

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

PRINTED: 01/11/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185291	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/22/2011
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NAME OF PROVIDER OR SUPPLIER  REDBANKS COLONIAL TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 142 ROGER POWELL RD SEEBREE, KY 42455
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS  An annual survey and an abbreviated survey (KY #16880) was conducted on 12/20/11 through 12/22/11, and a Life Safety Code survey was conducted on 12/21/11 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of an "F." KY #16880 was substantiated with no deficiencies.	F 000	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 157 SS-D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Shirley Utley, Administrator</i>	TITLE	(X6) DATE 1/18/12
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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 157	Continued From page 1  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to ensure notification of the physician and/or family for one resident (#8), in the selected sample of fifteen, when the resident experienced a change in condition. Resident #8 was re-admitted to the facility on 12/16/11, after a hospitalization, with a urinary catheter in place; however, there was no evidence of a physician's order for a catheter on the re-admission orders. The facility failed to notify the physician to determine the need for continuing the use of the catheter.  The findings include:  A review of the facility's policy/procedure, "Physician Legal Representative Notification," dated August 2006, revealed "nursing staff were to consult with the resident's physician, the resident's legal representative or an interested family member, when there was a need to alter treatment significantly (i.e. needed to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment)."  A record review revealed Resident #8 was admitted to the facility on 10/19/11, and re-admitted to the facility on 12/16/11 after a	F 157	1. Resident #8's physician was immediately notified of the change in condition related to the Foley Catheter on 12/21/11. 2. The two program managers, DON, and MDS Nurse audited charts on all residents with Foley catheters for physician orders, physician notification, indwelling Catheter Justification forms and care plans. On 12/23/11. 3. Within 72 hours of admission or re-admission, the program managers will review the charts, hospital H&P, and complete a head-to-toe assessment to compare with the admission assessment. All nurses will complete an 6 hour class on admission assessment, to include head-to-toe physical assessment, forms to complete and the admission process. Each nurse will be required to successfully complete a head-to-toe return demonstration. All nursing new hires will receive the 6 hour class with orientation. Program managers will continue to review all admissions and re-admissions within 72 hours of admission for 3 months and then a	1/20/12

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F 157	<p>Continued From page 2</p> <p>hospitalization, with diagnoses to include Dementia and Bacteremia with Methicillin Resistant Staphylococcus Aureus (MRSA).</p> <p>A review of the annual Minimum Data Set (MDS), dated 10/26/11, revealed the facility identified Resident #8 to be severely cognitively impaired and alert/oriented to name only. The resident required extensive assistance with all activities of daily living and had occasional incontinence of bladder, but was continent of bowel. He/she required a pull-up brief, was able to verbalize the need to void and required the assistance of two staff members for toileting.</p> <p>A review of the "At Risk for Frequent Urinary Tract Infections (UTIs) and Self Care Deficit" care plan, dated 11/02/11, revealed interventions to include that staff members were to provide proper peri-care technique during incontinent care, and to monitor for signs and symptoms of a UTI.</p> <p>A review of the pre-printed physician's order form dated 12/16/11, revealed, upon re-admission to the facility, there was a line marked through the area regarding the catheter care.</p> <p>An observation of Resident #8, on 12/21/11 at 9:30 AM and 10:20 AM, revealed there was a urinary catheter connected to a bedside drainage system with pale yellow urinary drainage in the tubing, and the catheter bag was covered with a dignity bag. Contact precautions were in place for the resident.</p> <p>An interview with Licensed Practical Nurse (LPN) #1/ Unit Manager, on 12/22/11 at 2:25 PM, revealed the urinary catheter was not on the</p>	F 157	<p>random sample monthly for completeness and accuracy. BSN, QA Nurse completed nursing education classes on 1/5/12, 1/12/12, 1/16/12, and 1/19/12. Staff Development Nurse will complete the 6 hour education thereafter.</p> <p>4. The CQI indicators for the monitoring of Catheter Use and Notification of Change will be utilized monthly X 3 months and then quarterly as per established CQI calendar under the supervision of the Director of Nursing or designee.</p>		

