

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/22/2013
NAME OF PROVIDER OR SUPPLIER CALVERT CITY CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029	
(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 A recertification survey was conducted on 03/19/13 through 03/22/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of a "G", with no opportunity to correct.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	1. An investigation regarding cause of bruising on Resident #11 was conducted by the West Wing RN Unit Supervisor on 3/20/2013. CNA #4 who observed bruising on resident #11 was in-serviced by the Administrator on 4-5-2013 in a group in-service for CNA's and Licensed Nurses regarding proper reporting of any abnormal skin issues to the charge nurse on duty immediately. CNA #4 was 1:1 instructed by the DON on 4-10-2013 to always immediately report any noticed bruises, skin tears, any other abnormal skin issues, or suspected abuse to the charge nurse responsible for the care of the resident at that time. 2. All residents have the potential to be affected by the deficient practice. A skin assessment is being completed by RN's & LPN's on all residents to identify any non-identified skin issues.	



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

[Handwritten Signature]

TITLE

Ann. V. [Handwritten Title]

(X6) DATE

4/22/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review it was determined the facility failed to ensure an injury of unknown origin were reported immediately for one (1) resident (#11), in the selected sample of nineteen (19) residents. Resident #11 who was cognitively impaired was observed to have bruising to the arm which had not been reported to the nurse so the source could be identified.</p> <p>Findings include:</p> <p>A review of the facility's Abuse/Neglect policy, last revised 01/30/13, revealed in order to protect the health and welfare of each resident to assure each was free from abuse, exploitation and incidents of unknown source, staff would be educated on what an incident of unknown source was, how to recognize signs of abuse, and how to identify events, like bruising, trends and patterns.</p> <p>A record review revealed Resident #11 was admitted to the facility on 02/23/09 with diagnoses to include Dementia, Abnormal Posture,</p>	F 225	<ol style="list-style-type: none"> 3. All direct care nursing staff were In-service by the Administrator on 4-5-2013 to follow the facility abuse policy and report any abnormal skin issues immediately to the charge nurse whether the origin of the incident is known or unknown. An In-service by the DON is scheduled for 4-19-2013 for all direct care nursing staff. In-service content to include proper facility protocol for reporting, notification, and the investigation of incidents. Any employee not present at the scheduled DON In-service without an excuse will be disciplined per personnel policy handbook by the DON or Administrator. Any employee unable to attend the 4-19-2013 DON In-service will be rescheduled for 1:1 in-service with the DON within 1 week. 4. Random repeat skin assessments & audits of the weekly skin assessments done by charge nurses will be completed on 5 residents weekly by the RN unit Supervisor for two months thereafter, The LPN QI Coordinator or designee will conduct 5 random skin assessments/audits monthly to monitor for continued compliance. Any problems identified in the monitoring process will be reported to the Director of Nursing, or Administrator, or designee for reeducation and/or disciplinary action, if indicated, per personnel policy handbook by the DON or Administrator. 5. Completion Date: 4-26-2013 	4-26-2013

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F 225	<p>Continued From page 2</p> <p>Parkinson's and Other Persistent Mental Disorder with Behavior.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 03/18/13, revealed the facility had assessed Resident #11 with a BIMS score of 3 revealing severe cognitive impairment and he/she required extensive assistance with transfers and activities of daily living and was nonambulatory.</p> <p>Observation on 03/19/13 at 3:05 PM and on 03/20/13 at 9:30 AM, 10:30 AM, 11:30 AM and 1:45 PM revealed the resident was in the hall area or dining room seated in a Broda chair with an alarming seatbelt. Resident #11 had multiple discolored areas that were visible on the right forearm. Interview was attempted with the resident during each observation; however, due to the resident's impaired cognitive status, he/she could not provide any reliable information.</p> <p>Observation on 03/20/13 at 2:30 PM, during a skin assessment performed by Licensed Practical Nurse (LPN) #3 and Registered Nurse (RN) #2, revealed Resident #11 had two areas of bruising to the right forearm. One area measured 6 centimeters (cm) by 4 cm and was purple and red with yellow around the perimeter. The other area was irregular shaped and measured 3 cm by 3 cm by 2.7 cm and was purple and blue. RN #2 and LPN #3 had no explanation as to the origin of the bruising.</p> <p>A review of a weekly skin assessment documentation, dated 03/18/13, revealed the only area identified of the resident was a fading discoloration to the right forearm. Additionally,</p>	F 225			

