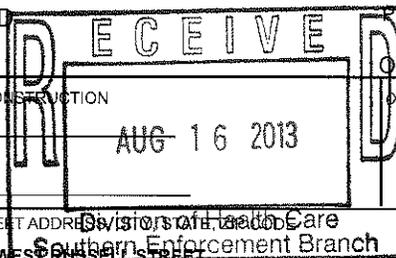


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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PRINTED: 08/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230	(X2) MULTIPLE CORRECTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2013
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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER	STREET ADDRESS 945 WEST RUSSELL STREET ELKHORN CITY, KY 41522
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F 000	INITIAL COMMENTS A standard health survey was conducted on 07/09-11/13. Deficient practice was identified with the highest scope and severity at "E" level.	F 000	<p>This Plan of Correction is submitted under Federal and State regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute an agreement by that facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Furthermore, we request this Plan of Correction serve as our credible allegation of compliance.</p> <p><u>F # 246</u></p> <ol style="list-style-type: none"> Resident's # 11 and # 12 were not found to have been affected by this practice. Upon notification by the surveyor on 7/11/13 that residents Broda Chairs did not have footrests, nursing notified Maintenance, and footrests were placed on both chairs. Care Plans and Care Directives were updated to reflect both residents need for footrests while in Broda Chairs. The Director of Maintenance and Assistant Director of Maintenance completed a 100% audit on July 11, 2013 of all Broda Chairs in use to ensure leg and footrests were in place and providing lower 	
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure services were provided to reasonably accommodate the needs of two of sixteen sampled residents (Residents #11 and #12). Residents #11 and #12 were observed to be sitting up in a Broda chair (high back chair); however, the chairs did not have a foot/leg support for the residents' lower extremities.</p> <p>The findings include: Interview with the Nurse Consultant on 07/11/13, at 2:40 PM, revealed the facility did not have a policy/procedure related to the use of the Broda chairs or footrests. The Nurse Consultant stated</p>	F 246		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Judith Bronkum</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>8/16/13</i>
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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 246	Continued From page 1 the residents' feet should be supported and not dangling over the edge of the chair. 1. During the initial facility tour conducted on 07/09/13, at 1:45 PM, Resident #11 was observed to be sitting in a reclined Broda chair with thigh straps in place. The resident's feet were observed to be dangling over the edge of the chair with no support for the lower extremities. Additional observations conducted on 07/11/13, at 10:30 AM revealed a facility nurse was administering medications to Resident #11 while the resident was sitting in a reclined Broda chair with both legs extended with no support for the lower extremities. Resident #11 was then observed in the dining room for the noon meal on 07/11/13, at 12:15 PM to be in the reclined Broda chair with his/her legs extended and no support was noted for the resident's lower extremities. Interview conducted with Licensed Practical Nurse (LPN) #1 on 07/11/13, at 2:10 PM, revealed she administered medications to Resident #11 on 07/11/13, at 10:30 AM. LPN #1 stated the resident required the reclined Broda chair for positioning support. The LPN stated the footrests were to be used to support the resident's lower extremities. LPN #1 stated she had not checked the resident's Broda chair to make sure the footrests were in use. An interview conducted with Occupational Therapist (OT) #1 on 07/11/13, at 2:20 PM, revealed the Broda chairs should have a footrest in place to support the resident's lower extremities when the chair was in a reclined position. The OT confirmed the resident's feet should not be allowed to dangle over the edge of the chair.	F 246	extremity from dangling and to provide support and ensure reasonable accommodation of needs are met. The Director of Maintenance/Assistant Director of Maintenance and Director of Nursing/Assistant Director of Nursing conducted a 100% audit on August 16, 2013 of all equipment and assistive devices in use to ensure all equipment/assistive devices were functional, in good repair, and meeting the residents reasonable accommodation of needs. 3. The Maintenance Director, Director of Nursing and Assistant Director of Nursing/Staff Development Coordinator inserviced all nurses and nursing assistants on July 18, 2013, and July 26 regarding the use of Legrests and footrests with Broda Chairs. The Assistant Director of Nursing/Staff Development Coordinator provided an in-service for all nurses and nursing assistants on August 9, 2013, regarding the observation and use of any equipment/assistive devices utilized by residents. This was to ensure all equipment is functional, in good repair, and meeting the residents' reasonable accommodation of needs.	

