

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

PRINTED: 08/31/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185436	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/17/2012
NAME OF PROVIDER OR SUPPLIER WELLINGTON PARC OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD RD OWENSBORO, KY 42303	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual survey was conducted on 08/15/12 through 08/17/12 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 "E," with the facility having an opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	Disclaimer: 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 the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 282 SS=E	483.20(K)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written 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 ensure services were provided by qualified persons according to each resident's written plan of care related to fall interventions for three residents (#1, #8, and #10) and pressure sore interventions for one resident (#3), in the selected sample of eleven residents. Findings include: 1. A record review revealed the facility admitted Resident #1 on 03/29/10 with diagnoses to include Senile Dementia and Generalized Anxiety. A review of the quarterly Minimum Data Set (MDS), dated 06/18/12, revealed the facility	F 282	F 282 483.20(K)(3)(ii) SERVICES PROVIDED BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility shall be provided by qualified persons in accordance with each resident's written plan of care. Criteria #1: Resident #1 is kept away from hand rails while up in the geri-chair in accordance with his/her plan of care. Resident # 8's fall risk care plan has been reviewed/revised; the personal alarm was changed to a sensor pad alarm on 8/27/12 and is utilized in accordance with his/her plan of care. Resident # 10 had an alarm placed onto his/her personal recliner on 8/17/12; it is utilized in accordance with his/her plan of care. Resident # 3 no longer resides at this facility. Criteria #2: An audit of all residents with personal/sensor alarms has been completed on 9/12/12 by the DON and ADON to determine that alarms were in place and functioning as per plan of care. An audit of residents with a history (past 90 days) of falls related to over turning their wheelchair or geri-chair was completed on 9/6/12 by the DON to determine that that fall prevention interventions are being utilized in accordance with their plan of care. Continued on next page	

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

TITLE: *[Signature]* DATE: 8/10/12

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 282	<p>Continued From page 1</p> <p>identified Resident #1 as severely cognitively impaired and required extensive assistance of two staff members with transfers and ambulation. A review of the Fall Assessment Screening Tool (FAST), dated 09/10/11, revealed the facility assessed Resident #1 at high risk for falls.</p> <p>A review of the Event Report Investigation, dated 01/05/12, revealed the resident grabbed onto the handrails in the hallway, causing his/her wheelchair to flip over. The resident was assessed as having a laceration to the right eye. An intervention included keeping the resident away from the hand rail and was put into place after the fall. A review of the Potential for Injury care plan, dated 01/05/12, revealed nursing should not leave the resident unattended near the hand rails. An Event Report Investigation, dated 02/13/12, revealed the resident grabbed the hand rail again, causing a fall from a geri-chair.</p> <p>An interview with the Director of Nursing (DON), on 08/17/12 at 3:50 PM, revealed she expected the staff to follow the resident's care plan.</p> <p>2. A record review revealed the facility admitted Resident #8 on 07/25/12 and was re-admitted on 08/02/12 with diagnoses to include Alzheimer's Disease and Osteoarthritis. A review of the initial MDS, dated 08/10/12, revealed the facility identified Resident #8 as severely cognitively impaired and required total assistance with transfers. The assessment revealed Resident #8 did not ambulate. A review of the FAST, dated 08/02/12, revealed the facility assessed Resident #8 at high risk for falls.</p> <p>A review of the Event Report Investigation, dated</p>	F 282	<p>An audit of all residents with pressure reducing devices has been completed on 9/12/12 by the DON to determine that devices are utilized as per plan of care.</p> <p>Criteria #3: Facility CNA/NA's received in-service education on 9/12/12 as provided by the DON/DON which included, but was not limited to; reviewing the CNA Care Plan Record of each assigned resident prior to providing care (i.e., at the start of their shift); care is to be provided in accordance with the CNA Care Plan Record; reapplying personal alarms after toileting; utilizing pressure reduction devices. Facility LN's have received in-service education on 9/11/12 as provided by the DON/DON which included, but was not limited to; documentation of all skin assessments (scheduled and unscheduled) in the resident's clinical record; notification of MD of any significant changes noted during a skin assessment; timely implementation of a safety device after obtaining an order.</p> <p>Criteria #4: The CQI indicator for the monitoring of care plan implementation shall be utilized monthly X 2 months, then quarterly as per established CQI calendar under the supervision of the DON.</p> <p>Criteria #5: Target Date:</p>	9/28/12	

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F 282	<p>Continued From page 2</p> <p>08/08/12 and 08/14/12, revealed the resident was found beside his/her bed by staff. On 08/08/12, the report indicated the resident's bed alarm was turned off and did not sound.</p> <p>A review of the Potential For Injury Care Plan, dated 08/13/12, revealed an alarm to the wheelchair to alert staff of unassisted transfer attempts. Observation, on 08/17/12 at 9:40 AM and 10:20 AM, revealed the resident's wheelchair alarm was not attached. The resident was sitting in the hallway, and was not in view of the nurse's station.</p> <p>An interview with Certified Nurse Aide (CNA) #9, on 08/17/12 at 10:20 AM, revealed she took the resident to the bathroom about 9:00 AM; however, she did not re-attach the resident's wheelchair alarm.</p> <p>3. A record review revealed the facility admitted Resident #10 on 07/05/12 with diagnoses to include Paralysis Agitans, Osteoporosis, and Hallucinations. A review of the initial MDS, dated 07/18/12, revealed the facility identified Resident #10 as severely cognitively impaired and required total assistance with transfers and extensive assistance with ambulation. A review of the FAST, dated 07/05/12, revealed the facility assessed the resident at a moderate risk for falls.</p> <p>A review of the Event Report Investigation, dated 08/15/12, revealed the resident sustained a fall from the recliner with no injury. An intervention for an alarm was initiated when up in the recliner. A review of the CNA Care Plan, dated 08/15/12, verified an intervention of a chair alarm. Observation, on 08/17/12 at 9:40 AM and 10:25</p>	F 282			