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F 225	<p>Continued From page 3</p> <p>review of the a bath sheet which was completed during bathing by the Certified Nurse Aides (CNA), dated 03/18/13, revealed no bruising and stated "skin was intact".</p> <p>An interview with CNA #4, on 03/21/13 at 2:35 PM, revealed she first saw the bruises on Resident #11's arm on Tuesday (03/19/13) and thought she had told RN #3.</p> <p>An interview with RN #3, on 03/22/13 at 9:00 AM, revealed he did not recall anyone reporting bruising to Resident #11's arm and he would have documented the bruising if had been reported to him.</p> <p>An interview with the Director of Nursing (DON), on 03/22/13 at 9:05 AM, revealed bruising of unknown origin should be reported immediately, an incident form should be filled out and an investigation completed. She stated she did not feel the CNA reported the bruising to RN #3 and should have.</p>	F 225		
F 241 SS=D	<p>483.16(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to promote care for residents in a</p>	F 241	<ol style="list-style-type: none"> 1. Resident #7's physician was verbally educated by the Director of Nursing and the LPN QI Coordinator at the quarterly QI meeting on 4-8-2013 regarding residents rights to privacy and dignity. The physician was made aware that residents must be seen in the privacy of their room, or private space, not in public areas of the facility. 2. All residents have the potential to be affected by the deficient practice. 3. All facility physicians will be educated via a certified letter on the policy related to the Resident Care And Dignity Physician Assessment Policy written by the Administrator with regards to respecting the rights and dignity of the resident by only examining or questioning residents 	

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F 241	<p>Continued From page 4</p> <p>manner that maintained or enhanced each resident's dignity and respect for one (1) resident (#7), in the selected sample of nineteen (19) residents.</p> <p>Findings include:</p> <p>A review of the Resident Rights Document, undated, revealed a resident has the right to personal privacy, including medical treatment.</p> <p>A record review revealed Resident #7 was admitted to the facility on 12/15/11. A review of the quarterly Minimum Data Set (MDS) assessment, dated 01/21/13, revealed the facility assessed the resident as cognitively intact with a BIMS score of 13.</p> <p>An interview with Resident #7, on 03/21/13 at 9:15 AM, revealed the resident voiced concern related to visits with his/her personal physician. The resident revealed the physician asked him/her personal questions in the dining room. The resident felt it was "inappropriate."</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 03/22/12 at 10:30 AM, revealed she had witnessed physicians talking to the residents in the dining room and in the hallway. She revealed they may ask if the resident had any issues and would listen to the resident's lung sounds.</p> <p>An interview with the Director of Nursing (DON), on 03/22/13 at 2:50 PM, revealed she had witnessed physicians talking to residents in the dining room; however, they were supposed to take the resident to their room.</p>	F 241	<p>in the privacy of their room, or a private room in the facility, not in public places within the facility. The physician's will sign an affirmation of receipt and understanding of the letter/policy provisions which is to be returned to the Administrator by 4-25-2013. All nurses & CNA's will be in-serviced on 4-19-2013 by the Director of Nursing on the policy related to the resident's rights to privacy and dignity, that physician's are not to be examining or questioning residents in public places of the facility therefore staff will have to accommodate the physicians and ensure the resident is taken to their room or a private room in the facility to provide privacy when the physician is ready to examine or discuss care.</p> <p>4. Charge nurses on duty are to ensure residents are examined in the privacy of their room during a physicians visit. QI Coordinator, LPN, or designee will randomly monitor compliance on 10 residents monthly. Any noncompliance identified in the monitoring process will be reported to the Administrator. The Administrator will contact the Medical Director regarding the issue and schedule a meeting with the noncompliant physician and the Medical Director to resolve the issue. If compliance is not attained the noncompliant physician will be terminated.</p> <p>5. Completion Date: 4-26-2013</p>	4-26-2013
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		

