

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

PRINTED: 07/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2013
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NAME OF PROVIDER OR SUPPLIER PINE MEADOWS HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504
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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

A Standard Recertification Survey was conducted 06/19/13 through 06/21/13. Deficiencies were cited with the highest Scope and Severity of a "D".

F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
SS=D

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being for one (1) of twenty-two (22) sampled residents (Resident #11). The facility failed to ensure psychiatric services were provided in accordance with the Advanced Practice Registered Nurse's (APRN's) directions. Resident #11 had a Pharmacy Consultant Report that recommended a Gradual Dose Reduction (GDR) of the resident's Geodon dated 04/16/13. The APRN reviewed and directed the resident to have a "psych" follow up upon "psych's" next visit; however, the resident did not receive a "psych" visit until 06/20/13.

F 000

This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.

F 309

On June 12, we received a pharmacist communication to nursing that on April 13, 2013 the APRN "Joan" indicated to f/u with psych at next visit" for a gradual dose reduction. We immediately added resident #11 to the psych list and she was seen on June 20, 2013. An audit was conducted on 100% of residents in the building to see if any other Pharmacy or APRN recommendations were missed and no other residents were affected. The facility has instituted a procedure that once the APRN consents to changes in medical treatment (or even makes recommendations) that it will be written as an order. Additionally, the unit coordinator or



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rosa Wright</i>	TITLE Administrator	(X6) DATE 7/26/2013
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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 309 Continued From page 1

The findings include:

Review of the facility Consultant Visit (follow-up and Orders Received) policy, revised 11/01/11, revealed all Pharmacy, dietician, psychiatrist, podiatrist, etc. consultant recommendations should be completed within three (3) business days (M-F) of their receipt to the facility (whenever feasible). The nurse was to notify the Primary Care Physician and/or APRN, along with the resident and responsible party of the recommendations. Additionally, the policy stated Unit Coordinators were to inform the Director of Nursing (DON) when all recommendations were completed.

Review of Resident #11's medical record revealed the resident was admitted to the facility on 10/01/12, with diagnoses which included Drug Psych Disorder with Delusions, Drug Psych Disorder with Hallucinations. Review revealed upon admission, Resident #11 agreed to be seen by mental health services by signing a consent form dated 09/24/12.

Review of the Pharmacy Consultant Report dated 04/17/13, revealed the Consultant Pharmacist recommended to have a antipsychotic gradual dose reduction (GDR) for Resident #11's Ziprasidone/Geodon 60 milligram (mg) (an antipsychotic) to be decreased from 60 mg at night to 40 mg at night. Continued review of the Report revealed the Pharmacist also requested to have the resident's Citalopram 20 mg (an antidepressant) to be reduced to 10 mg every day. Review of the Consultant Pharmacy Report revealed the APRN ordered the Citalopram

F 309

designee will submit a copy of the "completed and approved" consultant recommendations to the DON/ADON.

The facility will monitor the performance to ensure solutions are sustained by using the copies of the "completed and approved" consultation recommendations to ensure that no recommendations were missed. The DON/ADON or QA nurse will complete monthly audits on all residents seen by Psychiatry and Pharmacy services for "gradual dosage reduction" for 6 months. If the facility is found in compliance, then we will conduct audits every other month (up to one year) and then discontinue the audits. If compliance is not found, we will continue with monthly audits until compliant.

Date Completed: 7/12/2013

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F 309	Continued From page 2 decreased to 10 mg as recommended on 04/19/13. Further review of the Consultant Pharmacy Report revealed, in regards to the recommendation of the Ziprasidone/Geodon, the APRN added a note indicating Resident #11 was to be followed up by "psych" on their next visit. Additional review of the Report revealed a notation which stated "social services aware" with no documented evidence of a date, time, or initials of who wrote the notation. Review of the Social Service Notes revealed no documented evidence of any referrals made to "psych" or documented evidence the Social Worker was aware of the APRN's directions for Resident #11 to be followed up by "psych" on their next visit. Review of the Psychiatrist's Report dated 06/20/13, revealed in the treatment plan a GDR reduction of Resident #11's Geodon to 40mg by mouth at bedtime for seven (7) days, then 20mg by mouth at bedtime for four (4) days, then discontinued thereafter. Interview, on 06/20/13 at 5:00 PM, with Resident #11 revealed he/she was not aware of being seen by "psych". Resident #11 stated he/she had been followed by "psych" when residing in Tennessee. The Resident stated he/she was aware of having psychotropic medications prescribed for him/her. Interview, on 06/21/13 at 9:00 AM, with Licensed Practical Nurse (LPN) #2 revealed she did not know Resident #11 was followed by "psych". LPN #2 stated it was her understanding that "psych" orders came from the Physician, then went to Social Services who would contact nursing to	F 309			

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F 309 | Continued From page 3
write an order for residents to be seen by "psych".