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F 282	<p>Continued From page 3</p> <p>AM, revealed the resident was up in the recliner chair with no alarm noted.</p> <p>An interview with CNA #1 and CNA #9, on 08/17/12 at 11:10 AM and 10:25 AM, respectively, revealed they were not aware of the resident having an alarm to the recliner. CNA #1 verified she did not check the resident's care plan prior to providing care. CNA #9 also verified she does not check the care plans daily.</p> <p>An interview with the DON, on 08/17/12 at 3:50 PM, revealed she expected the staff to follow the resident's care plan to ensure appropriate alarms were in place.</p> <p>4. A record review revealed the facility admitted Resident #3 on 06/22/12 with diagnoses to include Dehydration and Diabetes Mellitus. A review of the initial MDS, dated 06/30/12, revealed the facility identified the resident as severely cognitively impaired and required extensive assistance with bed mobility. Further review revealed the resident did not have any pressure sores upon admission. A review of the Braden Scale (for predicting pressure sore risk), dated 06/23/12, revealed the facility assessed the resident as a mild risk for pressure sores.</p> <p>A review of the Weekly Skin Assessment, dated 08/09/12, revealed no evidence of skin breakdown for Resident #3. A review of the Nurse's Notes, dated 08/14/12, revealed the facility identified an unstageable pressure area to the resident's right heel measuring 5 centimeters (cm) length by 4.5 cm width. A review of the Weekly Ulcer Progress Report, dated 08/14/12, revealed the pressure sore was purple in color. A</p>	F 282			

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F 282	Continued From page 4 review of the Skin Breakdown care plan, on 08/15/12, revealed an intervention to wear heel protectors at all times. Observations, on 08/16/12 at 8:30 AM, 9:30 AM, and 10:50 AM, revealed heel protectors were not utilized for Resident #3. At 8:30 AM, the resident was in bed; at 9:30 AM, the resident was up in the recliner with shoes on; and at 10:50 AM, the resident was back in bed. An interview with CNA #7, on 08/16/12 at 1:05 PM, verified Resident #3 did not have heel protectors on in bed, at 8:30 AM. She also verified the resident typically wore shoes when up in the recliner. She was not aware the care plan specified to wear heel protectors at all times. An interview with the DON, on 08/17/12 at 3:50 PM, revealed she expected the staff to follow the care plan and ensure heel protectors were applied at all times.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	F 314	F 314 483.25(c) Treatment to Prevent Pressure Sores Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Criteria #1: Resident # 3 no longer resides at this facility. Continued on next page	

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F 314	<p>Continued From page 5</p> <p>Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure a resident having pressure sores received necessary treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing for one resident (#3), in the selected sample of eleven residents.</p> <p>Findings include:</p> <p>A review of the facility's Skin Care Management policy/procedure, revised 03/12, revealed wound progress would be monitored daily. If no progress was demonstrated within two weeks, reevaluation of the plan of care and adherence to the plan of care was to be done. If at anytime deterioration was noted, reevaluation needed to occur.</p> <p>A record review revealed the facility admitted Resident #3 on 06/22/12 with diagnoses to include Dehydration and Diabetes Mellitus. A review of the initial Minimum Data Set (MDS), dated 06/30/12, revealed the facility identified the resident as severely cognitively impaired and required extensive assistance with bed mobility. The resident did not have any pressure sores upon admission. A review of the Braden Scale (for predicting pressure sore risk), dated 06/23/12, revealed the facility assessed the resident as a mild risk for pressure sores.</p> <p>A review of the Weekly Skin Assessment, dated 08/09/12, revealed no skin breakdown for Resident #3. A review of the Nurse's Notes, dated 08/14/12, revealed the facility identified an unstageable pressure area to the resident's right heel measuring 5 centimeters (cm) length by 4.5</p>	F 314	<p>Criteria #2: An audit of all residents with pressure reducing devices was been completed on 9/12/12 by the DON/ADON to determine that devices are utilized as per plan of care.</p> <p>An audit of all residents with pressure ulcers has been completed on 9/3/12 by the DON to determine if any significant changes have been noted during a skin assessment that would require MD notification and possible treatment changes – none were noted.</p> <p>Criteria #3: Facility CNA/NA's received in-service education on 9/5/12 as provided by the DON/ADON which included, but was not limited to: reviewing the CNA Care Plan Record of each assigned resident prior to providing care (i.e., at the start of their shift); care is to be provided in accordance with the CNA Care Plan Record; utilizing pressure reduction devices.</p> <p>Facility LN's have received in-service education on 9/11/12 as provided by the DON/ADON which included, but was not limited to: documentation of all skin assessments (scheduled and unscheduled) in the resident's clinical record; notification of MD of any significant changes noted during a skin assessment; timely implementation of a safety device after obtaining an order.</p> <p>Criteria #4: The CQI indicator for the monitoring of pressure ulcers treatment and prevention shall be utilized monthly X 2 months, then quarterly as per established CQI calendar under the supervision of the DON.</p> <p>Criteria #5: Target Date</p>	9/28/12

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F 314	<p>Continued From page 6</p> <p>cm width. A review of the Weekly Ulcer Progress Report, dated 08/14/12, revealed the pressure sore was purple in color. A review of the Skin Breakdown care plan, on 08/15/12, revealed an intervention to wear heel protectors at all times.</p> <p>Observations, on 08/16/12 at 8:30 AM, 9:30 AM, and 10:50 AM, revealed heel protectors were not utilized for Resident #3. At 8:30 AM, the resident was in bed; at 9:30 AM, the resident was up in the recliner with shoes on; and at 10:50 AM, the resident was back in bed. An observation of a skin assessment, on 08/16/12 at 9:00 AM, revealed increased measurement of the resident's right heel, 5 cm length by 5 cm width. The color of the unstageable pressure sore was black. A review of the resident's chart, on 08/17/12, revealed the skin assessment completed on 08/16/12, was not documented.</p> <p>An interview with CNA #7, on 08/16/12 at 1:05 PM, verified Resident #3 did not have heel protectors on in bed, at 8:30 AM. She also verified the resident typically wore shoes when up in the recliner. She was not aware the heel protectors were specified to wear at all times. She admitted she forgot to put them on when she put the resident to bed (10:50 AM).</p> <p>An interview with Registered Nurse (RN) #1, on 08/17/12 at 3:40 PM, revealed she performed the resident's skin assessment on 08/16/12 at the surveyor's request; however, did not document the assessment. She revealed the physician was not notified of the appearance of the wound as treatment just started.</p> <p>An interview with the Director of Nursing (DON),</p>	F 314			