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F 282 SS=G	Continued From page 5 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, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure services were provided by qualified persons in accordance with each resident's written plan of care for two (2) residents (#7 and #11), in the selected sample of nineteen (19) residents. Resident #7 was care planned for a chair pad alarm to the wheelchair as a safety intervention from a previous fall. The resident sustained a fall on 07/31/12 resulting in a left intertrochanteric femur fracture requiring surgical intervention. It was determined the chair pad alarm was not in place at the time of the fall to alert staff Resident #7 was attempting to rise. Resident #11 was care planned to have skin sleeves applied to the upper extremities while in the chair; however, observations revealed this intervention was not implemented. Findings include: A review of the Resident Falls Policy/Procedure, undated, revealed once a resident had been identified as being at risk for falling and interventions implemented to minimize the risk,	F 282	1. The date the incident occurred, 7/31/2012, resident #7 was sent to the hospital for evaluation and treatment. Resident # 7 is no longer a resident of the facility therefore no other corrective action could be accomplished. Skin sleeves were applied to bilateral upper extremities on resident #11 while she was up in the Broda chair immediately after being made aware that they were not in place by the state inspector during the annual survey on 3/20/2013. CNA's and Nurses on duty on that same date were verbally in-serviced by the DON that care plan interventions must be implemented and in place per the residents care plan and Nurses Assistant Assignment sheet/care plan. CNA's were reminded of where to locate their assignment sheet/care plan and the importance of reading it to know the appropriate care to provide to the residents. 2. All residents have the potential to be affected by the deficient practice. All residents care plans, Nurse Assistant Assignment sheet/care plans are being reviewed, revised, and updated, if indicated, by RN's and LPN's regarding preventative, protective, or safety interventions including visual checks to ensure the interventions are in place.	

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F 202	<p>Continued From page 6</p> <p>everything would be documented in the resident's chart. The resident's care plan would list all interventions that were used to minimize the potential for a fall. All direct care staff would need to know what interventions were needed to prevent an occurrence. A written assignment sheet was implemented monthly to alert direct care staff.</p> <p>A record review revealed Resident #7 was originally admitted to the facility on 12/15/11 with diagnoses to include Senile Dementia, Epilepsy, and Generalized Muscle Weakness.</p> <p>A review of the initial Minimum Data Set (MDS) assessment, dated 12/27/11, revealed the facility assessed Resident #7 with a BIMS score of 13 revealing he/she was cognitively intact and required extensive assistance with ambulation and transfer. A review of the Fall Incident Investigation, dated 03/22/12, revealed the facility assessed the resident as needing a chair pad alarm to the wheelchair after a fall in the dining room. A review of the Fall Risk Assessment, dated 06/06/12, revealed the facility assessed the resident at high risk for falls.</p> <p>A review of the Comprehensive Care Plan and Nurse Assistant Assignment sheet, dated 06/06/12, revealed staff should place a chair pad alarm to the wheelchair.</p> <p>A review of the Fall Investigation Form, dated 07/31/12 at 11:00 AM, revealed Resident #7 sustained a fall in the dining room resulting in left hip pain. Review of the Safety/Alarm Check sheet, dated 07/31/12, revealed Certified Nurse Aides (CNA) #1 initialed she checked the</p>	F 202	<p>3. The printing format of the Nurse Assistant Assignment sheets/care plan are being revised to put all pertinent interventions related to falls, safety devices, protective, or preventative on one page (the first page of the Assignment sheets) where it will isolate those interventions and be more reader friendly. The RN Unit Supervisors are responsible for the revision of the assignment sheets. LPN's and RN's are reviewing all residents care plans/Nurse Assignment sheets fall, safety, protective, or preventative interventions and making revisions and updates, if indicated, to reflect the appropriate care for the resident's current condition. The Director of Nursing will in-service all Nurse Aides and Nurses on 4-19-2012 regarding the revised format for the Nurse Assistant Assignment sheets/Care plans and on the proper protocol/procedure regarding care planned interventions related to falls, safety, or protective devices. Emphasis will be placed on the importance of ensuring the care planned interventions are implemented and the resident's plan of care is followed, i.e. making sure alarms are in place and working correctly, skin sleeves, cushions, and any other protective/preventative devices are in place per the care plan. Any employee not present at the scheduled DON in-service without an excuse will be disciplined per personnel policy handbook by the DON or Administrator. Any employee unable to attend the 4-19-2013 DON in-service will be rescheduled for</p>	

