

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

PRINTED: 03/08/2013
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185316	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/22/2013
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NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445
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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 000	INITIAL COMMENTS An annual survey was conducted on 02/19/13 through 02/22/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of an "F."	F 000	DISCLAIMER: Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157	F157 <u>483.10(b)(11) Notify of changes</u> It is the practice of Princeton Health and Rehab Center to notify physicians regarding changes of resident's conditions. <u>Corrective Measures for Resident Identified in the deficiency:</u> Resident #6 physician was contacted on 2/21/13 and 2/22/13 by the licensed nurse regarding the residents skin condition and orders were received and signed by the Physician for the treatment of the area. <u>How Other Residents Were Identified Who May Have Been Impacted by the Practice:</u> Any resident with a current skin condition was reviewed to validate that the MD had been notified with a current treatment order in place. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> All licensed nurses have been in-serviced by the Staff Development Coordinator / Director of Nurses regarding the policy and procedure for physician notification with a written post test to validate understanding of training. Resident condition updates and changes are reviewed each weekday utilizing the 24 hour report in the daily Quality Assurance meeting to validate notification to the physician has occurred.	04/03/13

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

Kathy Golden

TITLE

NHA

(X6) DATE

3/18/13

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

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure the physician was notified of changes in a wound for one resident (#6), in the selected sample of seventeen (17) residents. Findings include: A review of the facility's policy/procedure for notification requirements, revised 05/22/12, revealed it was the policy of the facility to notify the resident, his or her attending physician, and representative of changes in the resident's condition. A record review revealed the facility admitted Resident #6 on 02/01/13 with diagnoses to include Muscle Weakness, General Osteoarthritis, Lumbago, Occupational Theray (OT) Rehabilitation, Lumbar Pain, Anxiety, Degenerative Arthritis, and Status Post Fall. A skin observation completed by Licensed Practical Nurse (LPN) #1 and LPN #2, on 02/21/13 at 4:30 PM, revealed Resident #6 had a pressure sore above the coccyx area, which measured one centimeter by one and two tenth's centimeter, the area was reddened and had a superficial layer of skin missing. A review of the nurse's notes documented by LPN #1, dated 02/21/13 at 6:17 AM and 5:25 PM,	F 157	<u>E157(cont)</u> <u>Monitoring Measures to Maintain On-going Compliance:</u> An audit will be conducted by the Director of Nurses or Unit Manger on a weekly basis for 4 weeks for those residents with any new skin condition to validate the MD was notified and gave orders for the identified area. Findings will be reported at the monthly Quality Assurance and Assessment meeting for review and recommendations for a minimum of 6 months. If any additional concerns are identified in the ongoing daily review process for notification of changes to the physician, the audits will be re-implemented for further review and analysis in the monthly Quality Assurance and Assessment Meeting.		

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F 157	<p>Continued From page 2</p> <p>revealed new orders were received.</p> <p>A review of the physician's order, dated 02/21/13 (no time indicated on order), signed by LPN #1, revealed staff should continue to apply Protective Ointment to the the red blanchable area and surrounding skin of the coccyx as a protective every shift times ten days.</p> <p>A phone interview with Resident #8's physician, on 02/22/13 at 9:30 AM, revealed no one from the facility had contacted him on 02/21/13 to discuss Resident #8's wound on coccyx and revealed he was in a deposition all day in Nashville. He stated the staff must have spoken with his Nurse Practitioner.</p> <p>A phone interview with Resident #8's Nurse Practitioner, on 02/22/13 at 11:00 AM, revealed she spoke with the staff at the facility on 02/21/13 regarding the resident's lab work; but nothing was discussed about the resident's wound on the coccyx. She stated she expected the facility to notify her of any change in a wound.</p> <p>An interview with LPN #1, on 02/22/13 at 3:45 PM; revealed she spoke to Resident #8's physician several times on 02/21/13. The LPN stated she told the physician staff were going to continue the same treatment he/she currently had, and the physician said, "OK, "Thanks". The LPN revealed the current order we had was running out, so she needed an order to continue it.</p> <p>An interview with the Director of Nursing, on 02/22/13 at 4:45 PM, revealed if the nurse documented she spoke to the physician in the</p>	F 157			

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F 157	Continued From page 3 nurse's notes, then she believed the nurse did contact the physician.	F 157		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior related to scuffed, scratched doors in thirteen residents' rooms on the facility's 100 hall. Observations of the scuffed, scratched doors occurred through the duration of the survey. Findings include: A review of the facility's policy/procedure, "Environment Maintenance," revised 12/05/12, revealed "It is the policy of this facility to provide a safe clean, well maintained facility and grounds. The facility will be maintained and equipped to provide a sanitary, orderly and comfortable environment that protects the health and safety of residents, personnel and the public." Observations on the 100 hall, on 02/19/13 at 8:00 AM, on 02/20/13 at 8:50 AM, on 02/21/13 at 9:00 AM, and on 02/22/13 at 9:00 AM, revealed there were thirteen residents' bathroom doors/door frames, closet doors, and doors to residents'	F 253	<u>F253</u> <u>483.15(h)(2) Housekeeping And Maintenance Services</u> It is the practice of Princeton Health and Rehab to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. <u>Corrective Measures for Resident Identified in the deficiency:</u> Room numbers 102,103,104,105,106,107,108,109,110,111, 112,113,and 114 have had additional vinyl covers ordered on 3/7/13 and will be added to the backs of room doors, bathroom doors, and closet doors as soon as delivered. Anticipated delivery date is 3/25/13. <u>How Other Residents Were Identified Who May Have Been Impacted by the Practice:</u> An audit was completed on all resident room doors on back side, bathroom doors, and closet doors to review for additional vinyl covers to cover any scratched or scuffed areas on the doors. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> The facility maintenance service will add the vinyl covers to 10 resident rooms per month until all resident doors, bathroom doors and closet doors have had the added vinyl covers placed.	4/3/13

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F 253	Continued From page 4 rooms which were severely scamed and scratched. These included room numbers #102, #103, #104, #105, #108 (unoccupied), #107, #108, #109 (unoccupied), #110, #111, #112, #113, and #114. Interview with the Plant Services Director, on 02/22/13 at 2:15 PM, revealed he was responsible for the facility's maintenance/repairs. He stated he was aware of the condition of the doors which was related to wheelchairs and other equipment "bumping" these areas, causing the damage. He stated he had placed a vinyl cover on the residents' doors awhile back; however, it might require replacing the doors.	F 253	<u>F253 (Cont)</u> <u>Monitoring Measures to Maintain On-going Compliance:</u> The maintenance director will maintain an ongoing audit tool to report progress on the addition of the vinyl covers to the doors and establish the priority level of the 10 rooms to be selected each month until all resident rooms have been completed. This will be reported at the monthly Quality Assurance and Assessment meeting for review and recommendations.		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based upon observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to ensure a resident having a pressure sore received necessary treatment and services to promote healing, prevent infection and prevent new sores from developing for one resident (#6), in the selected	F 314	<u>F314</u> <u>483.25(c) Treatment / SVCS to prevent heal Pressure Ulcers</u> It is the practice of Princeton Health and Rehab to provide care and services to prevent avoidable pressure ulcers from developing, provide treatment to promote healing, and prevent infection. <u>Corrective Measures for Resident Identified in the deficiency:</u> Resident #6 physician was contacted on 2/21/13 and 2/22/13 regarding the residents skin condition and orders were received and signed by the Physician for new treatment orders of the area. An analysis of the wound was completed by the licensed nurse that including the stage and measurements of the area on 2/25/13. <u>How Other Residents Were Identified Who May Have Been Impacted by the Practice:</u> A skin evaluation was completed for each resident by the unit managers or floor nurse to validate any present skin conditions were reported to and being treated by the resident's	04/03/13	