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F 157	Continued From page 3 transfer orders received from the hospital, or on the re-admission orders for Resident #8. The LPN could not provide an explanation as to how this was missed, and did not recall the physician being notified.	F 157		
F 309 SS-D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  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, record review and review of the "Admission Nursing Assessment/Status Upon Admission" document, it was determined the facility failed to ensure each resident receives the necessary care and services to attain and maintain optimum care, for one resident (#10), in the selected sample of fifteen, related to the failure to identify an abdominal abscess and determine if treatment was necessary, or if there was an improvement or decline in the abdominal abscess.  The findings include:  A review of the "Admission Nursing Assessment/Status Upon Admission" document, on 12/19/11, revealed the admitting nurse was to use the diagram provided to indicate all body marks such as old/recent scars (surgical and	F 309		

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F 309	<p>Continued From page 4</p> <p>other), bruises, discolorations, abrasions, pressure ulcers, or questionable markings. Indicate the size, depth (in centimeters), color and drainage. Any comments, treatments and procedures were to be noted on this form</p> <p>A record review revealed Resident #10 was admitted to the facility on 12/19/11 with diagnoses to include Methicillin Resistant Staphylococcus Aureus (MRSA) of a sacral wound, Colonoscopy, Left Above the Knee Amputation (AKA) on 12/07/11, and a history of an Abdominal Abscess, according to hospital records, dated 12/05/11.</p> <p>A review of the interim care plan, dated 12/19/11, revealed a wound vac for treatment of a sacral decubitus and dressing changes, a recent left AKA with treatment for removal of staples; however, there was no documentation of the abdominal wound. The resident was assessed to need total assistance of two staff members with activities of daily living and on contact precautions.</p> <p>An observation of a skin assessment for Resident #10, on 12/22/11 at 9:40 AM, revealed a folded four-by-four (4 X 4) dressing, secured with mesh tape to the resident's midline abdominal, umbilical area. There was no initials or date observed on the dressing. Further observation revealed a scant amount of dry, sticky brown substance around a puncture type wound, measuring 0.5 centimeters in diameter.</p> <p>A review of the record, to include the admission assessment, dated 12/19/11; skin assessments, dated 12/19/11 through 12/22/11; physician's orders and treatment records, dated December</p>	F 309	<ol style="list-style-type: none"> <li>1. The physician and POA of resident #10 was notified of the abdominal wound on 12/22/11. New treatment orders were received. The abdominal wound was measured and documentation placed on the TAR for daily monitoring on 12/22/11.</li> <li>2. The program managers and DON completed a physical assessment on all admissions for the previous 30 days. .</li> <li>3. Within 72 hours of admission or re-admission, the program managers will review the charts, hospital H&amp;P, and complete a head-to-toe assessment to compare with the admission assessment. All nurses will complete an 6 hour class on admission assessment, to include head-to-toe physical assessment, forms to complete and the admission process. Each nurse will be required to complete a head-to-toe return demonstration. All nursing new hires will receive the 6 hour class with orientation. Program managers will continue</li> </ol>	1/20/12	

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F 309	<p>Continued From page 5</p> <p>2011, revealed no evidence of the resident's abdominal wound or treatment for this wound.</p> <p>An interview with Licensed Practical Nurse (LPN) #2/Unit Manager, on 12/22/11 at 9:40 AM, 11:43 AM, and 2:20 PM, revealed she was unaware of the origin of the abdominal wound or the treatment required for the wound. She stated she was unaware of the abdominal wound and dressing, and had assessed the resident's sacral and AKA dressing; however, she was unaware of the abdominal abscess. She stated this was possibly hidden behind the colonoscopy bag during the assessments. She stated the resident was 'very tired' upon admission to the facility and the initial skin assessment was not completed.</p> <p>An interview with LPN #3, on 12/22/11 at 2:00 PM, revealed she completed the resident's skin assessment upon re-admission to the facility on 12/19/11; however, she did not recall an abdominal wound or dressing on the resident during the initial admission or skin assessment.</p> <p>An interview with Registered Nurse (RN) #1, on 12/22/11 at 3:05 PM, revealed she assisted with the resident's skin assessment on 12/19/11 and on 12/20/11; however, she stated she did not notice the abdominal wound or dressing.</p> <p>Further interview with LPN #2/Unit Manager, on 12/22/11 at 12:00 PM, revealed the process the nurses were to follow upon admission of a resident was to complete a total head-to-toe physical assessment of the resident, obtain vital signs and an oxygen saturation, and obtain the appropriate equipment ordered by the physician. There was to be monitoring of the resident and</p>	F 309	<p>to review all admissions and re-admissions within 72 hours of admission for 3 months and then a random sample monthly for completeness and accuracy.</p> <p>BSN, QA Nurse presented nursing education classes on 1/5/12, 1/12/12, 1/16/12 and 1/19/12. Staff Development Nurse will present the 6 hour education to new hires thereafter.</p> <p>4. The CQI indicators for the Admission/Re-admission Review will be utilized monthly X 3 months and then quarterly as per established CQI calendar under the supervision of the DON or designee.</p>		

