

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

PRINTED: 09/16/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185312</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/03/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>PADUCAH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>501 NORTH THIRD STREET PADUCAH, KY 42001</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS  Based upon implementation of the POC, the facility was deemed to be in compliance, 09/02/13 as alleged.	{F 000}			

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

TITLE

(X6) DATE

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

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NAME OF PROVIDER OR SUPPLIER  PADUCAH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 NORTH THIRD STREET PADUCAH, KY 42001	
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F 000	INITIAL COMMENTS	F 000		
F 160 SS=B	<p>** Amended SOD** - F323 deleted</p> <p>A recertification survey was conducted on 08/07/13 through 08/09/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "E".</p> <p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH</p> <p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>This REQUIREMENT Is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure residents who had money in Resident Accounts, had their money transferred to the resident's estate within thirty (30) days after the death of the resident, for four (4) residents (#16, #17, #18 and #19) out of five (5) sampled residents.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Resident #16 expired on 06/01/13 and the account was not closed until 07/25/13.</li> <li>2. Resident #17 expired on 12/21/12 and the account was not closed until 07/25/13.</li> <li>3. Resident #18 expired on 05/23/13 and the</li> </ol>	F 160	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, <b>Paducah Center</b> does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p><b>F 160</b> Resident #16: account was closed on 7/25/13. Funds were transferred to the estate by Quality Accounts Manager. Resident #17: account was closed on 7/25/13. Funds were transferred to the estate by Quality Accounts Manager. Resident #18: account was closed on 7/01/13. Funds were transferred to the estate by Quality Accounts Manager. Resident #19: account was closed on 5/2/13. Funds were transferred to the estate by Quality Accounts Manager.</p>	9/2/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE 8/28/13

An agency 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 160	Continued From page 1 account was not closed until 07/01/13.  4. Resident #19 expired on 02/21/13 and the account was not closed until 05/02/13.  An interview with the Business Office Manager (BOM), on 08/08/13 at 10:00 AM, revealed she was aware the account needed to be closed within 30 days, and this was the facility policy to do this, but the previous BOM took another position, back in February of 2013. There was a "corporate person helping out" yet some things were missed.  An interview with the Administrator, on 08/09/13 at 2:45 PM, revealed the facility had been trying to replace the previous BOM and it took longer than expected. She had tried to help with the accounts but these accounts were overlooked.	F 160	On 8/26/13, the Business Office Manager audited all current year discharges to determine (upon the death of a resident with deposited personal funds) if funds were transferred within thirty (30) days to the individual or probate jurisdiction administering the resident's estate. No other residents were affected.  On 8/26/13, the Administrator educated the Business Office Manager to ensure resident funds were transferred within thirty (30) days after their death to the individual or probate jurisdiction administering the resident's estate. The Administrator and/or the Regional Accountant will be the backup to the Business Office Manager as needed to ensure compliance.		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225	The Administrator and Business Office Manager will audit all resident discharges on a weekly basis for three (3) months to ensure resident funds were transferred within thirty (30) days after their death to the individual or probate jurisdiction administering the resident's estate. The Business Office Manager will bring the findings to the monthly Performance Improvement Committee meeting for further recommendations.		

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F 225	<p>Continued From page 2</p> <p>misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure a background check was completed, prior to hiring a staff member, for one Certified Nurse Aide (CNA) #1, in the sample of four disciplines, reviewed in the Personnel Record Review.</p> <p>The findings include: A review of the facility policy "Background Screening (Employees)", dated January 2010, revealed employees that are rehired or re-instated after a thirty day break in employment require a new background screening. A new background screening is required if more than 60 days pass from the time of screening to the hire</p>	F 225	<p>F 225 9/2/13</p> <p>CNA #1 had a new background screening performed on 8/9/13 by the Administrator. The background screening, nurse aide registry and/or licensing authorities concluded she was without any violations involving mistreatment, neglect, abuse, including misappropriation of funds towards a resident or others.</p> <p>The Payroll/HR coordinator audited all current year employee files on 8/26/13 to ensure background screenings were completed and eligible. No other employees were affected.</p> <p>On 8/8/13, the Administrator educated the Payroll/HR Coordinator regarding the background screening requirements by the state of Kentucky survey and certification agencies to include the following. All background screenings will be done prior to starting work. The facility must not employ individuals who have been guilty of abusing, neglecting, mistreating or misappropriation of funds of residents by a court of law or have a finding entered into the state nurse aide registry or licensing authorities concerning such.</p> <p>All reported allegations to the Administrator must be thoroughly investigated, prevent further potential abuse while the investigation is in progress and be completed within 5 working days of the incident. If the</p>