Interview, on 06/21/13 at 9:15 AM, with LPN #4 revealed she believed Resident #11 had received "psych" services in the past. LPN #4 reviewed Resident 11's chart, and stated Resident #11 had signed a consent form for "psych" services on admission. The LPN indicated she could not locate documentation that the resident was followed by "psych". LPN #4 stated Resident #11 must not have been seen recently by "psych".

Interview, on 06/21/13 at 9:45 AM, with the Assistant Director of Nursing (ADON) revealed Resident #11 was seen by "psych" on 06/20/13. The ADON stated Resident #11 received his/her initial "psych" evaluation at that time. She confirmed Resident #11 had not been evaluated by "psych" prior to the 06/20/13 visit. The ADON indicated she did not believe an order was made for Resident 11's "psych" referral, based on statements listed on the Pharmacy Consultant Report. She stated she believed the prior Social Worker had made the notation which stated, "social service aware". She reported she could not locate any documentation by the former Social Worker in the Social Services Notes that would indicate Resident #11 received a referral to "psych". The ADON stated she believed the Resident should have been seen by "psych" services before 06/20/13.

Interview, on 06/21/13 at 11:15 AM, with the Social Service Director (SSD) revealed he received the request dated 04/19/13 for Resident #11's referral to "psych" approximately two (2) weeks prior to 06/20/13. The SSD reported he made the referral as soon as he received the

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F 309	Continued From page 4 notation added by the APRN. The SSD stated he was not aware of the date, 04/19/13, the recommendation was requested. Interview, on 06/21/13 at 1:45 PM, with the Director of Nursing (DON) revealed that during the time the APRN made the request for Resident #11 to be seen by "psych", there was a transition in Social Service Directors. The DON stated the APRN's request was missed, however Resident #11 was seen by "psych" later. She stated Resident #11 should have been evaluated by "psych" sooner as indicated by the APRN's recommendation. Interview, on 06/21/13 at 2:15 PM, with the APRN revealed that her expectation was that staff would follow her recommendations for Resident #11 to have "psych" follow up.	F 309			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced	F 514	The diagnosis of depression was added to resident #3's cumulative diagnosis sheet on June 21, 2013. The DON, ADON, and QA nurse audited 100% of in-house resident's charts for psychiatric diagnosis in which residents were prescribed medications and then checked to see if the diagnoses were added to the cumulative diagnosis sheet. Any diagnoses that were not on a resident's cumulative diagnosis sheet were added onto the sheet during		

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F 514	Continued From page 5 by: Based on interview, record review, and review of the facility's policy and standard of practice manual, it was determined the facility failed to have an effective system in place to ensure residents' clinical records were maintained in accordance with accepted professional standards and practices for completeness and accuracy of one (1) of twenty-two (22) sampled residents (Resident #3). The facility failed to ensure the Cumulative Diagnosis List was updated to include Resident #3's diagnosis of Depression. The findings include: Review of the facility's policy titled, "Charting and Documentation", revised on 03/29/12, revealed all services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record in a timely and accurate manner. Record review for Resident #3 revealed no documented evidence of a diagnosis of Depression listed on the Cumulative Diagnosis List. Further review revealed the resident was prescribed Cymbalta 30 milligram (mg) tablet at bedtime on 11/29/12 for Pain/Depression. Review of a Physician Progress Note dated 05/08/13, revealed a diagnosis of Depression for Resident #3. Interview, on 06/21/13 at 12:15 PM, with the Minimum Data Set (MDS) Coordinator revealed she had not checked Resident #3's current Medication Administration Record (MAR) for the month of March and did not notice the resident was on an antidepressant, and therefore the	F 514	the time of the audit. When a resident is due for an MDS and care plan, the MDS nurses are to check each resident's medical record for any new diagnoses. They are to pay particular attention to medications and why they are prescribed, MD/APRN progress notes, discharge summaries, and any consultant visits (in-house visits and outside appointments). Any new diagnoses will to be added to the cumulative diagnosis list. The facility will monitor its performance to ensure that solutions are sustained by adding a column to the current QA that verifies that any new diagnoses are added. The MDS nurse completing the initial MDS and care plan will complete the first QA. Copies of the QA will go to the DON/ADON, MDS coordinator, and QA nurse. The DON/ADON, MDS nurse, or QA nurse will utilize their copy of the initial QA form to randomly select		