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F 309	Continued From page 6 documentation for 72 hours, and complete daily skin assessments for three days after admission. The LPN was unable to provide an explanation related to the abdominal wound and dressing being left unnoticed.	F 309			

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K000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING 01</p> <p>PLAN APPROVAL: 1973, 1977</p> <p>SURVEY UNDER 2000 Existing</p> <p>FACILITY TYPE SN/FN</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system</p> <p>GENERATOR: Type II generator, fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 12/21/11. Redbanks Colonial Terrace was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for eighty seven (87) beds with a census of fifty eight (58) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K000	<p>Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Marilyn Utley, Administrator</i>	TITLE	(X6) DATE 1/19/12
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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 discloseable 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 discloseable 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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K000	Continued From page 1	K000		
K018 SS-D	<p>NFFA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-banded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors, in accordance with NFFA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for eighty seven (87) beds with a census of fifty eight (58) on the</p>	K018		

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K018	<p>Continued From page 2 day of the survey.</p> <p>The findings include:</p> <p>Observations, on 12/21/12 between 9:00 AM and 12:00 PM, with the Maintenance Supervisor revealed trash cans were holding resident room doors #24 and #26 open. Further observation revealed the door to resident room #9 was warped leaving a gap at the top that would not resist the passage of smoke.</p> <p>Interview, on 12/21/12 between 9:00 AM and 12:00 PM, with the Maintenance Supervisor revealed he was not aware the trash cans were being used to hold open the resident room doors and indicated that the hinges needed to be adjusted because of the doors tendency to self close. Further interview revealed he was not aware the door to resident room #9 was warped and would not resist the passage of smoke.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.</p> <p>A 19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.</p>	K018	<ol style="list-style-type: none"> <li>1. The trash cans holding resident Room #24 and #26 were removed immediately. The warped door to room #9 has been assessed With bids obtained and new door to arrive in four weeks.</li> <li>2. Housekeeping and nursing have Inspected all rooms being held open with trash cans. Friction catches were installed on doors to room #24 and #26. On 1/12/11 Maintenance Director readjusted the latch and tightened the hinges to the door to room #9, installed metal astragal to provide a proper seal until new door arrives.</li> <li>3. All staff received in-service education from the administrator on 12/28/11 and 1/5/12 on the need to not prop doors open with trash cans.</li> <li>4. The CQI indicator for monitoring of life safety code issues identified during survey, to include trash cans propping doors open and all doors to resident room being resistant to smoke will be utilized weekly X 3 months and then quarterly as per the established CQI calendar under the supervision</li> </ol>	1/12/12

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K018	<p>Continued From page 3 Reference: NFFA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-banded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFFA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2.</p> <p>Exception No. 1: Doors to toilet rooms,</p>	K018	Of Director of Housekeeping or Assistant Director of Housekeeping.		

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NAME OF PROVIDER OR SUPPLIER  REDBANKS COLONIAL TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 142 ROGER POWELL RD SEEBEE, KY 42455		
(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	
K018	Continued From page 4 bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K018			
K029 SS-D	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards, per NFPA Standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for eighty seven (87) beds with a census of fifty eight (58) on the day of the survey.	K029			