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F 225	Continued From page 3 date.  A review of the Personnel Records for CNA #1, revealed the employee's hire date was 06/11/13 and the background records checks, to include the Nurse Aide Abuse Registry and Criminal Background Checks were completed on 03/25/13.  An interview with the Assistant Director of Nurses (ADON,) on 08/08/13 at 2:20 PM, revealed the CNA originally applied in March of 2013, yet went to work at another facility. The CNA was hired on 06/11/13 and the background checks from 03/25/13 were used to determine eligibility for hire.  An interview with the Administrator, on 08/08/13 at 2:45 PM, revealed the employee should have had another background check completed.	F 225	alleged violation is verified, appropriate corrective action must be taken.  The Payroll/HR Coordinator will audit all newly hired employee files on a weekly basis for three (3) months to ensure all employees who are offered employment will have their background screened prior to starting work. The Payroll/HR Coordinator will bring the findings to the monthly Performance Improvement Committee meeting for further recommendations.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed	F 371	F 371 A new seal on the freezer door was installed on 8/27/13 by the Maintenance Director. The three unlabeled and undated plastic bags of meat were removed from the freezer on 8/8/13 by the Dietary Manager. A new trash can with a foot lever to lift the cover was purchased on 8/21/13. The cook was re-educated on hand washing and serving food under sanitary conditions on 8/13/13 by the Dietary Manager.  The Dietary Manager audited the kitchen area for storing and distribution of food under sanitary conditions on 8/8/13. The review included the coolers/freezers for open foods, labels and dates, frost and hand washing compliance. No other concerns were noted.	9/2/13

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F 371	<p>Continued From page 4</p> <p>to store, prepare, distribute and serve food under sanitary conditions. Observations of the kitchen, revealed undated food items stored in the freezer, improper hand washing and a thick frost around all of the edges of the freezer and a cracked seal around the freezer door.</p> <p>A review of the facility's census and condition, dated 08/07/13, revealed there were 74 residents in the facility and eight of those residents were tube feeders and did not eat food from the kitchen area.</p> <p>The findings include:</p> <p>A review of the facility "Food Storage- Cold" Policy, dated July 2007, revealed all food items are stored properly in covered containers, labeled and dated, and arranged in a manner to prevent cross-contamination.</p> <p>1. An observation of freezer and refrigerators, on 08/07/13 at 11:20 AM, revealed a thick frost on the inside and outside of the walk-in freezer door and the seal around the door was cracked. Further observation of the freezer revealed three unlabeled, undated plastic bags of meat.</p> <p>2. An observation of the tray line, on 08/07/13 at 11:30 AM, revealed the Cook to have changed gloves three times and throw the gloves in the trash can, that required the cook to lift the lid with his/her hands, and did not wash hands before applying more gloves.</p> <p>An interview with the Dietary Manager, on 08/07/13 at 11:25 AM, revealed she was the one who checked the freezer weekly for outdated items and was not aware the unlabeled, undated</p>	F 371	<p>All dietary staff was re-educated by the Dietary Manager on 8/13/13 related to hand washing techniques and 8/8/13 related to USDA food storage guidelines. The Dietary Manager was re-educated by the Administrator on 8/13/13 related to hand washing techniques and USDA food storage guidelines and monitoring her department.</p> <p>The Dietary Manager will audit the refrigerator and freezers for unlabeled and undated stored food items five (5) times a week for four (4) weeks and then weekly for two (2) months. The Dietary Manager will monitor proper hand washing and glove usage and complete a weekly audit of compliance for 3 months. The Dietary Manager will bring the findings to the monthly Performance Improvement Committee meeting for further recommendations.</p>		

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F 371	Continued From page 5 meat had been placed in the freezer. She also stated she was aware of issues with frost, on the freezer door from time to time, but had not noticed the seal. She also stated hands should have been washed anytime the trash can lid was raised.  An interview with the Dietician, on 08/08/13 at 10:50 AM, revealed she was not aware of the frost on the freezer or undated food items in the freezer. She stated hands should have been washed after contact with the trash can.	F 371			

