

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

PRINTED: 12/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2013
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NAME OF PROVIDER OR SUPPLIER WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2601 KENTUCKY AVENUE PADUCAH, KY 42003
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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)	(X6) COMPLETION DATE
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F 000	INITIAL COMMENTS A Recertification Survey was conducted on 11/19/13 through 11/21/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of a "F".	F 000		
F 371 SS=F	483.35(f) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure food was stored under sanitary conditions. A review of the facility Census and Condition, dated 11/19/13, revealed a census of 22 residents with all residents eating food from the kitchen. The findings include: Review of the Prevention of Contamination policy/procedure, revised 01/05, revealed raw meats were to be stored and covered with plastic wrap or foil. Date and name with present day of	F 371	POC F 371 The pan of ham located in the freezer not properly stored was discarded. The employee who saw that the ham had been stored improperly was verbally reprimanded on 11/19/2013. We discussed the proper storage of meat for placement in the freezer. The roll of raw ground beef was removed from the cooler on 11/19/2013 properly covered, labeled and dated. The roll was placed on the proper lower shelf of the cooler. The drippings in the cooler was cleaned from the pan and roll of turkey. The responsible employee was verbally reprimanded on 11/19/2013 for not following proper sanitation and infection control standards. All 22 patients in the TCU unit could have been affected but none were due to food was not served and proper storage or discarding of the cited food was corrected. The rest of the coolers and freezers were checked for compliance on 11/19/2013. No other issues were noted. The Director held a department meeting on 11/19/2013 and discussed the findings from the surveyors tour of the kitchen and the plan of correction. Every employee in the department has re-read the Food Safety and Sanitation Handbook. They have completed a test and signed the acknowledgement receipt agreeing to comply with the policy and procedures outlined in the handbook. All new employees are required to read the Food Safety and Sanitation Handbook, complete Continue on page 2 of 6	12/20/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Polly Bechtold RN MSN, MHA CNO/VP Nursing TCU Administrator TITLE: TCU Administrator (X6) DATE: 12/13/13

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 those 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 WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 KENTUCKY AVENUE PADUCAH, KY 42003	
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F 371	Continued From page 1 storage. Observation, on 11/19/13 at 10:45 AM, revealed the following: 1. One pan of "ham pieces" partially covered with plastic wrap, located in the freezer, with no label or date. The meat was visibly coated with ice. 2. A partial roll of hamburger meat lying on top of an empty box, located in the refrigerator, with no label or date. The roll was unsealed with a red liquid noted on the end of the roll, dripping into a pan with an unopened roll of ground turkey. Interview with the Director of Nutrition Services, on 11/21/13 at 10:45 AM, revealed meat in the refrigerator or freezer should be covered, labeled, and dated. Raw meat should be stored on the lower shelf, and should be sealed with plastic wrap to avoid contamination.	F 371	the test and sign the acknowledgement receipt agreeing to comply with the policies and procedures outlined in the handbook. Specific employce positions have been assigned specific coolers and freezers to inspect at the end of their shift for compliance with proper coverage, labels, dates and shelf placement. The storeroom clerk has been assigned to inspect every walk-in cooler and freezer at the beginning and end of their shift to ensure every item has proper coverage, labels, date and proper shelf placement. The supervisor working will verify compliance daily. All will initial compliance on a daily log. The Director or designee will perform an audit at unannounced times to ensure that staff meet the Federal and State requirements. The assigned TCU Dietician will report any compliance issues and process changes related to this citation in the January Quality Assurance/ Process Improvement meeting and the other 3 scheduled meetings for next year.	
F 431 SS=D	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	F 431	POC F 431 The saline solution bottle and saline flushes were removed from the room of resident #1 on 11/21/13 due to not having the capability to be in a locked drawer in the patient room as per Federal regulation 483.60 (d). All residents rooms had the potential to be affected by this same deficiency due to no locked drawers available in the resident rooms. All rooms were immediately checked for saline solution or flushes and any found were removed and bottles wasted on 11/21/13. The Director had an in-service which was held twice per day on 11/22, 11/25 and 11/26 with discussion on the hospital policy "Medication Administration General" and Federal Tag 431. The discussion was centered on storage of medications. Policy states "All medications stored at bedside must be kept out of sight of Continued on page 3 of 6	12/20/2013