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F 246	<p>Continued From page 2</p> <p>An interview conducted with Certified Nurse Aide (CNA) #2 on 07/11/13, at 2:25 PM, revealed she routinely provided care for Resident #11. The CNA stated she had not seen a footrest on the Broda chair for Resident #11 and would sometimes place a pillow underneath the resident's legs for support. CNA #2 stated she had never questioned anyone regarding footrests for the resident's Broda chair.</p> <p>2. Review of the medical record for Resident #12 revealed the facility admitted the resident on 10/10/07 with diagnoses including Alzheimer's Disease, Hypertension, Depressive Disorder, Insomnia, Anxiety, Generalized Pain, Polyneuropathy, Epilepsy, and Psychosis. A review of the physician's orders dated 06/10/13 revealed Resident #12 required the use of a Broda chair when out of bed for positioning.</p> <p>Observation of Resident #12 during the initial tour at 2:00 PM on 07/09/13 revealed the resident was sitting in a Broda chair with the resident's feet dangling over the end of the Broda chair. Further observations at 9:55 AM and 12:35 PM on 07/11/13 revealed the resident was in a Broda chair in a reclined position, and the resident's feet continued to dangle over the end of the chair.</p> <p>An interview was conducted with Licensed Practical Nurse (LPN) #1 at 4:15 PM on 07/11/13. The LPN acknowledged the resident did not appear to be in a comfortable position with the resident's feet dangling over the end of the Broda chair. The LPN stated she did not know when the footrests had been removed from Resident #12's Broda chair.</p>	F 246	<p>Education was provided to complete a maintenance request and to report to the Maintenance Director/Assistant Maintenance Director any need identified related to equipment or assistive devices in need of repair to ensure reasonable accommodation of needs for residents.</p> <p>The charge nurse and nursing assistants assigned to provide care to resident's daily will be responsible for ensuring equipment/assistive devices in use are functional, in good repair, and meeting reasonable accommodation of needs. If issues are identified the charge nurse will complete a repair requisition and notify maintenance for repair or replacement. The Executive Director will review maintenance requisitions and follow up with the Maintenance Director/Assistant Maintenance Director to ensure all equipment/assistive devices have been repaired or replaced in a timely manner.</p> <p>4. Audits will be conducted by the Director of Maintenance, Assistant Director of Maintenance, Director of Nursing/Assistant Director of Nursing and/or Unit Managers daily (Monday-Friday) x 4 weeks,</p>		

weekly x 4 weeks, then monthly x 2 months to ensure all equipment and assistive devices in use are functional, in good repair, and meeting residents reasonable accommodation of needs.

The results of these audits will be reviewed in the monthly Performance Improvement Committee Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance.

- 5. Date of Compliance – August 19, 2013.**

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F 246	Continued From page 3 An interview with the Director of Nurses (DON) on 07/11/13, at 2:40 PM, revealed footrests were to be applied to the Broda chairs to position/support the resident's lower extremities. The DON stated she was not aware the footrests had not been applied to Residents #11 and #12's Broda chair.	F 246		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility policy, it was determined the facility failed to ensure maintenance services to maintain a sanitary, orderly, and comfortable interior were provided. Observations on 07/11/13 revealed Resident #12 to be sitting in a chair with torn/jagged thigh straps attached that were in use for the resident. In addition, the surface of the hand sink in resident room 804 was worn, rough, and jagged and was in need of repair. The findings include: A review of the policy, Safety Management Program (03/14/04), revealed tours would be conducted for the purpose of discovering and correcting conditions and/or work practices that were unsafe. A review of the repair requisition (03/28/13) revealed when something was in need of repair in	F 253	F # 253 1. a) Resident # 12 was not found to have been adversely affected by this practice. Upon notification by the surveyor on July 11, 2013 of resident # 12's thigh straps being torn/jagged, new thigh straps were placed on residents Broda Chair with previous thigh straps discarded. b) Upon notification by the surveyor on July 11, 2013 of the hand sink in room 804 being worn, rough, and jagged the Director of Maintenance/designee sanded the sink to ensure sink was smooth and free from potential hazards. Residents utilizing this sink were not adversely affected by this practice. 2. a) The Director of Maintenance/Assistant Maintenance Staff completed a 100% audit on July 11, 2013 of residents' rooms to assure a sanitary, orderly and comfortable interior. The condition of room furnishings, equipment, and assistive devices in use by residents were reviewed as an	