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F 314	Continued From page 7 on 08/17/12 at 3:50 PM, revealed she would "probably" notify the physician of changes in size or color of a wound. She indicated the right heel wound on Resident #3 was identified a couple of days ago and she was not sure if she would notify the physician as the heel protectors have not have time to make a difference. She expected the staff to follow the care plan and ensure heel protectors were applied at all times.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 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 each resident received adequate assistance devices to prevent accidents for three residents (#1, #8, and #10), in the selected sample of eleven residents. Resident #1 sustained multiple falls by turning over a wheelchair/geri-chair, and the facility failed to assess the resident for the safe use of the devices after the falls. The facility assessed Resident #8 and Resident #10 for the use of personal alarms; however, observation during the survey revealed the alarms were not utilized.	F 323	F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (1)The facility shall ensure that the resident environment remains as free of accident hazards as is possible; and (2) each resident receives adequate supervision and assistant devices to prevent accidents. Criteria #1: The IDT (Interdisciplinary Team) reviewed the fall risk care plans and the Comprehensive Device Assessments for residents # 1, 8, and 10 on 9/12/12 to determine if current interventions and devices were effective; and made revisions if indicated. Resident #1 is kept away from hand rails while up in the geri-chair in accordance with his/her plan of care. Resident # 8's fall risk care plan has been reviewed/ revised; the personal alarm was changed to a sensor pad alarm on 8/27/12 and is utilized in accordance with his/her plan of care. Resident # 10 had an alarm placed onto his/her personal recliner on 8/17/12; it is utilized in accordance with his/her plan of care. Continued on next page	

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F 323	<p>Continued From page 8</p> <p>Findings include:</p> <p>A review of the facility's "Resident Safe Environment" policy/procedure, revised 12/07, revealed the first level of the protocol included recommended safety interventions to include adaptive/assistive devices. The protocol indicated to supervise resident use of the device until safe and appropriate use was demonstrated.</p> <p>A review of the facility's "Event Report" policy/procedure (not dated) revealed "It is the purpose of this report to assure that resident, visitor and volunteer events are documented and investigated comprehensively. An event report is to be completed for any occurrence which is (A) not considered a normal occurrence in a facility or (B) has an undesirable outcome or (C) results in, or may result in, more serious consequences. These events may include, but are not limited to, falls or suspected falls. The procedure included to describe the environment, position of the resident, and any equipment involved, the floor surface, and the site of any injury and was to be completed by the charge nurse on duty. The event investigation is to be utilized as a tool in the tracking/trending of events, and in the CQI process for continuous quality improvement. The investigation summary is to be initiated by the charge nurse completing the event report. The DON or assigned staff will then review and ensure that all areas on the form are completed. Summarize the investigation findings detailing what occurred and what actions were taken. Document all findings which the investigation determined may have been the cause of the event. The DON or designee will audit the nursing</p>	F-323	<p>Criteria #2: An audit of residents with a history (past 90 days) of falls related to over turning their wheelchair or geri-chair was completed on 9/6/12 by the DON to determine that that fall prevention interventions are being utilized in accordance with their plan of care. An audit of falls in the past 30 days was completed on 7/29/12 by the DON to determine if there were any involving a restrictive mobility device (i.e., Geri-chair, w/c with lap buddy or seat belt) that would need IDT review to determine continued safe usage of the device - none were noted. An audit of all residents with personal/sensor alarms has been completed on 9/12/12 by DON/ADON to determine that alarms were in place and functioning as per plan of care.</p> <p>Criteria #3: The facility's Comprehensive Device Assessment policy has revised to include a review of the assessment following any fall or unsafe act involving the device to determine: (1) that continued use of the device is appropriate, (2) if modification to the device use is needed, and (3) that the benefits of the device use still outweigh any potential risks. Facility LN's and IDT received in-service education on the revisions to Comprehensive Device Assessment policy on 9/11/12 by the DON.</p> <p>Facility CNANA's received in-service education on 9/5/12 as provided by the DON/ADON which included, but was not limited to: reviewing the CNA Care Plan Record of each assigned resident prior to providing care (i.e., at the start of their shift); care is to be provided in accordance with the CNA Care Plan Record; reapplying personal alarms after toileting.</p> <p style="text-align: center;">Continued on next page</p>	

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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
F 323	<p>Continued From page 9</p> <p>notes to verify all necessary event information was included. After interdisciplinary team review of the event findings, document the team recommended interventions. If the interventions require staff in-service education, verify the completion. After completion of the re-evaluation, document the resident response to interventions and check if the interventions are effective or if new interventions or necessary. Document any new interventions.</p> <p>1. A record review revealed the facility admitted Resident #1 to the facility on 03/29/10 with diagnoses to include Senile Dementia and Generalized Anxiety. A review of the quarterly Minimum Data Set (MDS), dated 06/18/12, revealed the facility identified Resident #1 as severely cognitively impaired and required extensive assistance of two staff members with transfers and ambulation. A review of the Fall Assessment Screening Tool (FAST), dated 09/10/11, revealed the facility assessed Resident #1 at high risk for falls.</p> <p>A review of the Event Report Investigation, dated 01/05/12, revealed the resident grabbed onto the handrails in the hallway, causing his/her wheelchair to flip over. The resident was assessed as having a laceration to the right eye. An intervention included to keep the resident away from the handrails which was put into place after the fall; however, there was no assessment for the safe use of the wheelchair after the fall. A review of the Event Report Investigation, dated 01/07/12, revealed the resident tipped the wheelchair forward, landing on his/her knees. The wheelchair was locked at the time of the fall and the facility added anti-tippers to the front of the</p>	F 323	<p>Facility LN's have received in-service education on 9/11/12 as provided by the DON/DON which included, but was not limited to: timely implementation of a safety device after obtaining an order.</p> <p>Criteria #4: The QA tool for the monitoring of fall prevention shall be utilized monthly X 2, then every 6 months under the supervision of the DON.</p> <p>Criteria #5: Target Date:</p>	9/28/12