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NAME OF PROVIDER OR SUPPLIER  <b>PADUCAH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>501 NORTH THIRD STREET PADUCAH, KY 42001</b>		
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{K 000}	INITIAL COMMENTS  Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 09/19/13 as alleged.	{K 000}			

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

TITLE

(X6) DATE

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NAME OF PROVIDER OR SUPPLIER  <b>PADUCAH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>501 NORTH THIRD STREET PADUCAH, KY 42001</b>		
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NAME OF PROVIDER OR SUPPLIER  PADUCAH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 NORTH THIRD STREET PADUCAH, KY 42001
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1963.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1963 with 19 smoke detectors and no heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1963 and upgraded in 2010.</p> <p>GENERATOR: Type II generator installed in 1984. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted on 08/07/13 and 08/08/13. Paducah Center was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Eighty-Six (86) beds with a census of Seventy-Four (74) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Paducah Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>K 025</p> <p>On 9/3/13 the smoke partition extending above the ceiling located in the center hall which was penetrated along the therapy wall was repaired by the Maintenance Director with materials capable of maintaining the smoke resistance of the smoke barrier.</p> <p>On 8/29/13, the Maintenance Director audited the building for penetrations in the smoke barriers, no other penetrations were identified.</p>	9/19/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator (X6) DATE: 8/28/13

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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000	The Maintenance Director was re-educated on 8/9/13 by the Administrator regarding maintaining smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards.  The Maintenance Director will randomly audit the building on a weekly basis for three (3) months to ensure any and all penetrations are identified and repaired. The Maintenance Director will bring all findings to the monthly Performance Improvement Committee meeting for further recommendations.	
K 025 SS=E	Deficiencies were cited with the highest deficiency identified at "E" level. 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 two (2) of four (4) smoke compartments, thirty-four (34) residents, staff and visitors. The facility is certified for Eighty-Six (86) beds with a census of Seventy-Four (74) on the day of the survey. The facility failed to ensure one (1) smoke barrier was sealed from outside wall to outside wall.  The findings include:	K 025		

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NAME OF PROVIDER OR SUPPLIER  PADUCAH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 NORTH THIRD STREET PADUCAH, KY 42001	
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K 025	<p>Continued From page 2</p> <p>Observations, on 08/07/13 between 1:45 PM and 2:30 PM with the Maintenance Supervisor, revealed the smoke partition extending above the ceiling located in the center hall was penetrated along the therapy wall.</p> <p>Interview, on 08/07/13 between 1:45 PM and 2:30 PM with the Maintenance Supervisor, revealed he was unaware to check the smoke barrier until it hit an outside wall. He was unaware the wall went down beside the therapy wall.</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> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(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</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> <li>1. Be made on either side of the smoke barrier, or</li> <li>2. Be made by an approved device designed for the specific purpose.</li> </ol>	K 025		

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K 025	Continued From page 3  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 026	<b>K 029</b>  On 9/6/13, the Maintenance Director installed a one (1) hour fire rated door, closure and latch on the old walk-in refrigerator used for dry storage in the kitchen. On 8/29/13, the Maintenance Director sealed the vent on the dry storage door in the kitchen. On 9/6/13, a vendor replaced the accounts payables sliding window with a solid piece of fire rated glass.	9/19/13
K 029 SS=D	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 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  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 one (1) of	K 029	On 8/29/13, the Maintenance Director audited the facility for further hazardous areas that may need protection in accordance with NFPA standards, no other hazardous areas were identified.  The Maintenance Director was re-educated by the Administrator on 8/9/13 regarding the requirements of protection of hazards in accordance with NFPA standards.	

