

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

PRINTED: 08/07/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014
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NAME OF PROVIDER OR SUPPLIER CEDAR RIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1217 US HIGHWAY 62 E CYNTHIANA, KY 41031
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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 07/22/14 and concluded on 07/24/14, with deficiencies cited at the highest Scope and Severity of an "F".	F 000		
F 356 SS=D	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356	 <p>This Plan of Correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.</p> <p>F 356</p> <p>1. There were no residents identified in this deficiency.</p> <p>The Director of Health Services began shift-to-shift re-education with licensed nurses (including LPN#2) on 7/25/14 regarding the regulation for posting the Daily Nurse Staffing data. On 7/25/14 the Daily Nurse Staffing data was posted per regulation at the beginning of each shift for both the Skilled and Memory Care units.</p> <p>The clear plastic sleeve was relocated by the Director of Plant Operations on 7/29/14 to an outside wall, in a prominent location clearly visible to residents and visitors.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James A. Ferguson, NHA TITLE: Ex Director (X6) DATE: 8/15/14

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 356	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the Daily Nurse Staffing form, it was determined the facility failed to post the Daily Nurse Staffing data at the beginning of each shift on the skilled living units. In addition, staffing information was not displayed in a prominent place readily accessible to residents and visitors on the Memory Care Unit. The findings include: Interview with the Administrator, on 07/24/14 at 4:40 PM, revealed the facility did not have a policy related to the posting of the nurse staffing hours. She stated the facility followed the regulation for posting of staffing information. 1. Observation of the posted Daily Nurse Staffing on the skilled living units, on 07/22/14 at 4:20 PM, revealed the posting covered all three (3) shifts for the 24-hour period. Subsequent observation, on 07/23/14 at 9:30 AM, revealed new staffing information for the skilled units was posted, again for all three (3) shifts. 2. Observation on the Memory Care Unit, on 07/23/14 at 12:27 PM, revealed the staffing list was laying between the wall and the hand rail, behind the nurses' desk. The staffing list was dated 07/23/14 and included staffing for the first, second and third shifts. Continued observation revealed the staffing information was not easily visible to staff, residents and visitors outside the nurses' station.	F 356	2. Campus residents have the potential to be affected. ED reviewed Resident Concern forms and Resident Council minutes for the previous 6 months on 7/25/14, revealing no concerns from residents or visitors regarding the Daily Nurse Staffing data posting. 3. Re-education of licensed nurses regarding the regulation for posting Daily Nurse Staffing data including the requirement to post data at the beginning of each shift and that data be posted in prominent location readily accessible to residents and visitors was completed by the DHS as of 8/16/14. The DHS and/or ADHS will review Daily Nurse Staffing data each weekday to determine accuracy and completion.		

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F 356	Continued From page 2 Subsequent observation on the Memory Care Unit, on 07/24/14 at 9:50 PM, revealed the staffing information was not posted and was not visible. Interview with Licensed Practical Nurse #2/Unit Manager, on 07/24/14 at 9:50 AM, revealed the staffing list had not been posted. She stated the information should be posted on the wall, but was located in a notebook on the desk. Continued interview with the Administrator, on 07/24/14 at 4:50 PM, revealed the staffing list should be posted on the wall in a clear plastic frame, in a location that could readily be seen by visitors. She stated the facility posted the nurse staffing hours daily in the morning, and she was not aware of the requirement for staffing to be posted at the beginning of each shift.	F 356	4. The DHS and/or ADHS will complete random audits, across all three shifts and to include both Skilled and Memory Care units to validate Daily Nurse Staffing data is posted per regulation at the beginning of each shift and in a prominent place readily visible to residents and visitors three times weekly for 30 days, then once weekly to verify ongoing compliance. Results of the audits will be presented to the QA Committee by the DHS/ADHS for review and recommendations until compliance is achieved. In addition, Daily Nurse Staffing data is reviewed for compliance at least twice annually during Peer Review process. Completion date: 8/17/14		
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 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility policy, it was determined the facility failed to store and prepare food under sanitary	F 371	F 371 1. A thermometer was placed in the ice cream freezer by the Director of Food Services on 7/22/14. The temperature of the ice cream freezer was noted to be appropriate at -5 degrees F at that time. The stove top was cleaned by the cook on 7/22/14. The deep fryer was deep cleaned by the DFS on 7/23/14. The undated/unlabeled items noted in the reach-in refrigerator were removed by the cook and/or dietary assistant and discarded once identified on 7/22/14 and 7/23/14.		