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NAME OF PROVIDER OR SUPPLIER WELLINGTON PARG OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE .2885 NEW HARTFORD RD OWENSBORO, KY 42303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 10</p> <p>chair. There was no assessment for the safe use of the wheelchair after the fall.</p> <p>A review of the physician's telephone orders, dated 01/10/12, revealed to discontinue the wheelchair, and a geri-chair with a tray was ordered. A review of the Acknowledgement of a Physical Restraint, dated 01/11/12, revealed to use the geri-chair with tray when out of bed. Risks for use of the restraint did not include falls/injury/bruises/abrasions. A review of the Event Report Investigation, dated 02/13/12, revealed the resident grabbed the handrail and turned the geri-chair over. A repeat intervention was used to keep the resident away from the siderail; however, there was no assessment for the safe use of the geri-chair with tray after the fall.</p> <p>An interview with the MDS Coordinator, on 08/17/12 at 2:45 PM, revealed she completed device assessments quarterly; however, it was not the policy of the facility to assess devices after each fall. She revealed wheelchairs were not assessed unless there was a restraint involved. She verified after a fall occurred, the nurse puts an immediate intervention in place. The Fall Committee would then meet (Monday through Friday) to ensure those interventions were appropriate. She revealed safety of assistive devices was discussed in the Falls Committee meetings; however, were not documented.</p> <p>An interview with the Director of Nursing (DON), on 08/17/12 at 1:40 PM and at 3:50 PM, verified the facility did not assess for the safe use of wheelchairs. Additionally, the facility did not assess assistance devices after a fall occurred.</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER WELLINGTON PARC OF OWENSBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD RD OWENSBORO, KY 42303
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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 323	<p>Continued From page 11</p> <p>2. A record review revealed the facility admitted Resident #8 on 07/25/12 and was re-admitted on 08/02/12 with diagnoses to include Alzheimer's Disease and Osteoarthritis. A review of the initial MDS, dated 08/10/12, revealed the facility identified Resident #8 as severely cognitively impaired and required total assistance with transfers. The assessment revealed Resident #8 did not ambulate. A review of the FAST, dated 08/02/12, revealed the facility assessed Resident #8 at high risk for falls.</p> <p>A review of the Event Report Investigation, dated 08/08/12 and 08/14/12, revealed the resident was found beside his/her bed by staff. On 08/08/12, the report indicated the resident's bed alarm was turned off and did not sound.</p> <p>A review of the Potential For Injury Care Plan, dated 08/13/12, revealed an alarm to the wheelchair to alert the staff when there was an unassisted transfer attempt. Observation, on 08/17/12 at 9:40 AM and at 10:20 AM, revealed the resident's wheelchair alarm was not attached. The resident was sitting in the hallway, not in view of the nurse's station.</p> <p>An interview with Certified Nurse Aide (CNA) #9, on 08/17/12 at 10:20 AM, revealed she took the resident to the bathroom about 9:00 AM; however, did not re-attach the resident's wheelchair alarm.</p> <p>3. A record review revealed the facility admitted Resident #10 on 07/05/12 with diagnoses to include Paralysis Agitans, Osteoporosis, and Hallucinations. A review of the initial MDS, dated</p>	F 323		
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NAME OF PROVIDER OR SUPPLIER WELLINGTON PARC OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD RD OWENSBORO, KY 42303	
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F 323	Continued From page 12 07/18/12, revealed the facility identified Resident #10 as severely cognitively impaired and required total assistance with transfers and extensive assistance with ambulation. A review of the FAST, dated 07/05/12, revealed the facility assessed the resident at a moderate risk for falls. A review of the Event Report Investigation, dated 08/15/12, revealed the resident sustained a fall from the recliner with no injury. An intervention for an alarm was initiated when up in the recliner. A review of the CNA Care Plan, dated 08/15/12, verified an intervention of a chair alarm. Observation, on 08/17/12 at 9:40 AM and at 10:25 AM, revealed the resident was up in the recliner chair with no alarm noted. An interview with CNA #1 and CNA #9, on 08/17/12 at 11:10 AM and at 10:25 AM, respectively, revealed they were not aware of the resident having an alarm to the recliner. An interview with the DON, on 08/17/12 at 3:50 PM, revealed she expected the staff to follow the resident's care plan to ensure appropriate alarms were in place.	F 323		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of the facility's policy/procedure, it was	F 332	F 332 485.25(m)(1) MEDICATION ERRORS The facility shall ensure that it is free of medication error rates of 5% or greater. Criteria #1: Residents #10, #12, and #13 are receiving their medication as ordered. Resident #3 no longer resides at the facility. Criteria #2: All current residents receiving medications have the potential to be affected by this alleged deficient practice. Continued on next page	