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F 253	<p>Continued From page 4</p> <p>the facility a requisition was filled out and turned into the Maintenance Supervisor or the Executive Director.</p> <p>Observation of Resident #12 on 07/11/13 at 10:00 AM revealed the resident was sitting in a Broda chair (reclining high-back chair) with thigh straps that had torn /jagged edges.</p> <p>An interview was attempted with Resident #12 on 07/11/13 at 10:00 AM; however, the resident did not respond to questions asked.</p> <p>An observation of resident room 804 was conducted on 07/11/13 at 10:00 AM. A hand sink was observed in the room and the finish on the front surface of the sink was worn, rough, and jagged, and in need of repair.</p> <p>Interview with the Maintenance Director on 07/11/13 at 10:30 AM revealed the Maintenance Department staff assessed five resident rooms each week for needed repairs. The Maintenance Director stated administrative staff also monitored resident rooms in the building and looked for needed repairs. According to the Maintenance Director, the torn/jagged thigh straps on Resident #12's chair and the hand sink in resident room 804 had not been reported as needing repairs.</p> <p>Interview with the Director of Nursing (DON) on 07/11/13 at 3:40 PM revealed staff was responsible for notifying Maintenance of any needed repairs for resident rooms and equipment. The DON stated staff should have reported the torn/jagged thigh straps utilized for Resident #12, and the hand sink in resident room 804 to Maintenance to be replaced/repaired.</p>	F 253	<p>integral part of the audit. Any areas identified were addressed.</p> <p>b) The Director of Maintenance, Assistant Director of Maintenance, and Housekeeping Supervisor completed a 100% audit on July 11, 2013 of the condition of all resident rooms to ensure no worn, rough, or jagged edges were present on sink and to identify any maintenance needs to maintain a sanitary, orderly and comfortable interior. Any maintenance issues identified were addressed.</p> <p>3. The Executive Director in serviced the Maintenance Director, Assistant Director of Maintenance and Housekeeping Supervisor on July 12, 2013 regarding inspection of rooms to ensure sinks did not have worn, rough, jagged edges and the importance of maintaining a sanitary, orderly, and comfortable interior.</p> <p>The Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator inserviced all staff on July 12, 2013 and July 26, 2013 regarding the notification of the Maintenance Department and completion of repair requisitions for room furnishings, equipment,</p>		

assistive devices, and any other maintenance required in resident rooms and throughout the interior of the facility in need of repair, to maintain a sanitary, orderly, and comfortable interior.

- 4. a) Audits will be completed by the Executive Director/Director of Maintenance/Housekeeping Supervisor/Director of Nursing/Assistant Director of Nursing/and/or Unit Managers' daily (Monday-Friday) x 4 weeks, weekly x 4 weeks, then monthly x 2 months to identify any maintenance needs and ensure they are corrected to maintain a sanitary, orderly and comfortable interior.**

The results of these audits will be reviewed in the monthly Performance Improvement Committee Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance.