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K 029	<p>Continued From page 5</p> <p>The findings include:</p> <p>Observation, on 12/21/11 at 12:02 PM, with the Maintenance Supervisor revealed the wall in the Dry Storage Room located in the Kitchen, was penetrated by a 12" x 24" built in opening in the wall to the Dietary Managers Office.</p> <p>Interview, on 12/21/11 at 12:02 PM, with the Maintenance Supervisor revealed they were not aware the Dry Storage Room was considered a hazardous storage area, or why the opening was built into the wall.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in 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> <p>(1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>) (3) Paint shops (4) Repair shops (5) Soiled linen rooms</p>	K 029	<ol style="list-style-type: none"> <li>The penetration in the wall to the Dietary Manager's office and the dry storage room located in the kitchen was assessed for materials needed to close the built in opening by the Maintenance Director 12/21/11.</li> <li>The penetration in the wall to the Dietary Manager's office and the dry storage room located in the kitchen was assessed for materials needed to close the built in opening by the Maintenance Director.</li> <li>The 12" X 24" penetration (built in opening) in the wall to the Dietary Manager's office and the dry storage room located in the kitchen was closed and sealed off with sheet rock 12/22/11</li> <li>The Director of Maintenance will Review code compliance for areas to be separated from other spaces by smoke resisting partitions and doors with the quarterly contracted inspections. The CQI Tool: Life Safety was updated 1/19/12 to include penetrations or areas separated from other spaces by smoke resisting partitions and</li> </ol>	1/20/12
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NAME OF PROVIDER OR SUPPLIER  REDBANKS COLONIAL TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 142 ROGER POWELL RD SEEBREE, KY 42455		
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K 029	Continued From page 6 (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029	doors. The CQI audit tool will be utilized monthly X 3 months and then quarterly as per established CQI calendar under the supervision of Director of Maintenance or Assistant Director of Maintenance.		
K 050 SS-F	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 fire drill review it was determined the facility failed to ensure fire drills were conducted at unexpected times under varied conditions. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for eighty seven (87) beds with	K 050	1. Fire drills will be held at unexpected times under varying conditions at least quarterly on each shift. 2. The Maintenance Director conducted fire drills at unexpected times on 12/29/11 at 10 A.M. and 12/20/11 at 4:15 P.M. 3. Maintenance Director received in-service education from the administrator on 12/22/11 on the need to have fire drills at unexpected times under varying conditions at least quarterly on each shift. 4. The CQI indicator for the Monitoring of fire and evacuation	12/30/11	

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K 050	Continued From page 7 a census of fifty eight (58) on the day of the survey.  The findings include:  Fire Drill review, on 12/21/11 at 9:54 AM with the Maintenance Supervisor revealed the fire drills were not being conducted at unexpected times under varied conditions. All facility fire drills were performed at shift change each quarter.  Interview, on 12/21/11 at 9:54 AM, with the Maintenance Supervisor revealed they were unaware the fire drills were not being conducted as required.  Reference: NFFA Standard NFFA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050	drills will be utilized monthly X 3 months and then quarterly as per established CQI calendar under the supervision of the Director of Maintenance or Assist. Director of Maintenance.	
K 056 SS-E	NFFA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system it is installed in accordance with NFFA 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 NFFA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	1. The walk-in cooler and freezer, as well as the porch roof located outside the exits at each end of the front hall were assessed for sprinkler installation with bids obtained and service completed.  2. The walk-in cooler and freezer, as well as the porch roof located outside the exits at each end of the front hall have been assessed for sprinkler installation with bids obtained and service completed.	1/5/12

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NAME OF PROVIDER OR SUPPLIER  REDBANKS COLONIAL TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 142 ROGER POWELL RD SEEBREE, KY 42155		
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K058	Continued From page 8  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for eighty seven (87) beds with a census of fifty eight (58) on the day of the survey.  The findings include:  Observation, on 12/21/11 between 9:00 AM and 12:00 PM, with the Maintenance Supervisor revealed a walk-in cooler, and freezer located in the Kitchen, were not sprinkler protected. Further observation revealed the porch roof located outside the exits at each end of the Front Hall were not sprinkler protected. Each porch extended out four (4) feet or greater and was made of combustible material.  Interview, on 12/21/11 between 9:00 AM and 12:00 PM, with the Maintenance Supervisor revealed they were not aware the walk-in cooler and freezer were required to be sprinkler protected. They were also not aware the porches were required to be sprinkler protected.  Reference: NFPA 13 (1999 Edition) 5-13.8.1	K058	3. The Director of Maintenance will review code compliance for the sprinkler system with the quarterly contracted inspection.  4. The CQI Indicator for the monitoring of sprinkler systems will be utilized monthly X 3 months and then quarterly as per established CQI calendar under the supervision of the Director of Maintenance or Assist. Director of Maintenance.		

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K058	Continued From page 9	K058		
K062 SS-D	<p>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.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for eighty seven (87) beds with a census of fifty eight (58) on the day of the survey.</p> <p>The Findings Include:</p> <p>Observation, on 12/21/11 at 10:46 AM, with the Maintenance Supervisor revealed items being stored within 18 inches of a sprinkler head located in the Housekeeping Central Supply Closet in the Front Hall.</p> <p>Interview, on 12/21/11 at 10:46 AM, with the</p>	K062	<ol style="list-style-type: none"> <li>The item being stored within 18" of a sprinkler head located in the Housekeeping Central Supply Closet in the front hall was removed immediately on 12/21/11.</li> <li>Housekeeping and Maintenance have inspected all storage areas to assure no other items were being stored within 18" of a sprinkler head.</li> <li>All Department Heads and Therapy Supervisor received in-service education from the administrator on 12/28/11 on the need to keep 18" of clearance from a sprinkler head.</li> <li>The CQI indicator for monitoring of life safety code issues identified during survey, to include 18" of clearance will be utilized X 3 months and then quarterly as per the established CQI calendar under the supervision of the Director of Housekeeping or Assistant Director of Housekeeping.</li> </ol>	1/5/12