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F 282	<p>Continued From page 7</p> <p>resident's chair pad alarm at 7:30 AM and again at 9:30 AM.</p> <p>An interview with CNA #1, on 03/22/13 at 10:20 AM, revealed the chair pad alarm was in the wheelchair the morning of 07/31/12 per her documentation; however, further review of the fall investigation revealed the chair pad alarm was not in the resident's wheelchair at the time of the fall.</p> <p>An interview with the Dietary Aide, on 03/22/13 at 11:15 AM and 12:50 AM, revealed she witnessed the fall involving Resident #7 on 07/31/12. She was in the kitchen area preparing to serve lunch when she looked up and saw the resident standing behind another resident's wheelchair, attempting to push it; however, she revealed there was no alarm sounding. She stated it was just a few seconds and the resident had fallen in the floor; however, she was unaware of how long he/she had been standing prior to the fall.</p> <p>An interview with the Business Manager, on 03/22/13 at 1:45 PM, revealed her office was directly across from the dining room. She was in her office on 07/31/12 and vaguely remembered when Resident #7 fell. She stated that she would have responded if an alarm sounded; however, she verified there was no alarm sounding prior to the fall.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 03/22/13 at 10:30 AM and 1:35 PM, revealed she was the nurse for Resident #7 on 07/31/12. She completed the Fall Investigation Form and documented the chair pad alarm was not in the wheelchair at the time of the fall.</p>	F 282	<p>1:1 In-service with the DON within 1 week.</p> <p>4. The LPN Staff Development Coordinator will monitor compliance by reviewing 10 random resident care plans/assignment sheets and visually checking to ensure the interventions are being implemented by staff weekly x 2 months, followed by 10 random checks monthly. Any non-compliance is to be reported to the Administrator or Director of Nursing. Any problems identified in the monitoring process will be addressed by the DON or Administrator with re-education and/or disciplinary action, if indicated, per personnel policy handbook.</p> <p>5. Completion Date: 4-26-2013</p>	4-26-2013	

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F 282	<p>Continued From page 8</p> <p>Although she could not remember details of the incident, she verified if it was documented, it was true. She revealed the CNAs were supposed to ensure the alarms were in the chair when getting a resident out of bed. She was responsible for monitoring staff to ensure alarms were in place and functioning; however, she "apparently" did not check the resident's alarm on 07/31/12, or would have questioned why it was not in place.</p> <p>An interview with the Director of Nursing (DON), on 03/22/13 at 2:50 PM, revealed while the CNA was responsible for documentation of the alarm, it was also the nurse's responsibility to monitor placement and functioning of alarms. She expected the CNA to follow the resident's care plan to ensure the chair pad alarm was in place and functioning.</p> <p>A review of the Nurse's Note, dated 07/31/12 at 11:30 AM, revealed the resident was transported to the emergency room for evaluation and treatment. A review of the Emergency Room Record, dated 07/31/12 at 12:06 PM, revealed the clinical impression in the emergency room included acute pain with a left intertrochanteric hip fracture and left femoral neck hip fracture. A review of the Radiology Report, dated 07/31/12, revealed the x-ray of the left hip and femur indicated a minimally displaced left femoral intertrochanteric fracture. Review of the Surgical Department Report, dated 08/02/12, revealed the resident had an open reduction and internal fixation of the intertrochanteric femur fracture. A record review revealed the resident was readmitted to the facility on 08/03/12.</p> <p>2. A record review revealed Resident #11 was</p>	F 282			