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NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1313 WEST MAIN ST. PRINCETON, KY 42445		
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F 314	Continued From page 5 sample of seventeen (17) residents. The facility failed to ensure physician notification policies were followed related to a resident's worsening pressure sore and to accurately assess the pressure sore to the coccyx area, on 02/21/13. Findings include: A review of the facility's Preventive Skin Care Program policy, revised 10/27/10, revealed based on skin review findings, appropriate preventive measures will be implemented and the resident's response to preventive measures will be monitored and altered to meet resident's needs. A significant change in the resident's skin condition will be communicated to the physician, resident and/ or responsible party. Further review of the facility's Admission/Weekly Wound Analysis Guidelines, dated 07/28/12, revealed a Stage II was a partial thickness loss of dermis presenting as a shallow open ulcer with a wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. A record review revealed the facility admitted Resident #8 on 02/01/13 with diagnosis to include Muscle Weakness, Occupational Therapy (OT) Rehabilitation, Lumbago, General Osteoarthritis, Degenerative Arthritis, and Status Post Fall. A review of the Comprehensive Resident Assessment dated 02/01/13, revealed a dried spot to coccyx, pink and blanching. A review of the initial Minimum Data Set (MDS) assessment, dated 02/01/13, revealed the facility assessed Resident #6 cognition as severely impaired.	F 314	<u>F314 (cont)</u> physician. Any identified pressure areas had a wound analysis completed by the unit manger that includes the appearance, measurements, and staging of the pressure area. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> All licensed nurses were re-educated by the Staff Development Coordinator/ Director of Nurses starting on 2/22/13 continuing until all licensed staff have received the training regarding the facility policy for pressure ulcers to include prevention, measuring, treatments, change of condition and physician notification relating to pressure ulcers. A post test was completed by each nurse to validate understanding of the education provided. Any newly identified pressure ulcer will be reviewed by the Clinical Care Coordinator/Director of Nurses on the next business day to validate the staging of the wound, physician notification of the area and that a current treatment order is in place on the area. <u>Monitoring Measures to Maintain On-going Compliance:</u> The Director of Nurses will review a 20% sample of all pressure ulcers on a weekly basis to validate accuracy of the unit manager documentation regarding the ongoing appearance of the wound, updates to the physician for any changes in the wound, and that a current treatment order appropriate to the visualized factors of the wound is in place on the area weekly times 8 weeks. Findings will be reported to the monthly Quality Assessment and Assurance committee for review and recommendations for a minimum of 6 months and if no concerns are noted then frequency may be decreased at the discretion of committee.		

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F 314	<p>Continued From page 6</p> <p>A review of the Pressure Ulcer Risk analysis/Care Plan for Pressure Ulcers, dated 02/01/13, revealed the facility assessed Resident #6 as at risk for developing pressure ulcers and developed interventions to provide treatments as ordered by the physician, apply protective ointment to coccyx every shift for ten days and observe for skin condition changes, redness and/or break in skin integrity.</p> <p>An observation of a skin assessment, completed by Licensed Practical Nurse (LPN) #1 and LPN #2, on 02/21/13 at 4:30 PM, revealed Resident #6 had a pressure sore above the coccyx area, which measured one centimeter by one and two tenths centimeter and the area was reddened and had a superficial layer of skin missing.</p> <p>A review of a physician's order, dated 02/21/13 (no time indicated on order) signed by LPN #1, revealed staff should continue to apply Protective Ointment to the red blanchable area and surrounding skin of the coccyx as a protective every shift times ten days.</p> <p>A phone interview with Resident #6's physician, on 02/22/13 at 9:30 AM, revealed no one from the facility had contacted him on 02/21/13 to discuss Resident #6's wound on coccyx.</p> <p>A phone interview with Resident #6's Nurse Practitioner, on 02/22/13 at 11:00 AM, revealed she spoke with the staff at the facility on 02/21/13 regarding the resident's lab work; but nothing was discussed about the resident's wound on the coccyx. She revealed protective ointment would have been ordered for a stage I or redness, but the order would have been changed to PolyMem</p>	F 314			

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F 314	<p>Continued From page 7</p> <p>If the wound was identified as a stage II. She further revealed a wound missing a superficial layer of skin should be identified as a stage II wound, in her opinion. She stated she would expect the facility to notify her of any change in a wound.</p> <p>An interview with LPN #1, on 02/22/13 at 3:45 PM, revealed she spoke to Resident #6's physician several times on 02/21/13. The LPN stated she told the physician staff were going to continue the same treatment he/she currently had, and the physician said, "OK, thanks". The LPN revealed the current order we had was running out, so she needed an order to continue it.</p> <p>A review of the documentation of the skin assessment, dated 02/21/13, revealed there was a blanchable red area to the coccyx.</p> <p>An interview with Registered Nurse (RN) #1, RN #3, RN #5, LPN #1, on 02/22/13 at 10:30 AM, 1:30 PM, 2:00 PM and at 2:15 PM revealed residents' skin assessments are completed every week. The floor nurses complete the skin assessments but do not measure or stage the wounds. The Unit Charge Nurses measure and stage the identified wounds. The licensed staff stated if they identify something abnormal during a skin assessment, they would report it to the Unit Manager and the Unit Manager measures and stages the wound.</p> <p>An interview with LPN #2, on 02/22/13 at 11:30 AM and 3:30 PM, revealed her role during a skin assessment was to assess and measure the wound weekly and she would have charted the</p>	F 314		

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F 314	<p>Continued From page 8</p> <p>area on Resident #6's coccyx as a red, blanchable area. Further interview, revealed the staging of the wound is done by the Director of Nursing. The LPN stated she had no training on staging of a wound and she had not seen the area on Resident #6's coccyx until 02/21/13. She stated she would have considered it an open area until the DON staged it. She further revealed there was no weekly wound analysis sheet on Resident #6's coccyx area.</p> <p>An interview with RN #4, on 02/22/13 at 2:30 PM, revealed she was supposed to assess and measure the wounds weekly, and stage when needed. She revealed when the floor nurses find an area of concern they let me know. She stated she sometimes would discuss the staging of the wound with the DON. She revealed a Stage II was a blister, abrasion, and/or shearing if it affects the first layer of the skin. She stated she would stage an area missing a superficial layer of skin as a Stage II, because it effects the first layer of the skin.</p> <p>An second skin observation of Resident #6's coccyx area, on 02/22/13 at 2:55 PM, was completed per the DON's request. The coccyx area still had superficial skin loss, was red in color, and there was a slight white ring surrounding the area from the cream applied to the area.</p> <p>Interview with the DON, on 02/22/13 at 4:45 PM, revealed she sometimes goes to some of the skin assessments, but not all the time. She stated sometimes the clinical care coordinator will go. She revealed LPN #2 usually comes and gets her or another nurse to go with her to complete a skin</p>	F 314			