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K062	Continued From page 10 Maintenance Supervisor revealed they were aware items could not be stored within 18 inches of a sprinkler head, but not aware who placed the items so close to the sprinkler head.  Reference: NFPA 13 (1999 Edition)  5-5.5.2 Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 5-5.5.2	K062		
K072 SS-E	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  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for eighty seven (87) beds with a census of fifty eight (58) on the day of the survey.	K072	<ol style="list-style-type: none"> <li>1. Linen carts, trash carts and lifts will be stored out of the corridors when not making Q 2 hour nursing rounds.</li> <li>2. Available storage areas for linen carts, trash carts and lifts were immediately assessed by the administrator and Maintenance Director. Linen carts will be stored in the clean linen rooms. Trash carts will be stored in the shower rooms. Lifts will be stored in the wheelchair storage room and/or shower rooms when showers are completed for the day.</li> <li>3. All Department Heads and other staff received in-service education from the administrator</li> </ol>	1/5/12

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K 072	Continued From page 11 The findings include:  Observation, on 12/21/11 between 9:00 AM and 12:00 PM, with the Maintenance Supervisor revealed linen carts, trash carts, and lifts, were being stored in the Front and Back Hall.  Interview, on 12/21/11 between 9:00 AM and 12:00 PM, with the Maintenance supervisor revealed the facility routinely stored linen carts, trash carts, and lifts in the corridors.  Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 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.	K 072	On 1/5/12 on the need to store linen carts, trash carts and lifts out of the corridors when not making Q 2 hour rounds.  4. The CQI indicator for monitoring storage of linen carts , trash carts and lifts will be utilized daily on all three shifts by the charge nurse X 3 months, then quarterly as per established CQI calendar under the supervision of the DON or Assistant DON.		
K 147 SSE	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for eighty seven (87) beds with a census of fifty eight (58) on the day of the survey.  The findings include:	K 147	1. All extension cords were removed immediately on 12/21/11. Medical equipment was plugged directly into wall outlets. The refrigerator was removed from the housekeeping closet on 12/21/11. An electrical contractor installed electrical wall plugs in the med room #2 and power strips removed. 2. The housekeeping supervisor audited All resident rooms for extension Cords/power strips on 12/22/11.	1/5/12	

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K 147	<p>Continued From page 12</p> <p>Observation, on 12/21/11 between 9:00 AM and 12:00 PM, with the Maintenance Supervisor revealed:</p> <ol style="list-style-type: none"> <li>1) An extension cord plugged into a power strip located in the Conference Room.</li> <li>2) Arriri nebulizer was plugged into a power strip located in room #13.</li> <li>3) A refrigerator was plugged into a power strip located in the Housekeeping Office.</li> <li>4) An oxygen concentrator was plugged into a power strip in the Therapy Room off of the Dining Room.</li> <li>5) An extension cord was plugged into a multi-plug adaptor locate in the Kitchen.</li> <li>6) An extension cord was plugged into a power strip in the Dietary Managers Office.</li> <li>7) Two (2) refrigerators were plugged into a power strip located in Med Room #2.</li> </ol> <p>Interview, on 12/21/11 between 9:00 AM and 12:00 PM, with the Maintenance Supervisor revealed they were not aware of the extension cords and power strips being misused.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2.D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid</p>	K 147	<ol style="list-style-type: none"> <li>3. All staff has received in-service education On 12/28/11 and 1/5/11 from the administrator that extension cords are prohibited and all medical equipment is to be plugged directly into a wall outlet.</li> <li>4. The CQI Indicator for the monitoring of the life safety code issues identified during survey, to include extension cords and the need for medical equipment to be plugged into the wall outlet, will be utilized weekly X 3 months and then quarterly as per the established CQI calendar under the supervision of the Housekeeping Director or Assist. Director of Housekeeping.</li> </ol>	
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K 147	Continued From page 13 the need for extension cords or multiple outlet adapters.	K 147			