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F 282	<p>Continued From page 9</p> <p>admitted to the facility on 02/23/09 with diagnoses to include Dementia, Abnormal Posture, Parkinson's and Other Persistent Mental Disorder with Behavior.</p> <p>A review of the quarterly MDS assessment, dated 03/18/13, revealed the facility had assessed Resident #11 with a BIMS score of 3 revealing severe cognitive impairment and he/she required extensive assistance with transfers and activities of daily living and was nonambulatory.</p> <p>A review of Resident #11's Comprehensive Care Plan, titled "Potential for Alteration in Skin Integrity", dated 01/03/13, revealed an intervention for staff to apply skin sleeves to the upper extremities when the resident was in the chair. A review of the Nurse's Assistant Assignment sheet, dated 03/01/13, revealed Resident #11 was to have protective skin sleeves while up in the Broda chair.</p> <p>Observations on 03/19/13 at 3:05 PM and on 03/20/13 at 9:30 AM, 10:30 AM, 11:30 AM and 1:45 PM revealed the resident in the hall area and/or dining room seated in a Broda chair. The resident's bilateral forearms were visible as there were no protective sleeves on the resident's arms. There were multiple discolored areas that were visible on the resident's right forearm. Interview was attempted with each observation; however, due to the resident's impaired cognitive status, he/she could not provide any reliable information.</p> <p>Observation on 03/20/13 at 2:30 PM, during a skin assessment performed by LPN #3 and Registered Nurse (RN) #2 revealed Resident #11</p>	F 282			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 04/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/22/2013
NAME OF PROVIDER OR SUPPLIER CALVERT CITY CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029		
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F 282	Continued From page 10 had two areas of bruising to the right forearm. One area was 6 centimeters (cm) by 4 cm and was purple and red with yellow around the perimeter. The other area was irregular shaped with a 3 cm by 3 cm by 2.7 cm and was purple and blue. An interview with Certified Nurse Aide (CNA) #4, on 03/20/13 at 1:45 PM revealed she was providing care for Resident #11 on this date and revealed she had not put protective sleeves on Resident #11 and had not seen the resident with protective sleeves in a long time. CNA #4 verified an intervention on the Nurse Assistant Assignment sheet included "Skin Sleeve on upper extremities while up in Broda chair". An interview with CNA #5, on 03/20/13 at 1:50 PM, revealed she was not aware the resident was to have protective sleeves on the arms. An interview and observation on 03/20/13 at 2:30 PM with the DON verified Resident #11 did not have the protective sleeves in place and she expected the staff to ensure those protective sleeves were in place as per the resident's care plan. Furthermore, she stated it was the Nurses' responsibility to ensure placement.	F 282			
F 323 SS=G	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.	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 04/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185294	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/22/2013
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NAME OF PROVIDER OR SUPPLIER

CALVERT CITY CONVALESCENT CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

1201 FIFTH AVE
CALVERT CITY, KY 42029

(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

Continued From page 11

F 323

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 supervision and assistance devices to prevent accidents for two (2) residents (#7 and #11), in the selected sample of nineteen (19) residents. The facility assessed Resident #7 at high risk for falls requiring a chair pad alarm when up in the wheelchair. Resident #7 sustained a fall, on 07/31/12, resulting in a left intertrochanteric femur fracture requiring surgical intervention. It was determined the residents' chair pad alarm was not in place at the time of the fall but the facility failed to complete a thorough investigation of the fall and develop an action plan to correct the identified concerns. In addition, the facility failed to ensure a construction area in the facility was supervised to prevent residents from being injured. Resident #11 wheeled self into the construction area and caused a ceiling tile to fall and hit him/her in the shin causing a 13.5 centimeters (cm.) by 4 cm. skin tear.

Findings include:

1. A review of the Resident Falls Policy/Procedure, undated, revealed after the resident had been carefully assessed for fall risk factors, interventions would be implemented that were individualized, according to the resident's needs.