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F 314	Continued From page 9 assessment. The DON stated she would expect the nurses to document any change of the area and what the area looks like.	F 314			
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure it was free of a medication error rate of five (5) percent or greater. Observation of medication passes revealed the facility had eight (8) medication errors out of forty three (43) opportunities to equal a medication error rate of eighteen (18) percent. Findings include: A review of the policy/procedure "Medication Administration General Guidelines", dated 09/10, revealed medications were administered in accordance with written orders of the prescriber. Medications were administered within sixty (60) minutes of the scheduled time, except before or after meal orders, which were based on meal times. 1. An observation of a medication pass, on 02/20/13 at 9:00 AM, revealed Kentucky Medication Aide (KMA) #2 administered Lisinopril 10 milligrams (mg) to Resident #19 at 9:00 AM.	F 332	<u>F332</u> <u>483.25(m)(1) Free of Medication Error Rates of 5% or More</u> <u>Corrective Measures for Resident Identified in the deficiency:</u> Resident # 4,19, 20,21 have had their medications delivered in the appropriate time frame and administered medications with meals as required. <u>How Other Residents Were Identified Who May Have Been Impacted by the Practice:</u> An audit was completed of all medication passes to validate that medications were administered within the one hour time frame and that orders requiring administration with meals were administered appropriately. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> All certified medication techs and licensed nurses will be in-serviced on medication pass compliance times and delivering medications with meals or food by the Director of Nurses / Staff Development Coordinator. A detail review of the medication pass times was completed by the Director of Nurses and the medication times were adjusted with approval of the physician to validate that medications were passed within the acceptable time frame for BID, TID, with meals or food as applicable. <u>Monitoring Measures to Maintain On-going Compliance:</u>	04/03/13	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185316	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2013
NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445		
(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 332	<p>Continued From page 10</p> <p>A review of the Physician's Orders and Medication Administration Record (MAR) for Resident #19, dated February 2013, revealed an order for Lisinopril 10 mg twice daily at 7:00 AM and 7:00 PM.</p> <p>2. An observation of a medication pass, on 02/20/13 at 9:10 AM, revealed KMA #2 administered Potassium Chloride (CL) liquid 20 milliequivalents (meq) and Namenda 10 milligrams (mg) to Resident #4 at 9:10 AM. The resident was not eating a meal during the observation. Additionally, KMA #2 obtained Betoptic S 0.25 percent (%) eye drops from the resident's medication drawer; however, the eye drops were not administered during the observation.</p> <p>A review of the Physician's Orders and MAR, dated February 2013, revealed the following orders for Resident #4: Potassium CL 20 meq liquid twice daily with meals at 7:00 AM and 4:30 PM, Namenda 10 mg twice daily at 7:00 AM and 7:00 PM, and Betoptic S 0.25% eye drops, one drop to the right eye daily at 7:00 AM. The MAR revealed KMA #2 initialed all three medications given at 7:00 AM.</p> <p>A phone interview with KMA #2, on 02/22/13 at 12:00 PM, revealed she had an hour before or after the scheduled time to give a medication. She was not sure what happened on 02/20/13 as she "usually" had enough time to pass medications within compliance. She revealed she should have ensured the Potassium was administered to Resident #4 during breakfast. She stated the eye drops were given to Resident #4 after the observation; however, she did not</p>	F 332	<u>F332 (Cont)</u> Audits will be conducted by the Director of Nurses, Unit Managers or Staff Development Coordinator three times per week for 8 weeks to validate medication pass is completed timely and that medications ordered with meals/ food were administered as ordered. Findings will be reported to the monthly Quality Assurance and Assessment committee for review and recommendations for a minimum of 6 months and if no concerns are noted then frequency may be decreased at the discretion of committee.		

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F 332	<p>Continued From page 11</p> <p>ensure the surveyor observed the administration.</p> <p>3. An observation of a medication pass, on 02/21/13 at 9:20 AM, revealed KMA #1 administered Potassium CL 20 meq (two tablets), Docusate Sodium 100 mg, and Peractin 4 mg to Resident #20 at 9:20 AM.</p> <p>A review of the Physician's Orders and MAR, dated February 2013, revealed the following orders for Resident #20: Potassium CL 20 meq tablet (2 tablets) three times daily with meals at 7:00 AM, 11:00 AM, and 5:00 PM; Docusate Sodium 100 mg (2 capsules) twice daily at 7:00 AM and 7:00 PM; Peractin 4 mg twice daily at 7:00 AM and 7:00 PM.</p> <p>4. An observation of a medication pass, on 02/21/13 at 9:45 AM, revealed KMA #1 administered Docusate Sodium 100 mg to Resident #21 at 9:45 AM.</p> <p>A review of the Physician's Orders and MAR, dated February 2013, revealed an order for Docusate Sodium 100 mg three times daily at 7:00 AM, 1:00 PM, and 7:00 PM.</p> <p>An interview with KMA #1, on 02/22/13 at 10:45 AM, revealed she could give medications one hour before or after the scheduled time. She was aware the medications were given late to Resident #20 and #21; however, she did not have an explanation. She revealed the Potassium for Resident #20 should have been administered with breakfast.</p> <p>An interview with the Director of Nursing (DON), on 02/22/13 at 4:20 PM, revealed staff should</p>	F 332			

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F 332	Continued From page 12 pass medications one hour before or after the scheduled time. If the KMA was unable to give the medication within compliance, she expected the nurse to notify the physician to verify if the medication should still be administered. She expected staff to follow the policy for medication administration.	F 332		
F 372 SS=F	483.35(l)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure the proper disposal of garbage as the facility's dumpsters were not located on a washable surface. Findings include: A review of the Environment Maintenance policy/procedure, revised 12/05/12, revealed the facility would be equipped to provide a sanitary, orderly, and comfortable environment that protected the health and safety of residents, personnel, and the public. An observation, on 02/20/13 at 1:45 PM, revealed four dumpsters (3 for trash, 1 for recycled cardboard) near the back of the facility on a gravel surface. An interview with the Administrator, on 02/22/13 at 4:00 PM, revealed the facility had planned to	F 372	<u>F372</u> <u>483.35(l)(3) Dispose Garbage and Refuse Properly</u> It is the practice of Princeton Health and Rehab Center to dispose of garbage and refuse properly. <u>Corrective Measures for Resident Identified in the deficiency:</u> No residents were identified in this deficiency. <u>How Other Residents Were Identified Who May Have Been Impacted by the Practice:</u> Four dumpsters on the facility grounds require a washable surface underneath. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> Rubber matting is being placed under the four dumpsters secured with steel rods by the Environmental Services Director to create a washable surface under the containers by 4/3/12. <u>Monitoring Measures to Maintain On-going Compliance:</u> The Environmental Services Director will audit the new rubber matting system under the four dumpsters for placement and cleanliness 3 times per week for 8 weeks and report findings to the monthly Quality Assurance and Assessment meeting for review and recommendations.	04/03/13