- 5. Date of Compliance – August 19, 2013.**

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F 428 F 428 SS=E	Continued From page 5 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined the facility failed to ensure that drug irregularities and/or recommendations for Gradual Dose Reductions (GDRs) identified by the pharmacist were reported to the attending physician for four of sixteen sampled residents (Residents #5, #10, #11, and #12). On 07/14/12, Resident #10's physician prescribed 10 milligrams of Lexapro (antidepressant) to be administered on a daily basis, for the resident. However, a review of the monthly drug regimen conducted from August 2012 through June 2013 revealed no evidence the pharmacist had reviewed Resident #10's medication regimen for the use of the antidepressant medication or had assessed/recommended a gradual dosage reduction, if indicated, for the use of the antidepressant medication. In addition, Residents #11 and #5 also had physician's orders for a routine antidepressant and Resident #12	F 428 F 428	F # 428 1. The primary physician and consultant pharmacist were contacted by the Director of Nursing on July 11, 2013 in regards to reviewing residents # 5, 10, 11, 12 for the need of gradual dosage reductions secondary to psychotropic drug use. The consulting pharmacist made recommendations for gradual dosage reductions that were reviewed with the primary physician. The primary physician accepted the pharmacy recommendations for residents # 5,10,11, and 12 with new orders received and care plans revised accordingly. The pharmacist completed a pharmacy review of resident #5, 10, 11, and 12 medication regimen to ensure no changes were needed. No other medication changes were identified. 2. The consultant pharmacist completed a 100% audit of all residents' medication regimen to ensure that any resident receiving psychotropic medications and/or if there are any drug irregularities had a recommendation for a		

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F 428	<p>Continued From page 6</p> <p>had a physician's order for a routine antianxiety medication. However, there was no evidence the consultant pharmacist had conducted a thorough review to evaluate for a gradual dosage reduction for these medications.</p> <p>The findings include:</p> <p>Review of the facility policy entitled "Psychotropic Medication Administration, Mental Health Referral Consultation" (undated), revealed the consultant pharmacist was responsible to conduct a drug regimen review for each resident monthly and to make recommendations as necessary. Further review of the policy revealed, "Psychotropic medications include anti-psychotic, anti-depressant, anti-anxiety and sedative/hypnotics. An antipsychotic gradual dose reduction should be attempted twice within the first year of initiation of therapy (or admission) in two separate quarters and annually thereafter."</p> <p>1. Review of the medical record revealed the facility readmitted Resident #10 on 07/13/12 with diagnoses of Depression, Left Lung Mass, Insomnia, Hypertension, Parkinson's, and Hypothyroidism. The resident was admitted with physician's orders for 10 milligrams (mg) of Lexapro (antidepressant) to be administered on a daily basis.</p> <p>Review of the Minimum Data Set (MDS) assessment dated 05/02/13 revealed facility staff documented Resident #10 had experienced mild depression during the assessment reference period.</p> <p>Further review of the medical record revealed the pharmacist had conducted a monthly drug</p>	F 428	<p>gradual dose reduction or change within the regulatory timeframe and to ensure no changes were needed related to the current medication regimen. Recommendations were made and reviewed with the primary care physicians with new orders received and revision to care plans made as indicated.</p> <p>3. The Executive Director and Director of Nursing spoke with the consult pharmacist on July 19, 2013 related to gradual dosage reduction attempts and the new system for tracking gradual dosage reduction attempts as well as the requirement to review irregularities. Monthly review of all resident medication regimens was discussed with the consultant pharmacist to ensure all residents medication regimen was reviewed monthly by the pharmacist when completing a pharmacy visit.</p> <p>The Executive Director inserviced the Director of Nursing, Assistant Director of Nursing and the Social Service Director on July 31, 2013 regarding the review of medication regimens and tracking of gradual dosage reduction attempts and drug irregularity notices.</p>		