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K 029	<p>Continued From page 4</p> <p>four (4) smoke compartments, residents, staff and visitors. The facility is certified for Eighty-Six (86) beds with a census of Seventy-Four (74) on the day of the survey. The facility failed to ensure three (3) rooms were properly protected due to the storage in the rooms.</p> <p>The findings include:</p> <p>Observation, on 08/07/13 between 2:30 PM and 4:00 PM with the Maintenance Supervisor, revealed the dry storage room, in the old refrigerator unit, in the kitchen did not have a door or a closer installed on the storage room. The other dry storage closet in the kitchen had a vent installed in the door. Further observation revealed the Accounts Payable office had a, unrated sliding window installed in the corridor. The room contains excessive paper due to the nature of the work conducted in the office therefore requiring the room to be separated from the corridor.</p> <p>Interview, on 08/07/13 between 2:30 PM and 4:00 PM with the Maintenance Supervisor, revealed he was unaware the rooms were considered hazardous thus requiring proper separation from the rest of the facility.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</p> <p>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</p>	K 029	<p>The Maintenance Director will randomly audit the building on a weekly basis for three (3) months to ensure the protection of hazards in accordance with NFPA standards. The Maintenance Director will bring all findings to the monthly Performance Improvement Committee meeting for further recommendations.</p>	

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K 029	Continued From page 5 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 <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), 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 48 in. (122 cm) above the bottom of the door.	K 029			
K 130 SS=D	NFPA 101 MISCELLANEOUS  OTHER LSC DEFICIENCY NOT ON 2788  This STANDARD is not met as evidenced by: Based on observation and Interview, it was determined the facility failed to maintain doors	K 130	K 130  The sliding bolts were removed from the outside of shared resident bathroom doors for resident rooms 146 and 147 on 8/8/13 by the Maintenance Director.	9/19/13	

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K 130	Continued From page 6 within a required means of egress in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, four (4) residents, staff and visitors. The facility is certified for Eighty-Six (86) beds with a census of Seventy-Four (74) on the day of the survey. The facility failed to ensure a resident bathroom did not have slide-bolt locks installed.  The findings include:  Observation, on 08/07/13 at 3:00 PM with the Maintenance Supervisor, revealed an unapproved lock (slide bolt type) was installed on both sides of the resident bathroom in rooms #146 and #147. The slide bolts were located on the outside of the bathroom doors  Interview, on 08/07/13 at 3:00 PM with the Maintenance Supervisor, revealed he was unaware the slide bolts had been installed on the doors.  Reference: NFPA 101 (2000 Edition)  19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130	On 8/9/13, the Maintenance Director audited all resident bathroom and resident rooms to maintain doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. No other doors in the facility were affected.  On 8/9/13, the Maintenance Director was re-educated on by the Administrator regarding doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.  On 8/30/13, the Ambassador Team (department managers) were educated by the Administrator regarding an addendum to their ambassador rounds, checking resident rooms and bathroom doors for latches and/or slide locks. They were instructed to inform the Administrator and/or the Maintenance Director of any findings for immediate correction.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

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K 147	<p>Continued From page 7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, thirty-four (34) residents, staff and visitors. The facility is certified for Eighty-Six (86) beds with a census of Seventy-Four (74) on the day of the survey. The facility failed to ensure electrical panels maintained three (3) feet of clearance around them.</p> <p>The findings include:</p> <p>Observations, on 08/07/13 between 2:30 PM and 4:00 PM with the Maintenance Supervisor, revealed the electrical panel in the phone room had storage of paint and a television within 3 feet of the electrical panels. Further observation revealed the panel in the dry storage room was blocked by the bread rack and the panel at the transfer switch was blocked by mop buckets, shop vacuums, bags of clothes, and a chair.</p> <p>Interview, on 08/07/13 between 1:45 PM and 2:30 PM with the Maintenance Supervisor, revealed he was unaware the items were being stored improperly within 3 feet of the electrical panels.</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>110-26. Spaces</p> <p>10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be</p>	K 147	<p>The Maintenance Director will randomly audit the building on a weekly basis for three (3) months to ensure doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. The Ambassador Team (dept managers) will audit resident rooms and bathrooms during their weekly rounds to ensure locks or latches were not installed that require the use of a tool on the egress side. All findings will be brought to the Administrator and/or Maintenance Director for immediate correction. The Maintenance Director and /or Administrator will bring all findings to the monthly Performance Improvement Committee meeting for further recommendations.</p> <p>K147</p> <p>On 8/8/13, the Maintenance Director removed the paint and television in the telephone room, the bread rack in the kitchen was moved and the mop buckets, shop vac, bags of clothes and a chair were removed from in front of the basement transfer switch.</p>	9/19/13