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F 372	Continued From page 13 "black top" the parking lot and dumpster area last year; however, it was not completed.	F 372			
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	<u>F431</u> <u>483.60(b),(d),(e) Drug Records, Label/Store Drugs & Biologicals</u> It is the practice of Princeton Health and Rehab to ensure an account of all controlled drugs is maintained and periodically reconciled, and to properly store controlled drugs in the refrigerator and keep updated supplies available in the emergency cart. <u>Corrective Measures for Resident Identified in the deficiency:</u> No residents were identified in this deficiency. <u>How Other Residents Were Identified Who May Have Been Impacted by the Practice:</u> Six out of six medication carts, one refrigerator containing narcotic EDK and one code cart are present in the facility to validate continued compliance. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> An audit was completed of all medication carts and any narcotics not currently in use were brought to the Director of Nurses for reconciliation and destruction. The refrigerator containing the narcotic kit on 100 hall is locked. A new narcotic count sheet was in-serviced to all licensed nurses and Certified Medication Techs and implemented on 3/2/12 by the Director of Nurses and Staff Development Coordinator that extends the tracking system to count the number of sheets present in the cart. The code cart was audited by the Director of Nurses to validate acceptable expiration dates on any included items. <u>Monitoring Measures to Maintain On-going Compliance:</u> Audits will be completed by the Unit Manager/ Staff Development Coordinator three times per week for 8 weeks to validate the narcotic count sheet correctly reflects the number of cards in the cart and that the refrigerator containing the narcotic E-Kit on 100 hall is locked. The code	04/03/13	

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NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445
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F 431	<p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure an account of all controlled drugs was maintained and periodically reconciled, and to ensure the proper storage of controlled drugs in the refrigerator. Additionally, the facility failed to ensure medical supplies available for use in the emergency cart were not expired.</p> <p>Findings include:</p> <p>1. A review of the Controlled Substance Disposal Protocol, undated, revealed at regular intervals, avoiding a large build up of medications, medication should be disposed of in a manner appropriate for the medication type.</p> <p>An observation, on 02/20/13 at 4:20 PM, revealed thirty four (34) narcotic medications were stored in the medication carts; however, the medications were not in use. The medications were observed in the carts with the narcotic count sheet wrapped around the medication.</p> <p>An interview with the Director of Nursing (DON), on 02/20/13 at 4:20 PM, revealed the majority of the narcotics were from discharged residents between 01/10/13 and 02/12/13. She revealed staff were supposed to bring the narcotics to her (to be reconciled) when a resident discharged or if a medication order changed/expired. She revealed when left in the medication cart, the staff were supposed to "count" them; however, it was not documented. There was no tracking system</p>	F 431	<p>F431 (cont)</p> <p>cart will be audited on a quarterly basis by the Director of Nurses / Unit Manger to validate expiration dates are acceptable. Findings will be reported to the monthly Quality Assurance and Assessment committee for review and recommendations for a minimum of 6 months and if no concerns are noted then frequency may be decreased at the discretion of committee.</p>	
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F 431	<p>Continued From page 15</p> <p>In place to ensure an accurate account of the narcotics (not in use).</p> <p>An interview with the Administrator, on 02/20/13 at 4:40 PM, revealed the Clinical Care Coordinator was responsible for monthly audits of the medication carts; however, the last audit was completed on 01/02/13.</p> <p>2. A review of the Controlled Medications Administration policy/procedure, revised 10/01/13, revealed Schedule II controlled medications subject to the Comprehensive Drug Abuse Prevention and Control Act were stored in a cabinet of substantial construction under a double-lock system, or as otherwise required by state regulations.</p> <p>An observation of the 100 hall medication room, on 02/19/13 at 10:10 AM, revealed an emergency narcotic kit of medications in the refrigerator, unlocked. The Clinical Care Coordinator (CCC) was present during the observation. The kit included the following narcotics:</p> <ol style="list-style-type: none"> 1. Morphine 20 milligrams (mg)/milliliter (ml) (30 ml vial) 2. Morphine 10 mg/ml (6 vials) 3. Fentanyl patch 25 microgram (mcg) (6 patches) 4. Lorazepam 0.5 mg (6 tablets) 5. Lorazepam 2 mg/ml (2 vials) 6. Hydrocodone/Apap 5/500 mg (6 tablets) <p>An interview with the CCC, on 02/22/13 at 2:15 PM, revealed the nurse should have ensured the refrigerator was locked before leaving the medication room.</p>	F 431		

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F 431	Continued From page 16 An interview with Registered Nurse (RN) #4, on 02/20/13 at 1:00 PM, revealed she was supposed to ensure the refrigerator in the medication room was locked at all times. An interview with the DON, on 02/22/13 at 4:20 PM, revealed when narcotics were present in the refrigerator, it should be locked at all times. 3. An observation of the emergency cart, on 02/19/13 at 10:10 AM, revealed the following supplies with an expired date, available for use: 1. three sterile saline bottles, expired December 2010 2. three packs of lubricating jelly, expired June 2010 3. two packs of lubricating jelly, expired June 2009 4. multiple alcohol prep wipes, expired November 2010 5. one bottle of hand sanitizer, expired February 2010 A review of the Emergency Cart Checklist, dated 02/17/13 and 02/19/13, revealed staff had documented the emergency cart was locked on the listed days. An interview with the CCC, on 02/22/13 at 2:15 PM, revealed third shift staff had documented the emergency cart was locked; however, they should have opened the cart to ensure the supplies were not expired. An interview with the DON, on 02/22/13 at 4:20 PM, revealed she expected third shift staff to	F 431			

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F 431	Continued From page 17 check the contents of the emergency cart at least monthly.	F 431		
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. (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	F 441	<u>F441</u> <u>483.65 Infection Control, Prevent Spread, Linens</u> It is the practice of Princeton Health and Rehab to 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. <u>Corrective Measures for Resident Identified in the deficiency:</u> Resident # 1,2,3 are being provided care and services using hand hygiene and glove use according to standard contact precautions with emphasis placed on incontinent care, skin evaluations, wound measurements and handling food at resident bedside. <u>How Other Residents Were Identified Who May Have Been Impacted by the Practice:</u> Audits have been completed on licensed nurses and certified nursing assistants by the Director of Nurses, Unit Managers and Staff Development Coordinator to validate residents are being provided care and services using hand hygiene and glove use according to standard precautions while performing incontinent care, skin evaluations, wound measurements and handling food at the resident bedside. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> All licensed nurses and certified nursing assistants have been in-serviced by the Director of Nurses / Staff Development Coordinator on infection control standard precautions to include hand washing and glove use while performing incontinent care, skin evaluations and food handling at the resident bedside. All licensed nurses have been in-serviced by the Director of	04/03/13

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F 441	<p>Continued From page 1B Infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of the facility's policy/procedure, it was determined the facility failed to 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 for three residents (#1, #2, and #3), in the selected sample of 17 residents.</p> <p>Certified Nurse Aide #8 failed to change her gloves after providing incontinent care to Resident #2, and proceeded to bathe the resident using the same dirty gloves. In addition, CNA #8 handled a package of cookies belonging to Resident #2 with her dirty glove, and then continued to provide care for the resident.</p> <p>Licensed Practical Nurse (LPN) #1 failed to change her contaminated gloves and wash her hands after completing per-care for Resident #3, and continued the resident's skin assessment.</p> <p>Additionally, Registered Nurse #3 measured the depth of a coccyx wound using her gloved "pinkie finger" during a skin assessment for Resident #1.</p> <p>Findings include: A review of the facility's protocol, "Hand Hygiene and Medical Glove Use," undated, revealed the use of gloves does not replace the need for</p>	F 441	<p><u>F441(cont)</u></p> <p>Nurses / Staff Development Coordinator on maintaining standard precautions during wound measurements. The in-service was initiated on 2/22/13 and will continue until all licensed staff and certified nursing assistants have received the education.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>Audits will be completed by the Director of Nurses/ Unit Managers/ Staff Development Coordinator 5 times per weeks for 8 weeks to validate residents are being provided care and services using hand hygiene and glove use according to standard precautions while performing incontinent care, skin evaluations, wound measurements and food handling at the resident bedside. Findings will be reported to the monthly Quality Assurance and Assessment committee for review and recommendations for a minimum of 6 months and if no concerns are noted then frequency may be decreased at the discretion of committee.</p>