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F 428	<p>Continued From page 7</p> <p>regimen review for Resident #10 from August 2012 through June 2013; however, the pharmacist failed to document recommendations to decrease and/or eliminate the use of the antidepressant for the resident in an effort decrease and/or eliminate adverse effects of the antidepressant that had originally been ordered on 07/14/12.</p> <p>An interview was conducted with the facility's Nurse Consultant on 07/11/13, at 2:45 PM. She stated that the Registered Pharmacist (RPh) had been doing the monthly medication reviews and acknowledged the pharmacist had not been recommending GDRs when indicated/required. The Nurse Consultant further stated that the facility had a "tracking tool" to aid in monitoring for when a GDR was indicated, but stated she had not monitored to confirm that the RPh was reviewing for GDRs.</p> <p>Interview conducted with the RPh on 07/11/13, at 4:45 PM, revealed he had not recommended a GDR for Resident #10's antidepressant medication (Lexapro) since his/her readmission on 07/13/12. The RPh stated, "Residents with diagnoses of chronic depression, I have not been aggressive with the GDRs regarding antidepressants unless they are exhibiting weight loss or a worsening condition." The RPh went on to say if a resident exhibited a weight loss or worsening condition, then he would recommend a GDR of the medication.</p> <p>2. Review of the medical record for Resident #11 revealed the facility admitted the resident on 02/17/10, with diagnoses including Paralysis Agitans, Alzheimer's, Depressive Disorder, Anxiety state, and Dementia. Review of the</p>	F 428	<p>A 100% review of all Consultant Pharmacist recommendations completed for the last 90 days will be completed by the Director of Nursing, Assistant Director of Nursing, and Unit Managers by August 9, 2013 to ensure all resident medication regimens have been reviewed by the Pharmacist monthly.</p> <p>The Director of Nursing/Assistant Director of Nursing/Unit Manager will audit pharmacy recommendations monthly to ensure all residents' medication regimens have been reviewed by the pharmacist and forwarded to the attending physician for review.</p> <p>The Director of Nursing/Assistant Director of Nursing/Unit Managers will complete a 100% audit by August 9, 2013 of all resident medication regimen and complete an individual tracking log to determine which resident's are receiving psychotropic medications, when their last gradual dosage reduction was attempted, and when their next gradual dosage reduction attempt is due and any medication irregularities are noted. The consultant pharmacist will be notified of any past due gradual dosage reductions or drug</p>	

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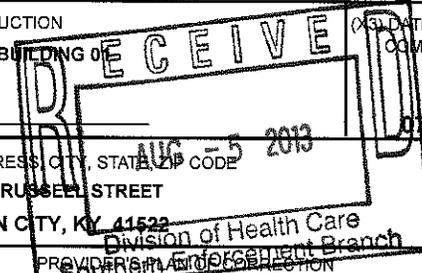
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F 428	<p>Continued From page 8</p> <p>Quarterly (MDS) Assessment with a reference date of 06/10/13, revealed the facility assessed Resident #11 to have minimal depression, no psychosis, and no behavioral symptoms. Review of the current physician's orders for July 2013 revealed the physician had prescribed Celexa (antidepressant) 20 mg to be administered daily for Resident #11.</p> <p>Review of the monthly medication regimen reviews conducted from August 2012 through June 2013 revealed there was no evidence a GDR had been recommended to the physician by the pharmacist.</p> <p>Interview conducted with the Director of Nurses on 07/11/13, at 2:45 PM, revealed the pharmacist had been conducting a monthly review of each resident's medications. The DON stated she received a list of recommendations made by the pharmacist monthly. In addition, the DON stated a tracking tool was maintained to ensure a GDR was recommended appropriately for residents receiving psychotropic medications; however, there was no tool to audit for GDR for antidepressant medications.</p> <p>Interview conducted with the Consultant Pharmacist (RPh) on 07/11/13, at 4:45 PM, revealed Resident #11 had been receiving Celexa routinely since 2007. The RPh stated he did not routinely consider antidepressant use for GDR unless the resident exhibited symptoms of adverse effects. The RPh confirmed he had not made recommendations to reduce the antidepressant medication for Resident #11 because the resident had a diagnosis of Chronic Depression and was stable with minimal symptoms of depression and no adverse effects</p>	F 428	<p>irregularities. The Director of Nursing/Assistant Director of Nursing/Unit Managers will review physician orders daily to detect any new psychotropic medications prescribed or any dosage variations in currently prescribed medications or any medication irregularities are identified. The Director of Nursing will also maintain a list comparing pharmacy recommendations to the gradual dosage reduction schedule to ensure that gradual dosage reductions are attempted appropriately and timely for all resident's receiving any type of psychotropic medication or medication irregularity. A combined psychotropic medication review and behavior management meeting will be conducted weekly to review any new or continued behaviors and medication regimen.</p> <p>4. The Director of Nursing/Assistant Director of Nursing will complete audits daily (Monday- Friday) x 4 weeks, weekly x 4 weeks, then monthly x 2 months to ensure that any resident receiving psychotropic medications have gradual dosage reduction attempts according to regulatory guidelines.</p>	