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F 431	<p>Continued From page 2 applicable.</p> <p>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.</p> <p>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.</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 drugs and biologicals used in the facility were stored appropriately.</p> <p>The findings include:</p> <p>A review of facility policy titled "Medication Administration, General", last revised August 2010 revealed in the section titled "Rules for Medication Administration", number 9, letter "h" states all medications stored at bedside must be kept out of sight of visitors (i.e. looked in bedside table drawer).</p> <p>Observation, on 11/19/13 at 9:05 AM, revealed two (2) liter bottles of Normal Saline (NS) stored</p>	F 431	<p>visitors(i.e. locked in bedside table drawer)". Staff was informed that due to the unit not having any locked drawers we can not leave saline solution bottles for patient care or flushes at the bedside since they are a medication. It was implemented immediately that for wet to dry dressings we use flushes and dispose of any remaining saline. If a bottle of any size has to be used it will need to have any unused portion wasted.</p> <p>Nurses at bed side reporting per shift will monitor rooms for flushes, and saline bottles. Any found will be removed and properly discarded. Charge nurses and Director will monitor on daily rounds. Safety officer was asked on 12/9/13 to please add (if not there) to the quarterly safety audit a response for no meds at bedside not locked. This process will be discussed and evaluated in the January Quality Assurance/Process Improvement meeting and in the other 3 Quarterly meetings for this next year under Safety practices.</p>	

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F 431	<p>Continued From page 3</p> <p>at the bedside in Resident #1's room. In additions, there were three (3) ten (10) milliliter NS syringes stored in the window.</p> <p>Observation, on 11/20/13 at 2:40 PM, revealed, two (2) liter bottles of NS stored at the bedside in Resident #1's room. In addition, there were two (2) ten (10) milliliter NS syringes stored in the window.</p> <p>Observation, on 11/21/13 at 10:30 AM, revealed one (1) liter bottle of NS stored at the bedside in Resident #1's room. In addition, there were two (2) ten (10) milliliter NS syringes stored in the window.</p> <p>Observation, on 11/21/13 at 10:45 AM, revealed two (2) liter bottles of NS stored at the bedside in Resident #1's room. In addition, there were two (2) ten (10) milliliter NS syringes stored in the window.</p> <p>Interview with the Charge Nurse, on 11/21/13 at 10:34 AM, NS syringes should not be stored at the bedside. The Charge Nurse stated that they store NS solution for dressings at the bedside.</p> <p>Interview with the Risk Manager, on 11/21/13 at 10:40 AM, revealed NS of any form should not be stored at the bedside.</p> <p>Interview with the Director of Transitional Care, on 11/21/13 at 11:31 AM, revealed NS is a medicated solution and should not be stored at bedside. The Director stated that there were no locking drawers in the residents' rooms so unused solution should be discarded. The Director stated that NS syringes are not to be stored at bedside as well.</p>	F 431		
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F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>POC F 441</p> <p>The CNA knew immediately after grabbing her phone that she should not have done so with her gloves on prior to completing the task. She immediately came to me after the task and told me she did something wrong due to being nervous. We discussed clean and dirty and that she should have removed her gloves then washed her hands or at least used an alcohol sanitizer then she was free to use the phone. This discussion took place on 11/20/13 around 11:00 AM.</p> <p>All patients have the potential to be affected by the same deficient practice if the CNA does not have a clear understanding of the concept of what is clean and what is dirty.</p> <p>For the CNA involved the Director and or Charge Nurse will do unannounced spot audits for hand washing and breach of infection control standards pertaining to direct patient care needs like peri care, foley care, bath care, foley outputs, oral care etc. The Director or Charge Nurse in the room watching with the permission of the patient will help the CNA if nerves were part of the reason for the non-compliance. The audits on this CNA will be every 2 Weeks on one aspect of the care per Audit and when there are 3 audits per direct care issue with out deficiency audits will then continue quarterly for the year. Any issues will be addressed with the CNA real time.</p> <p>The Director and Charge Nurse will do random direct care audits on RN's, LPN's and other CNA's at least monthly until no issues of in appropriate hand hygiene is identified. The Director did an in-service with the policy "Hand Washing Technique for Personnel". Discussion was centered on what to do if hands are not visibly soiled but contaminated and when hands continued on page 6 of 6</p>	12/20/2013	