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F 371	<p>Continued From page 3</p> <p>conditions as evidenced by the ice cream freezer temperatures were not recorded, the deep fryer was not cleaned according to schedule, and all food products were not labeled and dated in the reach-in refrigerator.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Food Production Guidelines-Sanitation and Safety" (dated 2009) revealed cold food was to be held at forty-one (41) degrees Fahrenheit or below; however, the policy did not address required temperatures for frozen foods. In addition, the policy did not indicate how often temperatures were to be checked in order to ensure food was adequately cooled and/or frozen. Continued review revealed food prepared in advance was to be covered, labeled, dated, refrigerated, and used within seventy-two (72) hours.</p> <p>Observation during the initial kitchen tour, on 07/22/14 at 1:40 PM, revealed no thermometer was found in the ice cream freezer, and no temperatures had been recorded. Continued observation revealed oil in the deep fryer was dark black in color, and splatter from the deep fryer was noted on the surface of the stove. In addition, the reach-in refrigerator held a clear plastic pitcher containing a purple liquid which was not labeled or dated.</p> <p>Observation during the follow-up kitchen tour, on 07/23/14 at 12:20 PM, revealed a clear container of a tan liquid, and a pitcher containing an opaque liquid, were stored in the reach-in refrigerator without labels or dates.</p> <p>Review of the Refrigerator/Freezer Temp Log,</p>	F 371	<p>2. The ED, DHS, and/or MDS Nurse reviewed the 24 Hour Nursing Reports and Resident Change of Condition forms for 7/19-7/23/14 as of 8/15/14 and there were no residents identified as possibly having food related symptoms or illness.</p> <p>3. The DFS re-educated cooks and dietary assistants regarding food storage and cleaning procedures as of 7/25/14. Education included documenting temperatures of freezers, prompt cleaning of food prep areas, cleaning schedule of deep fryer, and labeling and dating food/beverage for storage to be used within seventy-two hours.</p> <p>4. The ED and/or DFS will conduct kitchen sanitation audits twice weekly to validate temperatures are taken per policy, food prep areas/surfaces are clean, deep fryer cleaning is maintained, and food/beverage items in walk-in/refrigerators are labeled and dated appropriately for 30 days, then once weekly to verify ongoing compliance. The results of the audits will be presented to the QA Committee by the DFS for review and recommendations until compliance is achieved. In addition, kitchen sanitation and food storage is reviewed for compliance at least twice annually during Peer Review process.</p> <p>Completion date: 8/17/14</p>	
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F 371	<p>Continued From page 4 dated July 2014, revealed no temperatures were recorded for the ice cream freezer prior to 07/22/14, the date of the initial kitchen tour. Continued review of the Log revealed the reference point for freezer temperatures was zero (0) degrees Fahrenheit.</p> <p>Review of the Deep Fryer Cleaning Log revealed the deep fryer was cleaned once in March, on 03/18/14, and was cleaned twice each month from 04/15/14 through 07/21/14. Continued review revealed comments on the condition of the oil included "very dirty", "very, very dirty", and "really dirty".</p> <p>Review of the daily, weekly and monthly cleaning lists revealed the deep fryer was not listed for regularly scheduled cleaning.</p> <p>Interview with Dietary Aide #1, on 07/23/14 at 3:15 PM, revealed food containers were to be covered with plastic wrap, labeled and dated. She stated if the food was not dated, it should be thrown out. Continued interview revealed she was not assigned to clean the deep fryer, and the cook checked the equipment temperatures.</p> <p>Interview with Cook #1, on 07/23/14 at 3:20 PM, revealed all foods should be labeled and dated, and thrown out after three (3) days. She stated she checked the refrigerator and freezer temperatures; however, she stated the ice cream chest temperatures had never been checked. Continued interview revealed the deep fryer was supposed to be cleaned twice weekly, but she was not sure who was responsible.</p> <p>Interview with the Director of Food Service, on 07/23/14 at 3:30 PM, revealed open food</p>	F 371		
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F 371	Continued From page 5 containers were to be labeled and dated for seven (7) days and then discarded. She stated if food was not labeled and became outdated, bacteria could grow and make the residents sick. She further stated there was no temperature log for the ice cream freezer, and no temperatures had been checked or recorded prior to 07/22/14. Continued interview revealed the deep fryer was to be cleaned twice weekly, every Monday and Friday. She explained if the oil in the deep fryer was not changed regularly, bacteria could grow, food would not cook properly, and the taste of the food would be affected, with the result of a poor food product.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	F 441 1. Resident #10 and Resident A's oxygen tubing was changed, labeled with the date, and secured in a bag on 7/22/14 by the licensed nurse. Observations and/or assessments of Resident #10 and Resident A during the survey 7/22/14 thru 7/24/14 by the licensed nurse(s) did not reveal symptoms of infection or other adverse affects.	