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NAME OF PROVIDER OR SUPPLIER WELLINGTON PARC OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD RD OWENSBORO, KY 42303		
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F 332	<p>Continued From page 13</p> <p>determined the facility failed to ensure that it was free of medication error rates of five percent or greater. Observations of a medication pass on 08/15/12 and 08/17/12 revealed a total of forty (40) opportunities with six (6) errors, resulting in a medication error rate of 15 percent (%).</p> <p>Findings include:</p> <p>A review of the facility's Specific Medication Administration Procedures, undated, revealed to administer medications in a safe and effective manner. Read the medication label three times prior to administration.</p> <p>A review of the facility's policy/procedure for Oral Inhalation Administration, undated, revealed to have the resident rinse his/her mouth and spit out the rinse water after inhalation.</p> <p>A review of the Do Not Crush Guide, revised 09/02, revealed medications in sustained release formulation should not be crushed.</p> <p>1. A review of Resident #13's physician orders, dated 08/12, revealed "Acetaminophen Extended Release (ER) 650 milligrams (mg) twice daily."</p> <p>Observation of a medication pass for Resident #13, on 08/15/12 at 4:13 PM, revealed Certified Medication Tech (CMT) #1 crushed the Acetaminophen ER prior to administration of the medication to the resident.</p> <p>2. A review of Resident #10's physician orders, dated 08/12, revealed "Carbidopa Levodopa 25 mg -100 mg two tablets by mouth with meals and at bedtime, and Omeprazole 40 mg once daily</p>	F 332	<p>Criteria #3: Clarification orders have been obtained from the attending physicians for each resident receiving Miralax to mix the Miralax with 4 oz. water, rather than 8 oz. (package directions state 4-8oz).</p> <p>All LN's and KMA's have received in-service education on 9/11/12 by the pharmacy consultant on medication pass issues which included, but was not limited to: (1) following special instructions listed on the MAR with the medication (such as using proper amount of water with administration of laxatives, rinsing mouth after inhalers, timeliness of medication administration when ordered 'with meals'); (2) administering eye drops as ordered (1 eye or both eyes); (3) following the 'Do Not Crush' guidelines.</p> <p>CMT's # 1 and #2 have successfully completed a Medication Pass Competency Skills review conducted by the DON/ADON and/or pharmacy consultant on 9/14/12.</p> <p>Criteria #4: The CQI tool for the monitoring of medication administration shall be utilized monthly X 2, then quarterly as per established CQI calendar under the supervision of the DON.</p> <p>Criteria #5: Target Date</p>	9/28/12	

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NAME OF PROVIDER OR SUPPLIER WELLINGTON PARC OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD RD OWENSBORO, KY 42303		
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F 332	<p>Continued From page 14 with supper."</p> <p>Observation of a medication pass for Resident #10, on 08/15/12 at 4:20 PM, revealed CMT #1 administered the Carbidopa Levodopa and Omeprazole without food.</p> <p>An interview with CMT #1, on 08/15/12 at 5:20 PM, revealed she should not have crushed the Acetaminophen ER for Resident #13; however, the resident would not take it otherwise. The form should be changed as the resident will not take whole medications anymore. She stated she should not have given medications to Resident #10 until supper was served.</p> <p>3. A review of Resident #12's physician orders, dated 08/12, revealed "Miralex 100 percent powder 17 grams (gm) in 8 ounces (oz) of water."</p> <p>Observation of a medication pass for Resident #12, on 08/17/12 at 8:47 AM, revealed CMT #2 administered the resident's Miralex in 5 oz of water.</p> <p>4. A review of Resident #3's physician orders, dated 08/12, revealed "Advair Diskus 100-50 micrograms (mcg) one puff twice daily--rinse out mouth with water after administration, do not swallow. Sustane Ultra 0.3-0.4 percent eye drops, one drop to the left eye three times daily."</p> <p>Observation of a medication pass for Resident #3, on 08/17/12 at 9:07 AM, revealed CMT #2 administered the Advair Diskus without rinsing out the resident's mouth afterward. CMT #2 administered the Sustane Ultra eye drops to both eyes.</p>	F 332			

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F 332	Continued From page 15	F 332			
F 371 SS=E	<p>An interview with CMT #2, on 08/17/12 at 11:00 AM, revealed she usually administered the eye drops to Resident #3 in both eyes, and she should have looked at the order more closely prior to administration. She revealed she should have offered to rinse the resident's mouth out after administration of the Advair. She further revealed she did not offer Resident #12 the full 8 oz of liquid with his/her Miralax, as most days the resident would not drink it all; however, she revealed it should be administered per the order.</p> <p>An interview with the Director of Nursing (DON), on 08/17/12 at 3:50 PM, revealed she expected the staff to read the Medication Administration Record (MAR) and administer medications per the instructions.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure food was prepared and served under sanitary conditions. Observations,</p>	F 371	<p>F 371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility shall (1) procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute, and serve food under sanitary conditions.</p> <p>Criteria #1: The employee personal drink noted during the survey observation was removed that same day and no additional personal drinks have been allowed in the dietary department. All dry storage items noted on the floor on 8/15/12 were properly placed on shelving in the dry storage area on 8/15/12 by dietary staff. All mops, brooms, dustpans, etc. are properly stored in their appropriate holders and off of the floor.</p> <p>Criteria #2: All current residents have the potential to have been affected by this alleged deficient practice.</p> <p>Criteria #3: All dietary staff members received in-service education on 9/20/12 by the CDM on dietary sanitation, which included, but was not limited to: personal beverages are not allowed in the dietary department; timely storage/stocking of deliveries, proper storage of mops/brooms/dustpans.</p> <p>Criteria #4: The QA tool for the monitoring of dietary sanitation shall be utilized weekly X 4, then monthly as per established CQI calendar under the supervision of the Administrator.</p> <p>Criteria #5: Target Date:</p>	9/28/12	