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NAME OF PROVIDER OR SUPPLIER WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 KENTUCKY AVENUE PADUCAH, KY 42003		
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F 441	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure appropriate handwashing during care for one (1) of ten (10) sampled residents (Resident #1).</p> <p>The findings include:</p> <p>Review of the "Handwashing Technique for Personnel" policy/procedure, revised 12/07, revealed when hands were not visibly soiled but were contaminated, they should be decontaminated with an alcohol based rub. Situations Included after contact with body fluids, excretions, mucous membranes, non-intact skin, or wound dressings.</p> <p>Observation, on 11/20/13 at 10:30 AM, revealed State Registered Nurse Aide (SRNA) #1 provided catheter care for Resident #1. Afterwards, she made a phone call using a cell phone she obtained from her pocket while wearing soiled gloves.</p> <p>Interview with SRNA #1, on 11/20/13 at 10:35 AM, revealed she should have removed the soiled gloves and washed her hands prior to making a phone call.</p> <p>Interview with the Director of Nursing (DON), on 11/21/13 at 10:40 AM, revealed she expected staff to remove soiled gloves and wash hands before completing another task.</p>	F 441	<p>are visibly dirty or soiled. In-service was presented twice on 11/22, 11/25 and 11/26. Any noncompliant issues will be discussed real time with the individual involved. A general hand washing audit is completed monthly with several disciplines and will continue to be done. The noncompliant issues will be discussed and evaluated in the January Quality Assurance/Process Improvement meeting and continue on the agenda for the other three quarterly meetings for this next year.</p>		

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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: 1972.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: Six (6) story, Type 1 (443).</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1972 and upgraded in 2011, with 41 smoke detectors and 5 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1972 and upgraded in 2010.</p> <p>GENERATOR: Type I generator installed in 1972. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 11/19/13. Western Baptist Transitional Care Unit was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Twenty-Four (24) beds with a census of Twenty-Two (22) on the day of the survey.</p> <p>The findings that follow demonstrate</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Polly Beckwith RN MSN/MPH CNO/VP Neg TCU Administrator

TITLE
CNO/VP Neg TCU Administrator

(X6) DATE
12/13/13

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 noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 000		
K 052 SS=F	This STANDARD is not met as evidenced by: Based on interview and fire alarm inspection review, the facility failed to test the fire alarm system quarterly per NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for Twenty-Four (24) beds with a census of Twenty-Two (22) on the day of the survey. The facility failed to ensure the fire alarm for the facility had been tested quarterly.	K 052	POC K 052 No residents in the facility were found to be affected by the identifying deficiency of the fire alarm company not performing the quarterly inspection as stated per the contract. Residents with potential affect from the deficiency have been identified as those residing in the Transitional Care Unit. Primer inspected the fire alarm panels found deficient during the survey on 12/02/2013. Engineering has instituted a new preventative maintenanc schedule on a computer generated program to check the fire alarm panels on a quarterly schedule by a certified State Inspector starting on March 01, 2014 and on the first of every quarter thereafter. The engineering department will maintain a log of the PM and record all deficiencies found. This record will be reported under Fire Safety and monitored by the Safety Sub Committee during the bimonthly meeting starting January 2014 to assure compliance. These results will also be reported quarterly starting in January 2014 to the TCU Quality Assurance/ Process Improvement Committee for review of compliance. It will continue for the other 3 meetings scheduled for next year.	12/20/2013

