with the Director of Housekeeping and facility Janitor. The RDFM will demonstrate for both the Director of Housekeeping and Janitor on the proper technique for emptying and disposing of cigarette butts and ashes. On April 3, 2013, the Director of Housekeeping shadowed the Janitor while completing this task to ensure he was following the correct process for disposing of ash and other smoking debris. #4 Once a week for the next quarter and then monthly for the next 3 quarters, the Director of Housekeeping will shadow the Janitor while the ash trays are being emptied, to ensure the established procedure for disposing of smoking debris is being followed. Any observed deviations will be corrected at the time of occurrence and reported to the QA committee so that revisions to the procedure can be developed and implemented.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130		

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K 130	Continued From page 22 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the hazardous areas in accordance with NFPA standards. The deficiency had the potential to affect one (1) of twelve (12) smoke compartments, residents, staff and visitors. The facility is certified for one hundred sixty five (165) beds with a census of one hundred forty nine (149) on the day of the survey. The findings include: Observation, on 02/19/13 at 4:57 PM, with the Maintenance Director revealed sterno cans stored on an open shelf in the Kitchen and not stored in a rated room. Interview, on 02/19/13 at 4:57 PM, with the Maintenance Director revealed he was not aware they sterno cans were in the Kitchen. Interview, on 02/20/13 at 2:00 PM, with the Administrator revealed he was aware of the proper storage of sterno cans, however he was not aware of the cans located on the open shelf in the Kitchen. NFPA 101 (2000 Edition) 4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the	K 130	K130 #1 The Sterno cans cited with this tag were placed in the facility's flammable storage cabinet on February 22, 2013. #2 On March 13, 2013, the Administrator instructed all department directors, supply clerks, and other associates with purchasing authority, to review the MSDSs for their departments as a means of identifying products or chemicals that should not be stored in the building. In addition, On April 1, 2013, the Administrator, Director of Maintenance, and Regional Director of Facilities Management met to identify other items which might be stored in the building that could be in violation of this requirement. There were no additional items identified. #3 On April 1, 2013 the facility's Regional Director of Facilities Management (RDFM) will review the requirements of this regulation with the Administrator, Directors of Maintenance, Housekeeping, Dietary, and Supply Clerk. The facility safety committee, which currently monitors the introduction of chemical hazards to the facility, will now also track the introduction of flammable material hazards to the facility.	04/02/ 2013

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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 130	Continued From page 23 provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction.	K 130	K130 Continued from page 23 The Safety Committee chairperson will be responsible for verifying such hazards are being properly stored in the flammables storage cabinet.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation, generator testing record review, and interview, it was determined the facility failed to ensure the emergency generator was maintained in accordance with NFPA standards. The deficiency had the potential to affect twelve (12) of twelve (12) smoke compartments, residents, staff and visitors. The facility is certified for one hundred sixty five (165) beds with a census of one hundred forty nine (149) on the day of the survey. The findings include: Observation, on 02/20/13 at 12:00 PM, with the Maintenance Director revealed a buildup of corrosion on the battery for the facilities	K 144	#4 For the next 3 months and then quarterly for the reminder of the year, the Director of Maintenance will inventory the facility flammable storage cabinet and report the contents during the monthly safety committee. The Safety Committee will review the facility's flammable storage practices to determine compliance with this regulation. The Committee Chairperson will report issues of non compliance to the QA committee so revisions to the procedure can be developed and implemented. K144 #1 On February 26, 2013, the Maintenance Assistant removed the corrosion from the battery terminal and inspected the battery cables to ensure no part replacements were necessary.	04/02/2013

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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
	185300		02/20/2013

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K 144	Continued From page 24 emergency generator. Interview, on 02/20/13 at 12:00 PM, with the Maintenance Director revealed he was not aware of the corrosion. Interview, on 02/20/13 at 2:00 PM, with the Administrator revealed he was not aware of the corrosion on the generators battery. Reference: NFPA 110 (1999 Edition). 5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers ' recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals. Reference: NFPA 99 (1999 Edition) Actual NFPA Standard: NFPA 99, 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1.	K 144	K144 Continued from page 24 #2 The facility only has one emergency generator. On April 1st, the Regional Director of Facilities management reviewed the TELS preventive maintenance documentation for the generator as well as contractor service reports to verify the generator is being adequately maintained, tested, and that no recommended service has been deferred. No additional issues were identified. #3 On April 1, 2013, the facility's Regional Director of Facilities Management (RDFM) reviewed the requirements of this regulation with the Director of Maintenance and Senior Maintenance Assistant. As part of the weekly generator inspections already in TELS, the facility's preventive maintenance system, the Senior Maintenance Assistant will document the condition of the battery terminals in the "remarks" section of the generator inspection log. The Maintenance Director will review the logs weekly to confirm the condition of the generator battery is being checked as part of routine generator preventive maintenance. #4 Once a week for the next quarter and then monthly for the next 3 quarters,	

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K 144	Continued From page 25 (b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b). Actual Standard: NFPA 110, 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position. Actual Standard: NFPA 99, 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. (b) Inspection and Testing. 1. Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. 2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.	K 144	K144 Continued from page 25 the Director of Maintenance will shadow the Senior Maintenance Assistant when inspecting the generator, to ensure all generator checks required by TELS are being followed. Any observed deviations will be corrected at the time of occurrence and reported to the Safety committee so that revisions to the procedure can be developed and implemented. If ongoing compliance with this requirement is in doubt, the Safety Committee will refer the issue to the full QA committee for resolution. In addition, the RDFM will review TELS compliance on a monthly basis. Any deferred scheduled preventive maintenance or LSC required service will be reported to the Administrator who will bring the identified concerns to the QA committee for resolution.	

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

PRINTED: 03/06/2013
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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
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K 144	Continued From page 26 3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures. Actual Standard: NFPA 99, 3- 3-4.4.2. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.	K 144		

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