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NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445		
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F 441	<p>Continued From page 19</p> <p>cleaning your hands. Hand hygiene should be completed when appropriate regardless of the indications for glove use. Staff should remove his or her gloves to perform hand hygiene, when an indication occurs while wearing gloves. Discard gloves after each task and clean your hands, gloves may carry germs. Wear gloves when indicated according to Standard and Contact Precautions, otherwise they may become a major risk for germ transmission.</p> <p>1. A record review the facility admitted Resident #2 on 01/18/13 with diagnoses to include Diabetes Uncomplicated Type II, Diabetes Circulatory Disorder Type II, OT Rehab, and OT Malaise/Fatigue.</p> <p>Observation of a bed bath for Resident #2, on 02/20/13 at 8:50 AM, revealed CNA #6 used soap and water, washed head to toe, and used a separate washcloth for the per-area; however, the resident was incontinent of bowel/bladder, and CNA #6 did not change her gloves at this time. She proceeded to put her dirty gloved hand in the same water used for bathing the resident. She then washed the resident's back and buttocks. The CNA changed the resident's bed and again used the same gloves and used the same washcloth to cleanse the other side of the resident. CNA #6 assisted the resident to get dressed, as well as change his/her bed linens without ever changing her gloves or washing her hands. It was not until she was completely through with the resident's bath/incontinent care/bed linen change, that the CNA disposed of her gloves and washed her hands with soap and water.</p>	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185316	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2013
NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445		
(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 441	<p>Continued From page 20</p> <p>Additionally, on 02/20/13 at 12:45 PM, an observation during provision of Resident #2's incontinent care revealed CNA #8 pulled a package of cookies out of the resident's nightstand drawer with her dirty gloves on, and laid the packaged cookies on top of the nightstand. She then went directly back to assisting with the provision of the resident's care.</p> <p>An interview with CNA #8, on 02/20/13 at 2:00 PM, revealed she received training/in-service regarding proper glove use and handwashing protocol; however, she could not recall a date. During the interview process, she realized her errors during the "on hands" resident care, as well as handling the resident's cookies inappropriately. She stated "I was nervous, not thinking clearly."</p> <p>2. A record review revealed the facility admitted Resident #3 on 09/26/12 with diagnoses to include Alzheimer's Disease, Lung Cancer, Depression, Anxiety, Osteoarthritis, B Complex Deficiency, and Constipation.</p> <p>Observation of a skin assessment by LPN #1, on 02/20/13 at 2:00 PM, revealed LPN #1 opened Resident #3's incontinent brief, observed his/her perineal area and performed perineal care. After performing the perineal care, the nurse disposed of the dirty wipes in the garbage and continued with the skin assessment without removing her contaminated gloves, washing her hands, or</p>	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2013
NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445		
(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 441	<p>Continued From page 21</p> <p>reapplying new gloves. The nurse continued to perform the skin assessment wearing a contaminated pair of gloves, touched the resident's bilateral lower extremities, repositioned him/her in the bed and pulled up his/her sheet and blanket, before removing the contaminated gloves, and washing her hands. LPN #1 did not remove her gloves, wash her hands, or apply clean gloves after contact with Resident #3's perineal area and prior to the examination of the resident's bilateral lower extremities, repositioning him/her in bed, and pulling up his/her sheet and blanket.</p> <p>Arj interview, conducted on 02/21/13 at 10:10 AM with LPN #1, revealed she was knowledgeable about the facility's policy related to proper hand washing hygiene and gloving technique. LPN #1 stated she does not know why she did not follow the proper hand hygiene and gloving techniques. She stated she was "nervous" during the procedure due to being observed by surveyors.</p> <p>3. A record review revealed the facility admitted Resident #1 to the facility on 08/14/12 with diagnoses to include Congested Heart Failure, Explosive Personality, Aggression, Atrial-Fibrillation, Hypertension, Anxiety, Depression, Insomnia, Alzheimer's, Dementia OT w/ Behavioral Disturbance, Old Myocardial Infarction, and Gastroesophageal Reflux Disorder.</p> <p>Observation of a skin assessment, on 02/21/13 at 10:16 AM, completed by RN #3 and assisted by CNA #8, revealed Resident #1 with a Stage III pressure ulcer to his/her coccyx area measuring</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445		
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F 441	Continued From page 22 3.0 centimeters (cm) x 1.5 cm x 0.5 cm. During the skin assessment and measurement of the wound, RN #3, with gloved hands, measured the length and width of the wound using a tape measure; however, she used her gloved "pinky finger" to measure the depth of the wound. An interview with RN #3, on 02/22/13 at 11:23 AM, revealed she measured the wound's length x width in centimeters using a tape measure. When questioned about the measurement of the depth of the wound she replied, "I used my pinky finger." Further interview with RN #3 revealed the facility protocol for measuring wound depth involved the use of a Q-Tip and not "a finger." She reported the outcome from this incident could be an infection due to "sticking her gloved finger" in the resident's wound, and stated she forgot the Q-Tip for measuring the depth of the wound. An interview with the Director of Nursing (DON), on 02/22/13 at 2:45 PM, revealed she was unaware the staff did not use appropriate handwashing technique nor proper glove use related to infection control, and she was also unaware of the inappropriate handling of Resident #2's cookies; however, she expected the staff to use proper protocol during provision of resident care. She stated that all nursing staff were instructed on the facility's policies related to infection control, hand washing/gloving techniques during their orientation, as well as throughout the year at monthly inservices.	F 441			

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NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01. PLAN APPROVAL: 1972. SURVEY UNDER: 2000 Existing. FACILITY TYPE: SNF/NF. TYPE OF STRUCTURE: One (1) story, Type III (200). SMOKE COMPARTMENTS: Five (5) smoke compartments. FIRE ALARM: Complete fire alarm system installed in 1972, upgraded in 2011 with 38 smoke detectors and 5 heat detectors. SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1972 and upgraded in 2011. GENERATOR: Type II generator installed in 2011. Fuel source is Diesel. A standard Life Safety Code survey was conducted on 02/21/13. Princeton Health and Rehab Center was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for One-Hundred Four (104) beds with a census of Eighty-Two (82) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal	K 000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Kelly Alder