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NAME OF PROVIDER OR SUPPLIER WELLINGTON PARC OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD RD OWENSBORO, KY 42303		
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F 371	<p>Continued From page 16</p> <p>on 08/15/12, revealed food was being stored in the dry storage area directly on the floor, employee drinks were observed in the area by the clean dishes, and a mop, broom, and dustpan were observed stored directly on the floor instead of the appropriate holders.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Receiving Food" (no date), revealed "It is the policy of this facility to purchase food from a source that is approved or considered satisfactory by the health authorities. Food from such sources must be protected from contamination and spoilage during handling, packaging, transit and storage." The procedure section listed #10 "All items received will be placed in the proper storage area as soon as possible and placed on shelves, off the floor."</p> <p>A review of the facility's policy/procedure, "Employee Sanitary Practices" (no date), revealed "It is the policy of this facility to promote guidelines for employee sanitary practices." The procedure section listed #12 "Do not eat, drink, chew gum or use tobacco products in the kitchen areas."</p> <p>An observation of the facility kitchen, on 08/15/12 at 10:30 AM, revealed seventeen boxes of assorted dry goods and canned goods sitting directly on the dry storage room floor. A twenty-five pound bag of bread crumbs was also observed sitting directly on the floor. A twenty-ounce bottle of soda, partially empty, and a personal thermos glass with a straw, one-half full of liquid, was observed sitting on the counter</p>	F 371			

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NAME OF PROVIDER OR SUPPLIER WELLINGTON PARC OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD RD OWENSBORO, KY 42303		
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F 371	Continued From page 17 surface by racks of clean dishes. An interview with the Dietary Manager, on 08/15/12 at 10:30 AM and at 12:00 PM, revealed the boxes of food on the floor of the dry storage area were delivered the previous day (08/14/12) and should have been placed on the proper storage shelves off the floor to prevent contamination. The staff responsible to do this task left early on 08/14/12, and the Dietary Manager did not ensure the food was properly stored. The Dietary Manager stated employees were not to eat or drink in any kitchen area. Additionally, mops, brooms and dustpans were to be stored in the hanging racks on the wall and not sit directly on the floor.	F 371			

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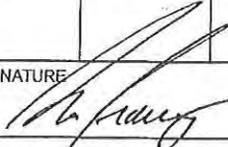
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NAME OF PROVIDER OR SUPPLIER WELLINGTON PARC OF OWENSBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD RD OWENSBORO, KY 42303
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1991, 1997</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200)</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system 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 08/15/12. Wellington Parc of Owensboro was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility has forty four (44) certified beds with a census of forty three (43) 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>	K 000	 <p>Disclaimer: 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 the 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 	TITLE Admin	(X6) DATE 9/21/12
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ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER WELLINGTON PARC OF OWENSBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD RD OWENSBORO, KY 42303
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K 000 K 038 SS=D	<p>Continued From page 1</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, twenty (20) residents, staff, and visitors. The facility has forty four (44) certified beds with a census of forty three (43) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 08/15/12 at 4:48 PM, with the Maintenance Director and the Administrator revealed a padlocked gate across the sidewalk leading to the public way. The sidewalk served the Hall 10 exit, and the Dining Room exit, both of which were equipped with thirty (30) second delayed egress.</p>	K 000 K 038	<p>K 038 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Criteria 1 –The padlocks have been removed from the gate leading to the public way on 9/27/12. Based on resident safety, the fence has been equipped with an automatic lock and the process/code to exit is identical to the two delayed egress exit doors and all staff can immediately open the gate.</p> <p>Criteria 2 –All other exits to public ways have been checked to ensure they are free of all obstructions.</p> <p>Criteria 3 –The Administrator and Maintenance director received in-service education on K038 from the facility's contracted consultant on the means of egress obstructions on 9/10/12. All staff received in-service training on the new lock and codes on 9/27/12</p> <p>Criteria 4 –The QA tool for monitoring life safety shall be utilized monthly X 2 and then quarterly as per established QA calendar under the supervision of the Administrator.</p> <p>Target Date –9/28/12</p>	9/28/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185436	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/15/2012
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NAME OF PROVIDER OR SUPPLIER WELLINGTON PARC OF OWENSBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD RD OWENSBORO, KY 42303
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K 038	<p>Continued From page 2</p> <p>Interview, on 8/15/12 at 4:48 PM, with the Maintenance Director and the Administrator revealed the gate was padlocked as a safeguard in the event a wandering resident was to get out of the building into this fenced area.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>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> <p>7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.</p> <p>7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way.</p> <p>Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2.</p> <p>Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6.</p> <p>Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23.</p>	K 038		
K 050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.</p>	K 050	K050 NFPA 101 LIFE SAFETY CODE STANDARD	

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K 050	<p>Continued From page 3</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, forty four (44) residents, staff and visitors. The facility has forty four (44) certified beds with a census of forty three (43) on the day of the survey.</p> <p>The findings include:</p> <p>Fire Drill review, on 08/15/12 at 2:19 PM, with the Maintenance Director and the Administrator revealed the facility failed to conduct fire drills at unexpected times on first, second and third shift. Fire drills on first shift were conducted between 8:15 AM and 10:45 AM, second shift fire drills were conducted between 2:15 PM and 2:40 PM with one drill at 9:25 PM, third shift drills were conducted were only conducted at the beginning of the shift between 10:07 PM and 10:24 PM, or at the end of the shift between 5:31 AM and 5:43 AM.</p>	K 050	<p>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</p> <p>Criteria 1-Fire Drills will be conducted with increased variance in time and continued varying conditions at least quarterly.</p> <p>Criteria 2- No other residents have the potential to be affected by this alleged deficient practice.</p> <p>Criteria 3-The Maintenance director received in-service training from the Administrator 9/10/12 on regulation K050 regarding fire drills.</p> <p>Criteria 4-The QA tool for monitoring of fire drills will be done monthly X 2 months and then quarterly as per established QA calendar under the supervision of the Administrator.</p> <p>Target Date-9/28/12</p>	9/28/12