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Plan approval: 1980</p> <p>Facility type: SNF/NF</p> <p>Type of structure: One story, Type III (unprotected)</p> <p>Smoke Compartments: 6</p> <p>Fire Alarm: Complete fire alarm with smoke detectors installed in corridor, heat detectors in laundry and kitchen area.</p> <p>Sprinkler System: Complete sprinkler system (dry).</p> <p>Generator: Type 2 generator powered by diesel.</p> <p>A life safety code survey was initiated and concluded on 07/10/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p>	K 000	<p>This Plan of Correction is submitted under Federal and State regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute an agreement by that facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Furthermore, we request this Plan of Correction serve as our credible allegation of compliance.</p> <p><u>K # 025</u></p> <ol style="list-style-type: none"> It is the practice of this facility to assure all fire/smoke cubicles remain within compliance at all times to include the smoke/fire wall barrier in zones 1, 3, and 5 attic areas. The Director of Maintenance/Maintenance Assistant inspected all smoke/fire barrier walls in the attic on 	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		



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

TITLE

(X6) DATE

Judith Bramham

Executive Director

8-05-13

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 025	<p>Continued From page 1</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barriers with at least a one-half hour fire resistance rating as required. This deficient practice affected three of six smoke compartments, staff, and approximately thirty residents. The facility has the capacity for 106 beds with a census of 79 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 07/10/13, at 9:10 AM, with the Director of Maintenance (DOM), a piece of sheetrock, approximately 2 feet by 2 feet square, was observed to be missing from the fire/smoke barrier wall located above the zone 1 fire doors in the attic area. In addition, during the survey a piece of sheetrock, approximately 1 foot by 2 feet, was observed to be missing from the attic fire/smoke barrier wall between zones 3 and 5. In a fire situation, defective fire/smoke barrier walls aid in the</p>	K 025	<p>7/12/13 to ensure compliance throughout the facility.</p> <p>3. The Director of Maintenance/Maintenance Assistant repaired the smoke/fire barriers on 8/1/13 using materials designed specifically for this purpose.</p> <p>4. The Director of Maintenance/Maintenance Assistant will inspect all smoke/fire barrier walls upon completion of any maintenance performed in the attic, quarterly for one year, and annually thereafter. These inspections will be documented in the facilities Preventive Maintenance Log.</p> <p>The Executive Director and Safety Committee will review the Preventive Maintenance Logs quarterly to ensure continued compliance for one year following the noted.</p> <p>The results of these inspections will be reviewed in the monthly Performance Improvement Committee Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance.</p> <p>5. Date of Compliance – 8/16/13</p>	

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K 025	<p>Continued From page 2</p> <p>spread of smoke and fire to other parts of the building.</p> <p>An interview with the DOM on 07/10/13, at 9:10 AM, revealed he was unaware the fire/smoke barrier wall had been damaged. The DOM stated the damage was caused by contractors working in the attic area about a month ago.</p> <p>The findings were revealed to the Administrator upon exit.</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"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <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"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 	K 025		

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K 025	Continued From page 3 19.1.1.3 Total Concept. All health care facilities shall be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. Because the safety of health care occupants cannot be ensured adequately by dependence on evacuation of the building, their protection from fire shall be provided by appropriate arrangement of facilities, adequate staffing, and development of operating and maintenance procedures composed of the following: (1) Design, construction, and compartmentation (2) Provision for detection, alarm, and extinguishment (3) Fire prevention and the planning, training, and drilling programs for the isolation of fire, transfer of occupants to areas of refuge, or evacuation of the building	K 025	<p style="text-align: center;"><u>K # 050</u></p> <ol style="list-style-type: none"> 1. It is the practice of this facility to assure fire drills are conducted at random times under varied conditions to educate staff regarding proper fire response procedures to maintain compliance at all times. 2. The Director of Maintenance is conducting inservices regarding fire procedures/drills for all staff members beginning 8/2/13 and will be completed by 8/9/13. 3. Each quarter fire drills will be conducted by the Director of Maintenance/ Maintenance Assistant and will be scheduled two hours apart in varied locations to ensure every department practices area specific drills. <p style="text-align: center;">An annual inservice will be conducted regarding Fire Response Procedures by Russell Phillips and Associates.</p> <ol style="list-style-type: none"> 4. The fire drill reports will be reviewed quarterly by the 	
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, the facility	K 050		