NHA

3/14/13

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 Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.	
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 three (3) of five (5) smoke compartments, seventy-two (72) residents, staff and visitors. The facility is certified for One-Hundred Four (104) beds with a census of Eighty-Two (82) on the day of the survey. The facility failed to ensure two (2) smoke barriers were sealed around pipes and wires to resist the passage of smoke. This deficiency was cited on the previous survey, on 12/20/11.	K 025	K025 It is the normal practice of Princeton Health and Rehab to maintain smoke barriers that will resist the passage of smoke between smoke compartments in accordance with NFPA standards. <u>Corrective Measures for those Residents identified in the deficiency:</u> No residents were identified in this deficiency. <u>How other residents who may have been affected by this practice were identified:</u> Residents in 3 of 5 smoke compartments have the potential to be affected by the practice. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> The smoke partitions penetrated by pipes and conduit on hall 2 and 3 were resealed with cement on 2/21/13 by the Maintenance Director. All remaining smoke barriers were checked on 2/21/13 by the Maintenance Director and no issues were identified. The Maintenance Director was re-educated by the administrator on 3/11/13 on utilizing the proper sealer and no areas of penetration can be present.	4/3/13

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NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445		
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K 025	<p>Continued From page 2</p> <p>The findings include:</p> <p>Observations, on 02/21/13 between 9:10 AM and 10:00 AM with the Maintenance Supervisor, revealed the smoke partitions, extending above the ceiling located at the front of hall 2 and 3, were penetrated by pipes and conduit. Further observation revealed quick foam was used on a concreted block wall.</p> <p>Interview, on 02/21/13 between 9:10 AM and 10:00 AM with the Maintenance Supervisor, revealed he was unaware of the penetrations in the smoke barriers as they had been inspected several times since the last survey. Further interview revealed he was unaware the quick foam was not suitable to seal a 2 hour wall.</p> <p>Interview, on 02/21/13 at 2:36 PM with the Administrator, revealed the facility followed the plan of correction submitted from the previous survey. The Maintenance Supervisor is the only individual that inspects the smoke barriers at the facility and he must have just missed the two (2) penetrations in the barriers.</p> <p>This is a repeat deficiency.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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 follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <p>1. Be filled with a material capable of maintaining</p>	K 025	<p>K-025 (cont)</p> <p><u>Monitoring Measures to Maintain Ongoing Compliance:</u></p> <p>The smoke barriers will be audited monthly by the Maintenance Director and/or the Maintenance employee to validate ongoing compliance that proper caulking/sealant is being utilized and no areas of penetration are present. The results will be reported to the Quality Assessment and Assurance committee on a monthly basis for review x one year to verify ongoing compliance.</p>	

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K 025	Continued From page 3 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. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from	K 029	K-029 It is the normal practice of Princeton Health and Rehab to meet hazards in accordance with NFPA Standards. <u>Corrective Measures for those Residents identified in the deficiency:</u> No residents were identified in this deficiency.	4/3/13

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K 029	<p>Continued From page 4</p> <p>other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, thirty-four (34) residents, staff and visitors. The facility is certified for One-Hundred Four (104) beds with a census of Eighty-Two (82) on the day of the survey. The facility failed to ensure two (2) rooms were properly protected due to the storage in the rooms.</p> <p>The findings include:</p> <p>Observation, on 02/21/13 between 10:00 AM and 3:30 PM with the Maintenance Supervisor, revealed the storage room at the back of hall 2 did not have a door closure installed on the door and the door for the pantry room was vented to the corridor.</p> <p>Interview, on 02/21/13 between 10:00 AM and 3:30 PM with the Maintenance Supervisor, revealed he was unaware the storage in a room determined whether the room was a hazardous storage area or not.</p>	K 029	<p>K-029 (cont)</p> <p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>Residents in 2 of 5 smoke compartments have the potential to be affected by the practice.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>A self closing device was installed on the storage room door at the back of hall 2 on 2/28/13 by the Maintenance Director. A new ventless door to the corridor was ordered for the pantry room on 3/7/13 by the Maintenance Director. The Maintenance Director was re-educated on the requirement for self-closers for rooms protecting hazardous combustibles on 3/11/13 by the Administrator.</p> <p><u>Monitoring Measures to Maintain Ongoing Compliance:</u></p> <p>Rooms that contain hazardous combustibles will be monitored to verify that self closures are present on the doors. This will be conducted quarterly by the Maintenance Director and/or the Maintenance assistant. The results of the findings will be reported to the Quality Assessment and Assurance committee on a quarterly basis for a minimum of one year to validate ongoing compliance.</p>	

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NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445		
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K 029	Continued From page 5 Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than	K 029			

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K 029	Continued From page 6	K 029		
K 045	48 in. (122 cm) above the bottom of the door.			
SS=E	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 five (5) smoke compartments, seventy (70) residents, staff and visitors. The facility is certified for One-Hundred Four (104) beds with a census of Eighty-Two (82) on the day of the survey. The facility failed to ensure the emergency lights had two (2) bulbs at two (2) exits. The findings include: Observation, on 02/21/13 at 11:15 AM with the Maintenance Supervisor, revealed the exterior exits at the smoking exit only had a single light for illumination of the outside of the exit and the back of the hall 3 did not have any exterior lighting. Interview, on 02/21/13 at 11:15 AM with the Maintenance Supervisor, revealed he was unaware the lighting fixtures serving the exterior exits must include more than one bulb for illumination of the egress path.	K 045	K-45 It is the normal practice of Princeton Health and Rehab Center to ensure exits were equipped with lighting in accordance with NFPA standards. <u>Corrective Measures for those Residents identified in the deficiency:</u> No residents were identified in this deficiency. <u>How other residents who may have been affected by this practice were identified:</u> Residents in 2 of 5 smoke compartments have the potential to be effected. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> The exterior exit at the smoking exit had a dual light installed on 3/12/13 by the Maintenance Director. On the back of hall 3 a dual light was installed on 3/12/13 by the Maintenance Director. The Maintenance Director was re-educated by the Administrator on 3/11/13 on the requirement for illumination of means of egress is arranged so that failure of a single light will not leave the area in darkness.	4/03/13

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445	
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K 045	Continued From page 7 Reference: NFPA 101 (2000 edition) 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-45 (cont) <u>Monitoring Measures to Maintain Ongoing Compliance:</u> All lighting by the exits for egress will be monitored quarterly by the Maintenance Director or Maintenance employee to verify ongoing compliance. The audit results will be reported to the Quality Assessment and Assurance Committee quarterly x 1 year.	
K 056 SS=F	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 observations and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for One-Hundred Four (104) beds with a census of Eighty-Two (82) on the day of the	K 056	K-56 It is the normal practice of Princeton Health and Rehab to ensure the building has a complete sprinkler system installed in accordance with NFPA standards. <u>Corrective Measures for those Residents identified in the deficiency:</u> No residents were identified in this deficiency. <u>How other residents who may have been affected by this practice were identified:</u> Residents in 5 of 5 smoke compartments have the potential to be affected by the practice. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> The lights in rooms # 204, #207, # 211, # 213, # 215, # 218 were moved so as to not block the sprinkler heads. This was completed by the	4/03/13