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F 441 Continued From page 6

(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 policy, it was determined the facility failed to ensure nasal cannula oxygen (O2) tubing was dated and/or covered when not in use, for one (1) of thirteen (13) sampled residents (Resident #10), and one unsampled resident (Resident A). In addition, the facility failed to ensure staff changed gloves and performed hand washing during the serving and distribution of food.

The findings include:
A review of the facility's policy "Guidelines for Administration of Oxygen (undated), revealed oxygen tubing was to be changed weekly and PRN (as needed). Further review revealed the tubing was to be labeled and dated when changed. Continued review revealed the policy did not address how tubing was to be stored when not in use. Interview with the Director of Nursing (DON), on 05/24/14 at 5:30 PM, revealed it was her expectation for O2 tubing to be

F 441

Dietary Assistant #2 was re-educated by the DFS on 7/23/14 regarding hand washing procedure, and when to wash hands and change gloves.

The ED, DHS, and/or MDS Nurse reviewed the 24 Hour Nursing Reports and Resident Change of Condition forms for 7/23-7/26/14 for residents on the 200 and 300 Halls as of 8/15/14 and there were no residents identified as possibly having new infectious processes related to Dietary Assistant not washing hands/changing gloves.

2. Rounds were conducted by the DHS, MDS Nurse, and Medical Records on 7/22/14 to determine that campus residents who use oxygen therapy, had oxygen tubing labeled with date and secured in bag if not in use. Tubing not secured in bag, was discarded and replaced immediately.

The ED, DHS, and/or MDS Nurse reviewed the 24 Hour Nursing Reports and Resident Change of Condition forms for 7/23-7/26/14 of other campus residents as of 8/15/14 and there were no residents identified as possibly having new infectious process related to Dietary Assistant not washing hands/changing gloves.