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K 052	Continued From page 2 The findings include: Fire alarm inspection review, on 11/19/13 at 3:50 PM with the Safety Officer, revealed the facility failed to provide documentation to show the fire alarm had been tested since February 25, 2013. The facility had an approved order for the fire alarm company to complete the inspections quarterly but the work had not been performed. Interview, on 11/19/13 at 3:50 PM with the Safety Officer, revealed she was under the impression the fire alarm panel had to be tested annually since that is what joint commssion required. Reference: NFPA 101 (2000 ed.) 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.	K 052		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.	K 066	POC K 066 No residents in the facility were found to be affected by the identified deficiency of multiple cigarette butts on the ground and ashtray receptacles of combustible material being in use. The cigarette butts were removed from the ground in the deficient area located in the smoking area by the power house on 11/19/2013 by the engineering department. The entire hospital grounds were surveyed on 11/19/2013 for cigarette butts by The engineering department and all butts found were removed. Ashtrays of non-combustible material and safe design were ordered on 11/22/2013. Continue on page 4 of 8	12/20/2013

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NAME OF PROVIDER OR SUPPLIER WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 KENTUCKY AVENUE PADUCAH, KY 42003	
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K 066	<p>Continued From page 3</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays at an entrance, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, twenty-four (24) residents, staff and visitors. The facility is certified for Twenty-Four (24) beds with a census of Twenty-Two (22) on the day of the survey. The facility failed to ensure ashtrays were being properly used at the smoking area and the metal bucket with self-closing lid was provided at the smoking area.</p> <p>The findings include:</p> <p>Observation, on 11/19/13 at 4:05 PM with the Safety Officer, revealed over fifty (50) cigarette butts on the ground at the resident smoking area. Further observation revealed there was not a metal bucket with a self-closing lid at the smoking area for the ashtrays to be emptied into.</p> <p>Interview, on 11/19/13 at 4:05 PM with the Safety Officer, revealed she was under the impression</p>	K 066	<p>Residents with potential affect from the deficiency have been identified as those residing in the Transitional Care Unit. As for the ashtray containers that are made from combustible material will be discarded when the new arrive to eliminatc the possibility of recurrence.</p> <p>To monitor for compliance with the issue of the cigarette butts a daily preventative maintenance schedule has been initiated on 11/19/2013 to survey the entire hospital facility for cigarette butts by the engineering department. the engineering department will maintain a log of the PM and record all deficiencies found. To monitor the ashtray deficiency the engineering department has instituted a new Preventative Maintenance Task on a computer generated program to check ashtrays for non-combustible material and safe design on a monthly schedule starting 12/1/2013. and on the first of every month thereafter.</p> <p>Both records will be reported under Fire Safety and monitored by the Safety Sub Committee during the bimonthly meeting starting January 2014 to assure compliance. The results and process changes will be reported to the TCU January 2014 Quality Assurance/Process Improvement meeting and the other 3 scheduled meetings for 2014.</p>	