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K 147	<p>Continued From page 8</p> <p>provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> <p>(A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code.</p> <p>(1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.</p> <p>Table 110.26(A)(1) Working Spaces</p> <table border="1"> <thead> <tr> <th>Nominal Voltage to Ground</th> <th colspan="3">Minimum Clear Distance</th> </tr> <tr> <th>Condition 1</th> <th>Condition 2</th> <th colspan="2">Condition 3</th> </tr> </thead> <tbody> <tr> <td>0-150</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> </tr> <tr> <td>151-600</td> <td>900 mm (3 ft)</td> <td colspan="2">1 m (3½ ft)</td> </tr> <tr> <td></td> <td></td> <td colspan="2">1.2 m (4 ft)</td> </tr> </tbody> </table> <p>Note: Where the conditions are as follows: Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts. Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick,</p>	Nominal Voltage to Ground	Minimum Clear Distance			Condition 1	Condition 2	Condition 3		0-150	900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	151-600	900 mm (3 ft)	1 m (3½ ft)				1.2 m (4 ft)		K 147	<p>On 8/29/13, an audit was done by the Maintenance Director and Administrator to ensure all electrical panels had a three (3) foot clearance around them. Items were removed and all panels have a three (3) foot clearance around them.</p> <p>On 8/9/13, the Administrator re-educated the Maintenance Director, Dietary Manager, Director of Nursing and Asst Director of Nursing, and Housckeping Supervisor regarding all electrical panels maintaining a three (3) foot clearance around them.</p> <p>The Maintenance Director will randomly audit the building on a weekly basis for three (3) months to ensure all electrical panels will maintain a three (3) foot clearance around them.</p> <p>The Maintenance Director will bring all findings to the monthly Performance Improvement Committee meeting for further recommendations.</p>	
Nominal Voltage to Ground	Minimum Clear Distance																							
Condition 1	Condition 2	Condition 3																						
0-150	900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)																					
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K 147	<p>Continued From page 9</p> <p>or tile walls shall be considered as grounded.</p> <p>Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between.</p> <p>(a) Dead-Front Assemblies. Working space shall not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other than the back or sides. Where rear access is required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided.</p> <p>(b) Low Voltage. By special permission, smaller working spaces shall be permitted where all uninsulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc.</p> <p>(c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service the installation.</p> <p>(2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels.</p> <p>(3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or</p>	K 147			

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K 147	Continued From page 10 platform to the height required by 110.26(E). Within the height requirements of this section, other equipment that is associated with the electrical installation and is located above or below the electrical equipment shall be permitted to extend not more than 150 mm (6 in.) beyond the front of the electrical equipment. (B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded. (C) Entrance to Working Space. (1) Minimum Required. At least one entrance of sufficient area shall be provided to give access to working space about electrical equipment. (2) Large Equipment. For equipment rated 1200 amperes or more and over 1.8 m (6 ft) wide that contains overcurrent devices, switching devices, or control devices, there shall be one entrance to the required working space not less than 610 mm (24 in.) wide and 2.0 m (6½ ft) high at each end of the working space. Where the entrance has a personnel door(s), the door(s) shall open in the direction of egress and be equipped with panic bars, pressure plates, or other devices that are normally latched but open under simple pressure. A single entrance to the required working space shall be permitted where either of the conditions in 110.26(C)(2)(a) or (b) is met. (a) Unobstructed Exit. Where the location permits a continuous and unobstructed way of exit travel, a single entrance to the working space shall be permitted. (b) Extra Working Space. Where the depth of the working space is twice that required by 110.26(A)(1), a single entrance shall be permitted. It shall be located so that the distance from the	K 147			

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NAME OF PROVIDER OR SUPPLIER  PADUCAH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 NORTH THIRD STREET PADUCAH, KY 42001		
(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 147	Continued From page 11 equipment to the nearest edge of the entrance is not less than the minimum clear distance specified in Table 110.26(A)(1) for equipment operating at that voltage and in that condition. (D) Illumination. Illumination shall be provided for all working spaces about service equipment, switchboards, panelboards, or motor control centers installed indoors. Additional lighting outlets shall not be required where the work space is illuminated by an adjacent light source or as permitted by 210.70(A)(1), Exception No. 1, for switched receptacles. In electrical equipment rooms, the illumination shall not be controlled by automatic means only.	K 147			