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F 441	<p>Continued From page 7</p> <p>changed immediately when or if it was found on the floor, or if were not properly dated and bagged.</p> <p>1. Medical record review revealed the facility admitted the Resident #10 on 12/27/10 with Diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Dementia, Depression, Anxiety, and a History of Cerebrovascular Accident (Stroke). Review of the Physician Order records, dated 03/20/14, revealed O2 was ordered for Resident #10 at two (2) liters per minute, as needed to keep the resident's oxygen saturation above ninety (90) percent. Review of the Care Plan revealed Resident #10 was at risk for altered breathing patterns relative to COPD.</p> <p>Medical record review revealed Resident A was admitted by the facility on 12/06/13 with diagnoses which included Dementia, Congestive Heart Failure (CHF), Diabetes Mellitus Type II and Pulmonary Hypertension. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/23/14, revealed the facility assessed the resident to be cognitively intact and interviewable.</p> <p>Review of the Physician Order records, dated 03/28/14, revealed Resident A was ordered to receive supplemental oxygen at two liters per minute as needed for shortness of breath. Review of the Care Plan revealed Resident A had altered breathing patterns related to CHF and became short of air at times.</p> <p>Observation during the initial tour of the facility, on 07/22/14 at 2:03 PM, revealed Resident #10's O2 tubing was lying across the resident's bed without being covered. Continued observation of the roommate, Resident A, revealed the O2 tubing</p>	F 441	<p>3. Licensed nurses and SRNAs (including SRNA #1) were re-educated as of 8/16/14 by the DHS regarding procedure to secure oxygen tubing when not in use and immediate action to be taken if oxygen tubing should not be secured properly in bag while not in use.</p> <p>Cooks and dietary assistants were re-educated by the DFS as of 7/25/14 regarding hand washing procedures and when to change gloves.</p> <p>4. The DHS and/or ADHS will complete rounds three times weekly to validate proper oxygen storage for 30 days, then once weekly to verify ongoing compliance.</p> <p>The DHS, ADHS, and/or DFS will conduct random meal service/tray pass observations three times weekly to validate proper hand washing and glove use for 30 days, then twice weekly to verify ongoing compliance.</p> <p>The results of the oxygen and meal service audits will be presented to the QA Committee by the DHS/ADHS and/or DFS for review and recommendations until compliance is achieved. In addition, campus infection control practices are reviewed at least twice annually during Peer Review process.</p> <p>Completion date: 8/17/14</p>	
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F 441	<p>Continued From page 8</p> <p>was on the floor under the resident's wheelchair, was uncovered, and was not dated. Subsequent observation, on 07/22/14 at 5:35 PM, revealed Resident #10's O2 tubing remained across his/her bed and Resident A's O2 tubing remained on the floor under the wheelchair.</p> <p>Interview with Resident A, on 07/22/14 at 5:38 PM, revealed he/she used the oxygen at night. Continued interview revealed the resident could not say how long the O2 tubing had been on the floor.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #1, on 07/22/14 at 5:40 PM, revealed she had not seen Resident A's O2 tubing on the floor. She stated she did not know tubing lying over the bed was a problem. She further stated she had been in-serviced on infection control practices. Continued interview revealed it would be a problem for the resident to use O2 tubing which was contaminated with germs.</p> <p>Interview with License Practical Nurse (LPN) #4, on 07/22/14 at 5:45 PM, revealed all SRNAs were in-serviced on infection control practices. He stated the SRNAs had been informed to change the tubing weekly, or report to the charge nurse. He further stated the Desk Nurse was responsible for making rounds and checking the residents' O2 settings and ensure the tubing was functional and dated. He stated the resident would be exposed to a potential problem with infection if the O2 tubing were not changed regularly.</p> <p>Interview with LPN #3, on 07/23/14 at 3:25 PM, revealed It was all of the nurses' responsibility to change, label and date O2 tubing. She stated O2 tubing should be bagged when not in use. She</p>	F 441		
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F 441	<p>Continued From page 9</p> <p>further stated a resident's system could already be weak, making it easier to contract an infection. Interview with The Director of Nursing (DON), on 07/23/14 at 3:35 PM, revealed it was her expectation for all staff to follow the facility's protocol for preventing infections. She stated in-services were provided on infection control for all staff, including the SRNAs.</p> <p>Interview with LPN #5, on 07/24/14 at 2:25 PM, revealed it was her responsibility to make rounds as part of her assignment. She stated as the desk nurse, she should have caught the oxygen tubing on the floor and across the resident's bed. Continued interview revealed if the potentially contaminated nasal cannula were placed back on the resident, it could increase the resident's risk of becoming infected.</p> <p>Subsequent interview with The DON, on 07/24/14 at 5:30 PM, revealed it was her expectation to reduce the risk for transmitting infections. She stated the tubing should have been changed and dated immediately once discovered on the floor. She further stated failure to do so placed the resident at risk for an infection.</p> <p>2. Observation on the 300 Hall, on 07/23/14 at 12:39 PM, revealed Dietary Aide #2 arrived with an ice cream cart and proceeded to serve residents in their rooms. Further observation revealed the Dietary Aide work gloves while serving the ice cream; however, she was observed to rub her eye and push her glasses up with her gloved hand, and continued to the next resident's room without changing her gloves and washing her hands.</p> <p>Interview with Dietary Aide #2, on 07/23/14 at 12:45 PM, revealed she had received Infection Control training. She stated she should have removed her gloves, washed her hands and</p>	F 441		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/07/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014
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NAME OF PROVIDER OR SUPPLIER CEDAR RIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1217 US HIGHWAY 62 E CYNTHIANA, KY 41031
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 441	<p>Continued From page 10</p> <p>applied new gloves after she rubbed her eye and pushed her glasses up. Continued interview revealed the process should be repeated during the serving of food, every time a resident or surface was touched, or if the gloves became soiled.</p> <p>Further observation, on 07/23/14 at 12:55 PM, revealed Dietary Aide #2 washed her hands, applied new gloves and proceeded to the 200 Hall to serve ice cream. The Dietary Aide knocked on a resident's door, turned the doorknob and entered the room. When the Dietary Aide returned to the hall, she changed her gloves but did not wash or sanitize her hands.</p> <p>Interview with the Director of Food Service, on 07/24/14 at 5:20 PM, revealed all dietary staff were trained on hand sanitation upon hire, and quarterly via computer training. Review of in-service records with the Director of Food Service revealed Dietary Aide #2 had completed infection control in-services as they were offered, since being hired in 2007.</p>	F 441		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185145	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2014
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NAME OF PROVIDER OR SUPPLIER CEDAR RIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1217 US HIGHWAY 62 E CYNTHIANA, KY 41031
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 2004 Addition 6/16/2010</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211) Protected</p> <p>SMOKE COMPARTMENTS: Fourteen (14) smoke compartments.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM (Original Installation)</p> <p>FULLY SPRINKLED, SUPERVISED (DRY SYSTEM) (Original Installation)</p> <p>EMERGENCY POWER: Type II Diesel Generator. (Original Installation)</p> <p>A life safety code survey using (2786S Short Form) was initiated and concluded on 07/15/14. The facility was found to be in compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire).</p>	K 000		
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RECEIVED
AUG 15 2014
NY

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *James P. Hurdon*, NHA TITLE: *EX Director* (X8) DATE: *8/15/14*

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.