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

PRINTED: 12/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185416	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - FLOOR 6 B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2013
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NAME OF PROVIDER OR SUPPLIER WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 KENTUCKY AVENUE PADUGAH, KY 42003
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K 066	<p>Continued From page 4</p> <p>that if the smoking area was equipped with a smoking pole then the metal bucket was not required. Further interview revealed she was unaware of the cigarette butts being placed on the ground.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily</p>	K 066		
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NAME OF PROVIDER OR SUPPLIER WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 KENTUCKY AVENUE PADUCAH, KY 42003	
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K 066	Continued From page 5 available to all areas where smoking is permitted.	K 066		
K 154 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>This STANDARD is not met as evidenced by: Based on interview and facility policy and procedure review, the facility failed to develop a fire watch policy in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for Twenty-Four (24) beds with a census of Twenty-Two (22) on the day of the survey. The facility failed to develop a fire watch policy for the sprinkler system.</p> <p>The findings include:</p> <p>Policy and Procedure review, on 11/19/13 at 3:55 PM with the Safety Officer, revealed the facility had no written fire watch policy for the sprinkler system being down.</p> <p>Interview, on 11/19/13 at 3:55 PM with the Safety Officer, revealed she was unaware that a policy</p>	K 154	<p>POC K 154</p> <p>K154 NFPA 101</p> <p>No residents in the facility were found to be affected by the deficiency of there was no fire watch policy for when the sprinkler system was not working. A fire watch policy was created on 11/26/13 by the Safety Officer.</p> <p>Residents with potential affect from the deficiency have been identified as those residing in the Transitional Care Unit.</p> <p>The engineering department was in-serviced on 12/5/2013 on the Fire Watch Policy and Fire Watch Rounds.</p> <p>A preventative maintenance schedule was initiated on 12/01/2013 as a computer generated program to review and revise the Fire Watch Policy every three years starting 11/26/2016 by the Policy Review Committee. The engineering department will maintain a log of each Fire Watch completed and record all deficiencies found. This record will be reported under Fire Safety and monitored by the Safety Sub committee during each bimonthly meeting starting January 2014 to assure compliance. Findings and plan of corrections will also go to the TCU Quality Assurance/Process Improvement January meeting and the other three meetings scheduled for next year.</p>	12/20/2013

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NAME OF PROVIDER OR SUPPLIER WESTERN BAPTIST HOSPITAL TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 KENTUCKY AVENUE PADUCAH, KY 42003	
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K 154	Continued From page 6 for a fire watch was required for the sprinkler system. Reference; NFPA 101 (2000 edition) 9.7.6* Sprinkler System Shutdown. 9.7.6.1 Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service.	K 154		
K 155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on interview and facility policy and procedure review, the facility failed to develop a fire watch policy to ensure the safety of occupants of the building in case the fire alarm system is out of service. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for Twenty-Four (24) beds with a census of Twenty-Two (22) on the day of the survey. The facility failed to develop a fire watch policy for the fire alarm system.	K 155	<u>POC K155</u> K155 NFPA 101 No residents in the facility were found to be affected by the deficiency of there was no fire watch policy for when the fire alarm system was not functioning for more than 4 hours in a 24 hour period of time. A fire watch policy was created on 11/26/13 by the Safety Officer. Residents with potential affect From the deficiency have been identified as those residing in the Transitional Care Unit. The engineering department was in-serviced on 12/5/2013 on the Fire Watch Policy and Fire Watch Rounds. A preventative maintenance schedule was initiated on 12/01/2013 as a computer generated program to review and revise the Fire Watch Policy every three years starting 11/26/2016 by the Policy Review Committee.	12/20/2013

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K 155	<p>Continued From page 7</p> <p>The findings include:</p> <p>Policy and Procedure review, on 11/19/13 at 3:55 PM with the Safety Officer, revealed the facility had no written fire watch policy for the fire alarm system being down.</p> <p>Interview, on 11/19/13 at 3:55 PM with the Safety Officer, revealed she was unaware that a policy for a fire watch was required for the fire alarm system.</p> <p>Reference; NFPA 101 (2000 edition) 9.6.1.8* Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.</p>	K 155	<p>The engineering department will maintain a log of each Fire Watch completed and record all deficiencies found. This record will be reported under Fire Safety and monitored by the Safety</p> <p>Continue on page 8 of 8</p> <p>Sub committee during each bimonthly meeting starting January 2014 to assure compliance. Findings and plan of corrections will also go to the TCU Quality Assurance/Process Improvement January meeting and the other three meetings scheduled for next year.</p>	