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K 056	Continued From page 8 survey. The facility failed ensure the sprinkler heads were not blocked by light fixtures in twenty-four (24) areas, located at least 4 inches from a wall in two (2) areas, two (2) rooms had sprinkler coverage. The findings include: Observations, on 02/21/13 between 10:00 AM and 3:30 PM with the Maintenance Supervisor, revealed the sprinkler heads located in resident rooms #116, #115, #113, #112, #106, #204, #207, #211, #213, #215, #218, #319, #317, #315, #316, #313, #314, #307, #306, #304, and #303 were blocked by light fixtures, within 1 foot of the sprinkler head, extending below the sprinkler heads. Further observation revealed the sprinklers were blocked by light fixtures in the clean linen room, copier room, and the front sun room. Interview, on 02/21/13 between 10:00 AM and 3:30 PM with the Maintenance Supervisor, revealed he was unaware that the light fixtures could block the spray pattern of the sprinkler head. Observation, on 02/21/13 between 10:00 AM and 3:30 PM with the Maintenance Supervisor, revealed sprinkler heads in the in resident closets of rooms #109 and #215 were located within 4 inches of the wall. Interview, on 02/21/13 between 10:00 AM and 3:30 PM with the Maintenance Supervisor, revealed he was unaware of the requirement that a sprinkler head must be installed at a minimum of 4 inches from any wall.	K 056	K-56 (cont) Maintenance Director on 3/5/13. The lights in rooms # 116, # 115, # 113, #112, # 106 were moved so as not to block the sprinkler heads. This was completed by the Maintenance Director on 2/29/13. The lights in rooms # 319, # 317, # 315, # 316, # 313, # 314, # 307, # 306, # 304 and #303 were moved so as not to block to the sprinkler heads on 3/11/13 by the Maintenance Director. The light fixtures in the clean linen room and the copier room were moved so as not to block the sprinkler heads on 2/29/13. This was conducted by the Maintenance Director on 2/29/13. The sprinklers in the front sun room, resident closets in room # 109, and #205 will be relocated by the Fire Sprinkler Company on 3/18/13 so as not to be blocked by the light fixtures. All sprinklers in the facility were audited by the Maintenance Director on 2/21/13 to verify that other sprinkler heads were not blocked by lighting fixtures. <u>Monitoring Measures to Maintain Ongoing Compliance:</u> All sprinklers in the facility will be audited monthly on an ongoing basis by the Maintenance Director and/or Maintenance employee to verify sprinklers are free from blockage. The findings will be reported to the Quality and Assessment and Assurance Committee on a quarterly basis for 1 year to validate ongoing compliance.	

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K 056	Continued From page 9 Observation, on 02/21/13 at 12:00 PM with the Maintenance Supervisor, revealed the resident closet and bathroom in room #302 did not have sprinkler protection. Interview, on 02/21/13 at 12:00 PM with the Maintenance Supervisor, revealed he was not aware that the areas listed did not have proper sprinkler protection. 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) <table border="1"> <thead> <tr> <th>Distance from Sprinklers to above Bottom of Side of Obstruction (A)</th> <th>Maximum Allowable Distance of Deflector Obstruction (in.) (B)</th> </tr> </thead> <tbody> <tr> <td>Less than 1 ft</td> <td>0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td>2 1/2</td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td>3 1/2</td> </tr> <tr> <td>2 ft to less than 2 ft 6 in.</td> <td>5 1/2</td> </tr> <tr> <td>2 ft 6 in. to less than 3 ft</td> <td>7 1/2</td> </tr> <tr> <td>3 ft to less than 3 ft 6 in.</td> <td>9 1/2</td> </tr> <tr> <td>3 ft 6 in. to less than 4 ft</td> <td>12</td> </tr> </tbody> </table>	Distance from Sprinklers to above Bottom of Side of Obstruction (A)	Maximum Allowable Distance of Deflector Obstruction (in.) (B)	Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	K 056		
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K 056	Continued From page 10 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). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall. Reference: NFPA 101 (2000 ed.) S&C letter detailing all long term care facilities must be fully sprinkled by 2013.	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, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for One-Hundred Four (104) beds with a census of Eighty-Two (82) on the day of the survey. The facility failed to ensure the gauges on the sprinkler riser had been replaced or recalibrated since 2004. The findings include:	K 062	K-62 It is the normal practice of Princeton Health and Rehab Center to maintain the sprinkler system in accordance with NFPA standards. <u>Corrective Measures for those Residents identified in the deficiency:</u> No residents were identified in this deficiency. <u>How other residents who may have been affected by this practice were identified:</u> Residents in 5 of 5 smoke compartments have the potential to be affected by the practice.	4/3/13	

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K 062	Continued From page 11 Record review, on 02/21/13 at 11:50 AM with the Maintenance Supervisor, revealed the facility failed to provide documentation that the gauges on the sprinkler riser and in the MDS room had been calibrated or replaced within the last 5 years. Further observation revealed the gauges had a date of 2004 on the ones on the sprinkler riser. Interview, on 02/21/13 at 11:50 AM with the Maintenance Supervisor, revealed he was not aware the gauges on the sprinkler riser and in the MDS room had not been changed recently and relied on his contractors to keep the facility in compliance. Reference: NFPA 25 (1998 Edition). 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.	K 062	<u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> The gauges on the sprinkler riser were replaced by the Fire and Sprinkler Company on 2/22/13. The gauge in the MDS room will be replaced on 3/18/12 by the Fire and Sprinkler Company. All sprinkler gauges in the facility were checked by the Maintenance Director on 2/21/13 to verify no other gauges were in need of replacement or calibration. An audit tool for monthly monitoring of the gauges has been developed and added to the Maintenance Directors Audit schedule. The Maintenance Director was re-educated on 3/11/13 by the Administrator that sprinkler gauges are to be monitored to verify that sprinkler gauges are calibrated or replaced every 5 years. <u>Monitoring Measures to Maintain On-going Compliance:</u> All sprinklers in the facility will be audited on a quarterly basis by the Maintenance Director and/or Maintenance employee to verify sprinkler gauges are calibrated and/or replaced in according to NFPA standards. The findings will be reported to the Quality and Assessment and Assurance Committee on a monthly basis for 1 year by the Maintenance Director to validate ongoing compliance.		