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K 050	Continued From page 4 failed to conduct fire drills to ensure that staff was prepared for response to incidence of fire under different staffing levels and conditions to include resident levels of alertness. This failure affected all residents and staff in the facility. The facility has the capacity for 106 beds with a census of 79 on the day of the survey. The findings include: During the Life Safety Code survey on 07/10/13 at 11:40 AM, an interview and record review with the Director of Maintenance (DOM) revealed the facility had not been performing fire drills at unexpected times and varying conditions on the second and third shifts as follows: three fire drills on the second shift from 11/26/12 through 05/29/13 were conducted between 3:15 PM and 3:45 PM. Three fire drills on the third shift from 12/27/12 through 06/08/13 were conducted between 6:21 AM and 6:45 AM. The DOM stated he was not aware fire drills should be conducted at unexpected times and under varying conditions. The findings were revealed to the Administrator upon exit.	K 050	Executive Director and the Safety Committee to ensure compliance. The results of these reviews will be reviewed in the monthly Performance Improvement Committee Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance. 5. Date of Compliance – 8/16/13.	
K 052 SS=E	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 052	<u>K # 052</u> 1. It is the practice of this facility to assure the fire alarm system is installed, tested, and maintained in accordance with NFPA 72(1999 Edition) to maintain compliance at all times to include: device functionality which allows	

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K 052	<p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire alarm system was being maintained according to NFPA standards. This deficient practice affected two of six smoke compartments, staff, and approximately thirty residents. The facility has the capacity for 106 beds with a census of 79 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour conducted on 07/10/13 at 9:55 AM with the Director of Maintenance (DOM), a test of the facility's fire alarm system revealed a pull station in zone 1 would not reactivate the fire alarm system after the initial testing in zone 5. This type of testing represents fire conditions spreading from one zone or smoke compartment to another zone or smoke compartment and should reactivate the fire alarm system as required.</p> <p>An interview with the DOM on 07/10/13 at 9:55 AM revealed he was not aware the fire alarm system should reactivate if fire conditions spread from one zone or compartment to another zone or compartment.</p>	K 052	<p>multiple area annunciation in multiple zones as multiple pull stations are active.</p> <ol style="list-style-type: none"> Maintenance staff was immediately inserviced by the Executive Director on 7/12/13 regarding multiple zone fires in relation to multiple pull station activation. A Kentucky licensed fire alarm service company was contacted and came to the facility on 7/12/13 to assess alarm functionality. It was discovered that the installed fire alarm system previously approved is not capable of multi-zone annunciation. A new main panel was quoted on 7/12/13 and is scheduled to be installed on 8/12/13 to allow the requested functionality. The Maintenance Director/Maintenance Assistant will assess the new panel installation and report progress to the Executive Director and Safety Committee upon completion. <p>The Maintenance Director/Maintenance Assistant will audit the new panel for functionality weekly x 4 weeks then monthly x 2 months to ensure proper function.</p>	

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K 052	Continued From page 6 The findings were revealed to the Administrator upon exit. Reference: NFPA 72 (1999 Edition). 1-5.7.1.1 The primary purpose of fire alarm system annunciation is to enable responding personnel to identify the location of a fire quickly and accurately and to indicate the status of emergency equipment or fire safety functions that might affect the safety of occupants in a fire situation. All required annunciation means shall be readily accessible to responding personnel and shall be located as required by the authority having jurisdiction to facilitate an efficient response to the fire situation. 1-5.7.3 For the purpose of alarm annunciation, each floor of the building shall be considered as a separate zone. If a floor is subdivided by fire or smoke barriers and the fire plan for the protected premises allows relocation of occupants from the zone of origin to another zone on the same floor, each zone on the floor shall be annunciated separately for purposes of alarm location.	K 052	Future compliance will be assured annually through a Kentucky licensed fire alarm vendor with inspection documented on their annual reports. The Maintenance Director/Maintenance Assistant will document annual reports in the facility Preventive Maintenance Log. These logs will be reviewed with the Performance Improvement Committee upon completion of installation and monthly x 12 months following the noted issue to ensure compliance. The results of these audits will be reviewed in the monthly Performance Improvement Committee Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance. 5. Date of Compliance- 8/16/13.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water	K 056	K # 056 1. It is the practice of this facility to assure that automatic sprinkler systems are installed and maintained in accordance with and NFPA 25 to remain in	