A record review revealed Resident #7 was

1. The date the incident occurred, 7/31/2012, Resident #7 was sent to the hospital for evaluation and treatment. Resident #7 is no longer a resident of the facility therefore no other corrective action could be accomplished. LPN #2 was verbally in-serviced by the DON on 3/22/2013 regarding the necessity of all falls being thoroughly investigated and documented. No fall investigation form should be filed until it's completely filled out with specific detailed documentation including any education given. LPN #1 was verbally in-serviced the same day by the DON regarding proper procedure/protocol for the fall investigation report. Emphasizing that she must be specific in describing the fall and all details on the form, For resident #11, on 10/12/2012, the date the incident occurred, medical treatment was initiated and it healed without any difficulty noted. On 3/21/2013 all maintenance employees and the front desk office employee was verbally in-serviced by the DON regarding any outside contractors are to check in at the front office and a maintenance employee is to be notified to escort and supervise them while working inside the facility. Maintenance employees were also advised to secure or block off any work areas, if indicated.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 04/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/22/2013
NAME OF PROVIDER OR SUPPLIER CALVERT CITY CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029		
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F 323	<p>Continued From page 12</p> <p>originally admitted to the facility on 12/15/11 with diagnoses to include Senile Dementia, Epilepsy, and Generalized Muscle Weakness. A review of the initial Minimum Data Set (MDS) assessment, dated 12/27/11, revealed the facility assessed the resident as cognitively intact with a BIMS score of 13 and required extensive assistance with ambulation and transfer.</p> <p>A review of the Fall Risk Assessment, dated 06/06/12, revealed the facility assessed the resident at high risk for falls. A review of the Comprehensive Care Plan and the Nurse Assistant Assignment sheet, dated 06/06/12, revealed staff should place a chair pad alarm to the wheelchair, as a safety intervention from a previous fall.</p> <p>A review of the Fall Investigation Form, dated 07/31/12 at 11:00 AM, revealed Resident #7 sustained a fall in the dining room resulting in left hip pain. Review of the Safety/Alarm Check sheet, dated 07/31/12, revealed Certified Nurse Aide (CNA) #1 initialed she checked the resident's chair pad alarm at 7:30 AM and again at 9:30 AM.</p> <p>An interview with CNA #1, on 03/22/13 at 10:20 AM, revealed the chair pad alarm was in the wheelchair the morning of 07/31/12 per her documentation; however, further review of the fall investigation revealed the chair pad alarm was not in the resident's wheelchair at the time of the fall.</p> <p>An interview with the Dietary Aide, on 03/22/13 at 11:15 AM and 12:50 AM, revealed she witnessed the fall involving Resident #7 on 07/31/12. She</p>	F 323	<p>2. To identify if there are other residents affected by the deficient practice a fall risk assessment is being conducted by LPN's and RN's on all residents. The care plan and Nurse Assistant Assignment sheet/care plan interventions related to falls, safety, prevention, or protection will be reviewed, revised, and updated, if indicated, by LPN's and RN's</p> <p>3. Fall risk assessments are being conducted by LPN's and RN's. All care plans and Nurse Assistant Assignment sheets/care plans are being reviewed to ensure the fall, safety, protective, or preventative interventions are appropriate for the resident's current condition and the interventions are being implemented by staff and are in working order. The care plan & Nurses Assistant Assignment Sheet will be updated, if indicated, to reflect the current interventions. The LPN's and RN's completing the fall risk assessments are also responsible for reviewing, revising, and updating the care plans and Nurse Assistant Assignment sheets, if indicated, and ensuring the implementation of interventions. The printing format for the Nurse Assistant Assignment sheet is being revised to put all pertinent interventions related to falls, safety devices, protection, or prevention on the first page of the assignment sheets where it will isolate those interventions and be more reader friendly. The revision of the assignment sheets and print format change is the responsibility of the RN Unit Supervisors. An in-</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 04/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/22/2013
NAME OF PROVIDER OR SUPPLIER CALVERT CITY CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029		
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F 323	<p>Continued From page 13</p> <p>was in the kitchen area preparing to serve lunch when she looked up and saw the resident standing behind another resident's wheelchair, attempting to push it; however, she revealed there was no alarm sounding. She stated it was just a few seconds and the resident had fallen in the floor; however, she was unaware of how long he/she had been standing prior to the fall.</p> <p>An interview with the Business Manager, on 03/22/13 at 1:45 PM, revealed her office was directly across from the dining room. She was in her office on 07/31/12 and vaguely remembered when Resident #7 fell. She stated that she would have responded if an alarm sounded; however, she verified there was no alarm sounding prior to the fall.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 03/22/13 at 10:30 AM and 1:35 PM, revealed she was the nurse for Resident #7 on 07/31/12. She completed the Fall Investigation Form and documented the chair pad alarm was not in the wheelchair at the time of the fall. Although she could not remember details of the incident, she verified if it was documented, it was true. She revealed the CNAs were supposed to ensure the alarms were in the chair when getting a resident out of bed. She was responsible for monitoring staff to ensure alarms were in place and functioning; however, she "apparently" did not check the resident's alarm on 07/31/12, or would have questioned why it was not in place.