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K 050	Continued From page 4 Interview, on 08/15/12 at 2:19 PM, with the Maintenance Director and the Administrator revealed the Maintenance Director is in charge of the fire drills; however the current Maintenance Director had only been on the job a few days. The Administrator revealed he was not aware the fire drills were not being conducted in accordance with NFPA standards. Reference: NFPA Standard NFPA 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		
K 056 SS=E	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 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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure complete sprinkler coverage, according to NFPA standards.	K 056	K056 NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 12, 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 supply for the system. Required sprinkler systems are equipped with water flow and tamper switched, which are electrically connected to the building fire alarm system. 19.3.5 Criteria 1- The facility automatic sprinkler system was inspected by the facilities contracted provider and a quote for adding necessary sprinklers at the exits of hall 10, 20, east 400 and in the shower stall area in 400 spa room was provided on 8/24/12. A quote for the services to	

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K 056	<p>Continued From page 5</p> <p>The deficiency had the potential to affect three (3) of four (4) smoke compartments, thirty (30) residents, staff and visitors. The facility has forty four (44) certified beds with a census of forty three (43) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 08/15/12 between 3:00 PM and 6:00 PM, with the Maintenance Director and the Administrator revealed three porches that extended out forty eight (48) inches or greater that were not sprinkler protected. The porches were located at the exit of Hall 10, Hall 20 to the courtyard, and the east exit of the 400 Hall.</p> <p>Interview, on 08/15/12 between 3:00 PM and 6:00 PM, with the Maintenance Director and the Administrator revealed they were unaware the porches met the requirement for sprinkler protection being required.</p> <p>Observation, on 08/15/12 at 5:50 PM, with the Maintenance Director and the Administrator revealed inadequate sprinkler coverage located in the 400 Hall Spa shower room.</p> <p>Interview, on 08/15/12 at 5:50 PM, with the Maintenance Director and the Administrator revealed they were not aware the shower room did not have complete sprinkler protection.</p> <p>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</p>	K 056	<p>be performed has been received and the service scheduled. New Sprinklers will be installed by 10/10/12.</p> <p>Criteria 2- No other porches or shower stalls are affected by this alleged deficiency.</p> <p>Criteria 3-The Administrator and Maintenance director received in service education on 9/10/12 from the facility's contracted consultant on regulation K056.</p> <p>Criteria 4-The sprinkler system shall be monitored through routine provider inspections. The QA tool for the monitoring life safety will be completed X 2 months and then quarterly per the established QA calendar under the supervision of the Administrator.</p> <p>Target Date-10/15/12</p>	10/15/12

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K 056	Continued From page 6 limited combustibile construction. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.	K 056		
K 068 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 This STANDARD is not met as evidenced by:	K 068	K068 NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2	

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K 068	<p>Continued From page 7</p> <p>Based on observation and interview it was determined the facility failed to ensure combustion air and ventilation for boilers, incinerators, and heater rooms were installed in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, twenty (20) residents, staff, and visitors. The facility has forty four (44) certified beds and had a census of forty three (43) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 08/15/12 between 3:00 PM and 6:00 PM, with the Maintenance Director and the Administrator revealed the fresh air vents for the area behind the dryers located in the laundry room, and the gas fired water heater located in the housekeeping storage room were not vented to the outside, but instead vented to the attic.</p> <p>Interview, on 08/15/12 between 3:00 PM and 6:00 PM, with the Maintenance Director and the Administrator revealed they were not aware the vents were vented to the attic and not aware they were required to vent directly to the outside.</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition)</p> <p>Section 19.5 Building Services</p> <p>19.5.2.2 Any heating device other than a central heating</p>	K 068	<p>Criteria 1-The fresh air vents in the noted areas have been inspected by the facility's contracted provider and have been vented out through the roof.</p> <p>Criteria 2-A review of all other fresh air vents will be completed to ensure that they are vented to the outside of the building and not into the attic.</p> <p>Criteria 3- The Administrator and Maintenance director received in service education on 9/10/12 from the facility's contracted consultant on regulation K068.</p> <p>Criteria 4-Inspection of the fresh air vents has been added to the yearly preventive maintenance log for inspection to ensure they continue to be vented to the outside of the facility and not into the attic. Target Date-10/15/12</p>	10/15/12

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K 068	Continued From page 8 plant shall be designed and installed so that combustible material will not be ignited by the device or its appurtenances. If fuel-fired, such heating devices shall be chimney connected or vent connected, shall take air for combustion directly from the outside, and shall be designed and installed to provide for complete separation of the combustible system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure.	K 068		
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, fifteen (15) residents, staff and visitors. The facility has forty four (44) certified beds with a census of forty three (43) on the day of the survey. The findings include: Observation, on 08/15/12 between 3:00 PM and 6:00 PM, with the Maintenance Director and the	K 070	K070 NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 Criteria 1- The space heaters in question have been removed from the facility. Criteria 2- QA rounds will be completed by Maintenance Director by 9/27/12 to ensure no other space heaters are in the facility. Criteria 3- A policy on portable space heating devices will be completed and all staff will receive in-service training by 9/27/12 on the use of portable space heating devices from the administrator. Criteria 4- The QA tool for monitoring life safety will be completed x2 months and then quarterly per the established QA calendar under the supervision of the administrator. Target Date-9/28/12	9/28/12

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K 070	<p>Continued From page 9</p> <p>Administrator revealed a portable space heater located in the Medical Records Office, and the Director of Nursing Office.</p> <p>Interview, on 08/15/12 between 3:00 PM and 6:00 PM, with the Maintenance Director and the Administrator revealed they were not aware the heaters could not exceed 212°F in non-sleeping, staff, and employee areas. Further interview revealed the facility did not have a policy on the use of portable heaters.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).</p>	K 070		
K 072 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit</p>	K 072	<p>K072 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 furnishing, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p>	