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K 056	<p>Continued From page 7</p> <p>supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure that the building sprinkler system was installed throughout the facility according to NFPA standards. This deficient practice affected one of six smoke compartments, staff, and approximately eight residents. The facility has the capacity for 106 beds with a census of 79 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 07/10/13 at 10:55 AM, with the Director of Maintenance (DOM), observation revealed a canopied walkway measuring approximately 7 feet wide by 40 feet long with a gable roof approximately 3 feet tall supported by wood posts, located at the exterior exit near room 101. The roof of the canopy shared the building's rain gutter system. Combustible canopies exceeding 4 feet in width are required to be sprinkler protected to help protect the main building from fire.</p> <p>An interview with the DOM on 07/10/13 at 10:55 AM, revealed he thought the canopy was constructed of regular wood construction. The DOM stated that he thought the canopy to be okay because the canopy was not directly attached to the building. The DOM stated he did</p>	K 056	<p>compliance at all times to include the combustible canopy on the rear walkway.</p> <ol style="list-style-type: none"> All canopy areas were inspected on 7/12/13 by the Director of Maintenance/Maintenance Assistant to ensure all canopies had required sprinkler systems in place. The combustible canopy on the rear walkway will be removed by August 14, 2013. All future canopy construction will be submitted to the Executive Director and Safety Committee to ensure NFPA 101 of the Life Safety Code standard is met. <p>The Maintenance Director/Maintenance Assistant will inspect grounds monthly x 12 months to ensure all combustible canopies have required sprinkler systems in place.</p> <p>The results of these inspections will be reviewed in the monthly Performance Improvement Committee Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance.</p>	

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K 056	Continued From page 8 not know how long the canopy had been in place. Past clarifications on the subject revealed although the combustible canopy is not directly attached to the building, the canopy still represents an exposure hazard to the facility. The facility was cited on 06/29/10 for the same deficient practice. The findings were revealed to the Administrator upon exit. Reference: NFPA 13 (1999 Edition). 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction. 5-13.1 Concealed Spaces. 5-13.1.1* Exception No. 5: Concealed spaces entirely filled with noncombustible insulation.	K 056	5. Date of Compliance – 8/16/13.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	<u>K # 144</u> 1. It is the practice of this facility to assure that the generator system is inspected and maintained per NFPA 99 to include transfer switch is being exercised monthly.	

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET ELKHORN CITY, KY 41522	
(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 144	<p>Continued From page 9</p> <p>This STANDARD is not met as evidenced by: Based on an interview and record review, the facility failed to maintain the generator set by NFPA standards. This deficient practice affected six of six smoke compartments, staff, and all the residents. The facility has the capacity for 106 beds with a census of 79 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 07/10/13 at 11:27 AM, an interview and record review with the Director of Maintenance (DOM) revealed the DOM was not aware that he should be manually testing the generator transfer switch on a monthly basis as required. This testing helps ensure the transfer switch is operating as intended.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p>	K 144	<p>2. The Maintenance Director was in-serviced by the Executive Director on 7/12/13 regarding manually transferring emergency power monthly without the use of any automatic timer per Life Safety Code standard.</p> <p>3. The Maintenance Director/Maintenance Assistant will document a manual emergency power transfer in the Preventive Maintenance Logs.</p> <p>The Maintenance Director completed and documented a manual emergency power transfer on July 31, 2013.</p> <p>4. Preventive Maintenance Logs will be reviewed by the Executive Director, Safety Committee, and Performance Improvement Committee monthly x 12 months to ensure continued compliance following noted issue.</p> <p>The results of these inspections will be reviewed in the monthly Performance Improvement Committee Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance.</p> <p>5. Date of Compliance – 8/16/13.</p>	