</p> <p>An interview with the Director of Nursing (DON), on 03/22/13 at 2:50 PM, revealed while the CNA was responsible for documentation of the alarm, it was also the nurse's responsibility to monitor</p>	F 323	<p>service for all direct care nursing staff is scheduled for 4/19/2013 by the Director of Nursing related to the proper procedure/protocol for completion of a fall investigation report, investigation of a fall, and implementation of the interventions. Education will also include the new printing format for the Nurse Assistant Assignment sheets and the importance of knowing those care planned interventions and ensuring they are implemented on each resident. Nursing staff will also be educated on completing the investigation form in its entirety, to be specific with detailed documentation, to ensure an intervention is put in place immediately after a fall, and the importance of ensuring all alarms are in place and in working order. Emphasis will be placed on thoroughly investigating the fall. The Director of Nursing will provide all of the listed in-service material on 4-19-2013. Any employee not present at the scheduled DON in-service without an excuse will be disciplined by the DON or Administrator per personnel policy handbook. Any employee unable to attend the 4-19-2013 DON in-service will be rescheduled for 1:1 in-service with the DON within 1 week. LPN #1 and #2 were in-serviced on 3/22/2013 by the DON as stated above in answer #1. The Administrator in-serviced CNA's and Licensed Nurses on 4/5/2013 related to the procedure/protocol for outside contractors in the facility. Contractors are to check in at the front desk office and the front desk employee will notify</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 04/05/2013
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER CALVERT CITY CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029		
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F 323	<p>Continued From page 14 placement and functioning of alarms.</p> <p>A review of the Nurse's Note, dated 07/31/12 at 11:30 AM, revealed the resident was transported to the emergency room for evaluation and treatment. A review of the Emergency Room Record, dated 07/31/12 at 12:06 PM, revealed the clinical impression in the emergency room included acute pain with a left intertrochanteric hip fracture and left femoral neck hip fracture. A review of the Radiology Report, dated 07/31/12, revealed the x-ray of the left hip and femur indicated a minimally displaced left femoral intertrochanteric fracture. Review of the Surgical Department Report, dated 08/02/12, revealed the resident had an open reduction and internal fixation of the intertrochanteric femur fracture. A record review revealed the resident was readmitted to the facility on 08/03/12.</p> <p>A review of the Resident Falls Policy/Procedure, undated, revealed as soon as possible, a complete and thorough investigation would be completed to determine contributory causes for the fall and what other actions needed to be completed to minimize the potential for a future fall.</p> <p>Further review of the Fall Investigation Form, dated 07/31/12, revealed the facility failed to complete a thorough investigation of the fall involving Resident #7 on 07/31/12 at 11:00 AM. The investigation indicated the chair pad alarm was not in the resident's wheelchair at the time; however, did not indicate an action plan to correct the identified concern. The investigation did not indicate a root cause of the resident's fall.</p>	F 323	<p>maintenance to come escort them to the work area. Nursing staff were educated to always remove resident's from any work area and a maintenance employee is to be supervising the contractor working inside the facility. Maintenance is to secure the area if indicated. Maintenance personnel & the front desk employee were in-serviced by the DON on 3/21/2013 to the protocol regarding supervision of contractors working inside the facility as stated above in answer #1.</p> <p>4. Post falls the LPN coordinator or RN Unit Supervisor will complete a fall risk assessment, review the fall investigation form ensuring it's filled out completely with detailed documentation including any education provided, ensure an appropriate intervention has been put in place, the care plan and Nurse Assignment sheet has been revised and updated to reflect the new intervention. Fall investigation reports will be taken to the next morning meeting by the LPN Staff Development Coordinator or designee to be discussed with the IDT. After the morning IDT meeting, the Administrator, LPN Q1 Coordinator, RN Unit Supervisors, and the LPN SDC/Fall Coordinator will meet to further discuss and review that the appropriate interventions are in place and the fall investigation form is completed. All completed fall investigation reports will be given to a nurse that has not been involved in discussion of the fall for review to ensure all components of the report has been</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 04/05/2013
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 15</p> <p>An interview with LPN #2, on 03/22/13 at 2:15 PM, revealed she was responsible for reviewing the fall investigation reports for completion and accuracy. She verified there was no documented interviews of the CNAs working on the unit with Resident #7 on 07/31/12. She was aware the chair pad alarm did not sound during the fall; however, she could not provide any documented evidence this was discussed at the time of the fall. She revealed an in-service was scheduled to discuss alarms.</p> <p>A review of the Mandatory Nursing Staff Meeting, dated 08/10/12, revealed "Alarms" were discussed during the meeting, ten days after the fall; however, it did not detail the content of the meeting.</p> <p>An interview with the Registered Nurse (RN) Unit Manager, on 03/22/13 at 2:00 PM, revealed she was not aware, but should have been notified about the resident's missing chair pad alarm on 07/31/12. She stated she would have educated the staff at that time; however, did not have the information. She did not review the fall investigation report as it was the responsibility of LPN #2.</p> <p>An interview with the DON, on 03/22/13 at 2:50 PM, revealed she was not aware of the issue with the chair pad alarm at the time of the fall. She stated "Honestly, I did not know for awhile." She expected the nurse to make her aware of the situation so the staff involved could be educated immediately. She could not provide content of the mandatory meeting on 08/10/12, related to alarm use. She further revealed LPN #2 was responsible for ensuring the fall investigations</p>	F 323	<p>completed and interventions have been implemented to monitor for continued compliance. A Maintenance employee will continually supervise contractors who are working inside the facility. The Maintenance supervisor will monitor for continued compliance. Any non-compliance is to be reported to the Administrator or Director of Nursing. Any problems identified in the monitoring process will be addressed with re-education and/or disciplinary action, if indicated, per personnel policy handbook by the Administrator or DON.</p> <p>5. Completion Date: 4-26-2013</p>	4-26-2013	