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K 072	<p>Continued From page 10</p> <p>access in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, thirty (30) residents, staff and visitors. The facility has forty (44) certified beds with a census of forty three (43) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 08/15/12 between 3:00 PM and 6:00 PM, with the Maintenance Director and the Administrator revealed storage of four (4) PTAC units in the Front Hall. Further observation revealed linen carts being stored in Hall 10, and six (6) chairs and two (2) tables located in the egress path of the Activities Room, which is part of the evacuation path for Hall 20.</p> <p>Interview, on 08/15/12 between 3:00 PM and 6:00 PM, with the Maintenance Director and the Administrator revealed the facility routinely stored items in these areas. Further interview with the Administrator revealed he was not aware the Front Hall would have to comply with the code due to it being predominately staff area.</p> <p>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.</p>	K 072	<p>Criteria 1-The (4) PTAC units have been removed from the front administrative hallway. The hall 10 linen cart is to be stored, when not in use, in an area out of the line of egress on hall 20. The (6) chairs and (2) tables in the egress path of the Activity exit have been removed from the pathway.</p> <p>Criteria 2-A QA review of all other egress paths will be completed by 9/28/12 to ensure nothing is stored in the egress area for emergency exits.</p> <p>Criteria 3-In-service training will be completed by 9/27/12 with all staff on K072 obstructions in the means of egress by the administrator.</p> <p>Criteria 4- The QA tool for life safety will be completed x2 months and then quarterly as per the established QA calendar under the supervision of the administrator</p> <p>Target Date-9/28/12</p>	9/28/12
K 104 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.</p>	K 104	<p>K104 NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts</p>	

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NAME OF PROVIDER OR SUPPLIER WELLINGTON PARC OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD RD OWENSBORO, KY 42303	
(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 104	Continued From page 11 This STANDARD is not met as evidenced by: Based on fire damper record review and interview, it was determined the facility failed to ensure fire/smoke dampers were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, twenty six (26) residents, staff and visitors. The facility has forty four (44) certified beds with a census of forty three (43) on the day of the survey. The findings include: Fire damper record review, on 08/15/12 at 3:00 PM, with the Maintenance Director and the Administrator revealed the facility did not have documentation for fire damper testing. Interview, on 08/15/12 at 3:00 PM, with the Maintenance Director and the Administrator revealed that no maintenance documentation was kept on the fire/smoke dampers. Reference: NFPA 90A (1999 edition) 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 104	are protected in accordance with 8.3.6. Criteria 1- The Fire Dampers will be inspected/repared by the facility's contracted company by 9/28/12 to assure that all dampers operate correctly. Criteria 2- A review of heating/cooling systems will be completed by 9/27/12. If additional fire dampers are found they will be inspected/repared by the contracted company. Criteria 3- The administrator and the maintenance director received in-service training on the facility policy on Maintenance and Testing of Fire/Smoke Dampers from the facility's contracted consultant on 9/10/12. Criteria 4- Fire and Smoke damper maintenance record will be utilized when testing dampers. The QA tool for Life Safety will be completed x2 months and then quarterly as per the established QA calendar under the supervision of the administrator. Target Date: 9/28/12	9/28/12

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K 144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, forty four (44) residents, staff and visitors. The facility has forty four (44) certified beds with a census of forty three (43) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 08/15/12 at 5:36 PM, with the Maintenance Director and the Administrator revealed the facility was equipped with an emergency generator. Stored inside the generator enclosure were three (3) one (1) gallon containers of oil.</p> <p>Interview, on 08/15/12 at 5:36 PM, with the Maintenance Director and the Administrator revealed they were not aware the flammable items were being stored inside the generator enclosure.</p>	K 144	<p>K144 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generator are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1</p> <p>Criteria 1-The (3) 1-gallon containers of oil have been removed from the generator enclosure.</p> <p>Criteria 2-All residents within the facility alleged to be affected.</p> <p>Criteria 3-In-service training with the administrator and the maintenance supervisor regarding not storing flammable containers in the generator enclosure will be completed by the facility's contracted consultant on 9/10/12.</p> <p>Criteria 4-Maintenance Director will check the generator enclosure weekly as part of preventive maintenance program. The QA tool for Life Safety will be completed x2 months and then quarterly as per the established QA calendar under the direction of the administrator.</p> <p>Target Date: 9/28/12</p>	9/28/12

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

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K 144	<p>Continued From page 13</p> <p>Reference: NFPA 110 (1999 Edition) 5-2.1 The EPS shall be installed in a separate room for Level 1 installations. EPSS equipment shall be permitted to be installed in this room. The room shall have a minimum 2-hour fire rating or shall be located in an adequate enclosure located outside the building capable of resisting the entrance of snow or rain at a maximum wind velocity required by local building codes. No other equipment, including architectural appurtenances, except those that serve this space, shall be permitted in this room.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, twenty (20) residents, staff, and visitors. The facility has forty four (44) certified beds with a census of forty three (43) on the day of the survey.</p>	K 144	<p>K147 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2.</p> <p>Criteria 1-The electric heat tape installed on the condensation line of the freezers condensing unit will be removed.</p> <p>Criteria 2- No other area is affected by this alleged deficient practice.</p> <p>Criteria 3-The administrator and maintenance director received in-service training on the use of heat tape and electrical cords penetrating through walls from the facility's contracted consultant on 9/10/12</p> <p>Criteria 4-The QA tool for Life Safety will be completed x2 months and then quarterly per the established QA calendar under the direction of the administrator.</p> <p>Target Date: 9/28/12</p>	9/28/12

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K 147	<p>Continued From page 14</p> <p>The findings include:</p> <p>Observation, on 08/15/12 at 5:20 PM, with the Maintenance Director and the Administrator revealed electric heat tape installed on the condensation line of the freezers condensing unit, due to the line freezing and not draining. The cord for the heat tape was passing through the freezer wall into the walk-in cooler where it was plugged into a receptacle.</p> <p>Interview, on 08/15/12 at 5:20 PM, with the Maintenance Director and the Administrator revealed them not aware electrical cords could not pass through walls, and heat tape could not be used due to poor installation of the condensate line.</p> <p>NFPA 70 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <ul style="list-style-type: none"> (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces 	K 147		