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K 062	<p>Continued From page 12 Reference: NFPA 25 (1998 Edition).</p> <p>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.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance</p> <table border="0"> <tr> <td>Item</td> <td>Activity</td> <td>Frequency</td> <td>Reference</td> </tr> <tr> <td>Gauges (dry, preaction deluge systems)</td> <td>Inspection</td> <td>Weekly/monthly</td> <td>2-2.4.2</td> </tr> <tr> <td>Control valves</td> <td>Inspection</td> <td>Weekly/monthly</td> <td>Table 9-1</td> </tr> <tr> <td>Alarm devices</td> <td>Inspection</td> <td>Quarterly</td> <td>2-2.6</td> </tr> <tr> <td>Gauges (wet pipe systems)</td> <td>Inspection</td> <td>Monthly</td> <td>2-2.4.1</td> </tr> <tr> <td>Hydraulic nameplate</td> <td>Inspection</td> <td>Quarterly</td> <td>2-2.7</td> </tr> <tr> <td>Buildings</td> <td>Inspection</td> <td>Annually (prior to freezing weather)</td> <td>2-2.5</td> </tr> <tr> <td>Hanger/seismic bracing</td> <td>Inspection</td> <td>Annually</td> <td>2-2.3</td> </tr> <tr> <td>Pipe and fittings</td> <td>Inspection</td> <td>Annually</td> <td>2-2.2</td> </tr> <tr> <td>Sprinklers</td> <td>Inspection</td> <td>Annually</td> <td>2-2.1.1</td> </tr> <tr> <td>Spare sprinklers</td> <td>Inspection</td> <td>Annually</td> <td>2-2.1.3</td> </tr> <tr> <td>Fire department connections</td> <td>Inspection</td> <td>Table 9-1</td> <td></td> </tr> <tr> <td>Valves (all types)</td> <td>Inspection</td> <td>Table 9-1</td> <td></td> </tr> <tr> <td>Alarm devices</td> <td>Test</td> <td>Quarterly</td> <td>2-3.3</td> </tr> <tr> <td>Main drain</td> <td>Test</td> <td>Annually</td> <td>Table 9-1</td> </tr> </table>	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	K 062		
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K 064	<p>Continued From page 14</p> <p>Observation, on 02/21/13 between 10:00 AM and 3:30 PM with the Maintenance Supervisor, revealed a fire extinguisher with no 6 year maintenance on the front porch dated 1990, one at the back of the 300 hall dated 2005, one at the front of 100 hall dated 2005, and one in the dining room dated 2006.</p> <p>Interview, on 02/21/13 between 10:00 AM and 3:30 PM with the Maintenance Supervisor, revealed the facility was not aware the portable fire extinguishers had not been serviced properly, by their extinguisher service company.</p> <p>Reference: NFPA 10 (1998 ed.) Actual NFPA Standard: NFPA 10, 4-4.3*. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. The removal of agent from halon agent fire extinguishers shall only be done using a listed halon closed recovery system. When the applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall begin from that date. Exception: Non-rechargeable fire extinguishers shall not be hydrostatically tested but shall be removed from service at a maximum interval of 12 years from the date of manufacture. Non-rechargeable halon agent fire extinguishers shall be disposed of in accordance with 4-3.3.3. Actual NFPA Standard: NFPA 10, 4-4.4*. Each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed and that identifies the person performing the service.</p>	K 064	<p>K-64 (cont)</p> <p>removed. All remaining fire extinguishers in the facility were checked on 2/21/13 by the Maintenance Director to verify no other extinguishers were in need of replacement. None were identified. An Audit tool was added to the Maintenance Director's schedule to conduct audits on all fire extinguishers on a quarterly basis. The Maintenance Director was re-educated on 3/11/13 by the Administrator on the requirement of 6 year maintenance on fire extinguishers.</p> <p><u>Monitoring Measures to Maintain Ongoing Compliance:</u></p> <p>All fire extinguishers in the facility will be audited quarterly by the Maintenance Director or Maintenance employee to verify that all fire extinguishers are maintained according to NFPA standards. The findings will be reported to the Quality and Assessment and Assurance Committee on a quarterly basis x 1 year by the Maintenance Director to validate ongoing compliance.</p>

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K 064	<p>Continued From page 15</p> <p>Actual NFPA Standard: NFPA 10, 4-4.4.1*. Fire extinguishers that pass the applicable 6-year requirement of 4-4.3 shall have the maintenance information recorded on a suitable metallic label or equally durable material having a minimum size of 2 in. by 3 1/2 in. (5.1 cm 8.9 cm). The new label shall be affixed to the shell by a heatless process, and any old maintenance labels shall be removed. These labels shall be of the self-destructive type when removal from a fire extinguisher is attempted. The label shall include the following information:</p> <p>(a) Month and year the maintenance was performed, indicated by a perforation such as is done by a hand punch</p> <p>(b) Name or initials of person performing the maintenance and name of agency performing the maintenance</p> <p>Actual NFPA Standard: NFPA 10, 4-4.4.2*. Each extinguisher that has undergone maintenance that includes internal examination or that has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch.</p> <p>Exception No. 1: Fire extinguishers undergoing maintenance before January 1, 1999.</p> <p>Exception No. 2: Cartridge/cylinder-operated fire extinguishers do not require a "Verification of Service" collar.</p>	K 064		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445	
(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 068 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Combustion and ventilation air for boiler, incinerator and heater rooms is taken from end discharged to the outside air. 19.5.2.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure combustion air and ventilation for boilers, incinerators, and heater rooms were installed in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, thirty-eight (38) residents, staff and visitors. The facility is certified for One-Hundred Four (104) beds with a census of Eighty-Two (82) on the day of the survey. The facility failed to ensure the boiler room did not vent into the attic.</p> <p>The findings include:</p> <p>Observation, on 02/21/13 at AM with the Maintenance Supervisor, revealed the fresh air vent for the fuel fired hot water heater located in the Minimum Data Set office was not sealed around the piping and was venting directly into the attic.</p> <p>Interview, on 02/21/13 at AM with the Maintenance Supervisor, revealed he was unaware the vent was not properly sealed to only take air directly from the outside.</p> <p>Reference: NFPA 101 Life Safety Code (2000)</p>	K 068	<p>K-68</p> <p>It is the normal practice of Princeton Health and Rehab Center to ensure combustion air and ventilation for boilers, incinerators, and heater rooms are installed in accordance with NFPA standards.</p> <p><u>Corrective Measures for those Residents identified in the deficiency:</u></p> <p>No residents were identified in this deficiency.</p> <p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>Residents in 1 of 5 smoke compartments have the potential to be affected by the practice.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>The fuel fired hot water heater located in the MDS office was sealed with a metal flashing on 3/4/13 by the Maintenance Director and is now vented to the roof so the boiler room no longer vents to the attic. All other areas relating to boilers, heater rooms, and incinerator rooms were checked on 2/21/13 by the Maintenance Director and no other issues were identified. The Maintenance Director was re-educated by the administrator on 3/11/13 on the requirement of combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air.</p>	4/3/13

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K 144	<p>Continued From page 18</p> <p>potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for One-Hundred Four (104) beds with a census of Eighty-Two (82) on the day of the survey. The facility failed to ensure the generator enclosure did not have any storage inside.</p> <p>The findings include:</p> <ul style="list-style-type: none"> Observation, on 02/21/13 at 11:50 AM with the Maintenance Supervisor, revealed the facility was equipped with an emergency generator. The enclosure for the generator had oil and antifreeze stored inside the enclosure. Interview, on 02/21/13 at 11:50 AM with the Maintenance Supervisor, revealed the contractor had been out recently to service the generator and must have left the items in the enclosure of the generator. <p>Reference: NFPA 110 (1999 Edition) 5-2.1 The EPS shall be installed in a separate room for Level 1 installations. EPSS equipment shall be permitted to be installed in this room. The room shall have a minimum 2-hour fire rating or shall be located in an adequate enclosure located outside the building capable of resisting the entrance of snow or rain at a maximum wind velocity required by local building codes. No other equipment, including architectural appurtenances, except those that serve this space, shall be</p>	K 144	<p>The oil and antifreeze were removed from inside the enclosure for the generator on 2/21/13 by the Maintenance Director.</p> <p>The Maintenance Director was re-educated by the Administrator on 3/12/13 to inspect generator after the Vendor conducts preventive maintenance or upgrades on the generator.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>The generator room will be audited after each work order fulfilled by Vendor by the the Maintenance Director or Maintenance employee. The results will be reported to the Administrator and also the Quality Assessment and Assurance Committee on a quarterly basis for a minimum of one year.</p>	4/3/13

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K 144	Continued From page 19 permitted in this room.	K 144			