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F 514	<p>Continued From page 6</p> <p>Cumulative Diagnosis List was not updated to reflect Resident #3's diagnosis of Depression.</p> <p>Interview, on 06/21/13 at 12:45 PM, with the Social Service Director (SSD) revealed that if Resident #3 had a Depression diagnosis, then it should have been placed on the Cumulative Diagnoses List.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 06/21/13, at 1:25 PM, revealed the process for updating the Cumulative Diagnoses List occurred when a resident was given a new prescription from the hospital, Physician, or Psychiatrist. She stated the Unit Manager would verify with the Advanced Practice Registered Nurse (APRN) of resident's new diagnoses, and if correct, the diagnoses would be added to the list. LPN #2 stated Resident #3 did not have a Depression diagnosis listed on the Cumulative Diagnoses List.</p> <p>Interview, on 06/21/13 at approximately 1:30 PM, with the APRN, revealed Resident #3 was prescribed Cymbalta for Pain and Depression. The APRN stated the Physician's Progress Note dated, 05/08/13, revealed the resident had a diagnosis of Depression. The APRN agreed that Resident #3 should have a diagnosis of Depression listed on the Cumulative Diagnoses List.</p>	F 514	<p>10 resident's charts on a monthly basis for 6 months to ensure that the cumulative diagnosis sheets were updated to reflect each resident's current diagnosis. If found 100% compliant, the DON/ADON, MDS coordinator, or QA nurse will then audit 10 resident's charts every-other month for 6 months. If still compliant, the audits will stop after one year. If found out of compliance, the DON/ADON, MDS coordinator, or QA nurse will continue with audits monthly until 100% compliance is met.</p> <p>Date Completed:</p>	7/12/2013

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 1 Survey under: NFPA 101 (2000 Edition) Plan approval: 1989, 1996 Facility type: SNF Type of structure: Type V (000) Smoke Compartments: Seven (7) Fire Alarm: Complete fire alarm with smoke detectors installed in corridors and basement. Sprinkler System: Complete sprinkler system (dry). Generator: Type 2 generator powered by Natural Gas installed in 1989 A Standard Life Safety Code survey was conducted on 06/20/13. Pine Meadows Health Care was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was one hundred six (106). The facility is licensed for one hundred twenty (120) beds.	K 000	This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
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	K 029	1) No residents were affected. 2) All doors have been inspected and self closers installed.	

RECEIVED
JUL 26 2013
BY: _____

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Ara Wright* TITLE *Administrative* (X6) DATE *7/26/2013*

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 029

Continued From page 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 ensure hazardous areas were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, sixteen (16) residents, staff and visitors.

The findings include:

Observation, on 06/19/2013 at 12:17 PM, revealed a supply room for Central storage was being used to store combustible items (cardboard boxes containing medical supplies). Further observation revealed the door was not equipped with a self-closer. Rooms used for the storage of combustible items must meet the requirements for a hazardous area. The observation was confirmed with the Assistant Maintenance Director.

Interview, on 06/19/2013 at 12:17 PM, with the Assistant Maintenance Director revealed he was

K 029

3) Penetrations have been filled with bolts.
4) Maintenance work order forms (attachment #1) have been revised to include Life Safety Code Compliant. By placing a check-mark beside Life Safety Code Compliant, the person completing the form is verifying the maintenance work completed for that order is completed in a manner that is compliant with Life Safety Code requirements.
5) 10 maintenance work orders will be audited every other month for six months. If compliance is achieved at this time, audits will be discontinued. If compliance is not achieved, audits will continue for an additional six months or until compliance is achieved. Completion Date:

7/12/13

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K 029	<p>Continued From page 2</p> <p>unaware the room was not equipped with a self-closer.</p> <p>Observation, on 06/19/2013 12:22 PM, revealed the door to laundry would not latch. Further observation revealed the laundry room door contained three (3) penetrations. The observations were confirmed with the Assistant Maintenance Director.</p> <p>Interview, on 06/19/2013 at 12:22 PM, with the Assistant Maintenance Director revealed the door would not latch while the fan to the laundry room was running. Further interview revealed the holes were left when the self/closer was replaced.</p> <p>Reference: NFPA 101 (2000 edition) 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:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), 	K 029		

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K 029	Continued From page 3 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 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one hundred twenty (120) residents, staff and visitors. The findings include:	K 050	1) No residents were affected. 2) Internal quality assurance audit identified fire drill non compliance to be corrected immediately. This audit was conducted prior to the annual survey on 06/14/2013. 3) Condensed fire drill forms to be utilized (attachment #2) to ensure the following: -Fire drills are conducted under varying conditions -At least quarterly on each shift. 4) Maintenance team in-serviced on these expectations.	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/19/2013
NAME OF PROVIDER OR SUPPLIER PINE MEADOWS HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504	
(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 050	Continued From page 4 Record review of fire drill logss on 06/19/2013 at 1:04 PM, revealed there were no documented fire drills conducted on 3rd shift. Fire drills must be conducted once per shift per quarter. The observation was confirmed with Assistant Director of Maintenance. Interview, on 06/19/2013 at 1:04 PM, with the Administrator revealed the facility had identified the problem with the missing fire drills and had started Quality Assurance measures to prevent the facility from failing to conduct the proper amount of fire drills on the proper shift. Reference: NFPA 101 (2000 edition) 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050	5) Monthly safety meetings to take place. 6) Monthly maintenance quality assurance audits to take place monthly for 6 months as assigned by Quality Assurance Nurse. If compliance is achieved at 6 months, this audit will occur quarterly. 7/12/2013
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by:	K 069	1) New sign installed over fire extinguisher indicating the fire extinguisher is a secondary backup means to the automatic fire suppression system. 6/21/2013

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NAME OF PROVIDER OR SUPPLIER PINE MEADOWS HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1808 HILL RISE DRIVE LEXINGTON, KY 40504	
(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 069	Continued From page 5 Based on observation and interview, it was determined the facility failed to ensure the kitchen was protected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments. The findings include: Observation, on 06/19/2013 at 12:33 PM, revealed the K-Type fire extinguisher in the kitchen did not have the proper signage. Fire extinguishers located in the kitchen area must have signage indicating the fire extinguisher is a secondary backup means to the automatic fire suppression system. The observation was confirmed with the Assistant Director of Maintenance. Interview, on 06/19/2013 at 12:33 PM, with the Assistant Director of Maintenance revealed he was not aware the K-Type fire extinguisher was missing. Reference: NFPA 96 (1998 edition) 7-2.1.1 A placard identifying the use of the extinguisher as a secondary backup means to the automatic fire suppression system shall be conspicuously placed near each portable fire extinguisher in the cooking area.	K 069	2) Dietary Manager will be in serviced on NFPA requirements outlined in Plan of Correction. Dietary Manager will audit kitchen fire extinguishers for sign indicating fire extinguisher is a secondary backup means to automatic fire suppression system biannually.	7/26/13
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072	1) No residents were affected. 2) All vending machines were relocated with at least 8 foot clearance in hallway and to ensure they are not obstructing means of egress.	7/12/2013

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NAME OF PROVIDER OR SUPPLIER PINE MEADOWS HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504
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K 072	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure means of egress was maintained free and clear of obstruction. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, forty resident (40), staff and visitors.</p> <p>The findings include:</p> <p>Observation, on 06/19/2013 at 11:56 AM, revealed three (3) vending machine located in an alcove on the 400 Hall were projected into the corridor 10 inches. The observation was confirmed with the Assistant Maintenance Director. Means of egress must be kept free and clear of obstructions.</p> <p>Interview, on 06/19/2013 at 11:56 AM, with the Assistant Maintenance Director revealed the facility was not aware the vending machines projecting into the corridor was considered obstructions to the means of egress.</p> <p>Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p>	K 072	<p>3) All vending machines and potential locations must have prior administrative approval prior to placement. Maintenance department in serviced on this requirement.</p>	7/26/13
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