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

 PRINTED: 04/05/2013
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/22/2013
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F 323	<p>Continued From page 16</p> <p>were completed accurately, including interviews with all staff or residents involved; however, she verified the fall investigation for Resident #7 was not thorough.</p> <p>2. A review of the facility's policy for Safe Environment, undated, revealed "All work areas should be secure with safety equipment to assure the protection of employees, contractors, visitors and residents".</p> <p>A record review revealed Resident #11 was admitted to the facility on 02/23/09 with diagnoses to include Dementia, Abnormal Posture, Parkinson's and Other Persistent Mental Disorder with Behavior.</p> <p>A review of the quarterly MDS assessment, dated 03/18/13, revealed the facility had assessed Resident #11 with a BIMS score of 3 revealing severe cognitive impairment and he/she required extensive assistance with transfers and activities of daily living and was nonambulatory.</p> <p>Observation on 03/19/13 at 3:05 PM and on 03/20/13 at 9:30 AM, 10:30 AM, 11:30 AM and 1:45 PM revealed the resident was in the hall area and/or dining room seated in a Broda chair with an alarming seatbelt. No reliable information could be obtained from Resident #11 due to the resident's impaired cognitive status.</p> <p>A review of the Nurse's Note, dated 10/12/12 at 1:50 PM, revealed Resident #11 propelled self in Broda chair into a construction area. A ceiling tile fell hitting the resident on the left shin causing a 13.5 cm by 4 cm skin tear.</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 04/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/22/2013
NAME OF PROVIDER OR SUPPLIER CALVERT CITY CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029		
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F 323	<p>Continued From page 17</p> <p>A review of an accident/incident report, dated 10/12/12 at 1:50 PM, revealed the resident had propelled self into construction area at nursing station and a ceiling tile fell and hit the resident's left shin. The section of the accident/incident report, titled "Results of Investigation" revealed "Someone is to be monitoring all construction areas".</p> <p>An interview with LPN #3, on 03/20/13 at 2:40 PM, revealed she was on duty on 10/12/12 and remembered when the ceiling tile fell and injured Resident #11's leg. She stated a telephone man had been installing a line or something and the area was not secured as he did not rope off the area. She stated the injury looked bad and the telephone man felt terrible.</p> <p>An interview with the DON, on 03/21/13 at 1:30 PM, revealed that outside contractors were to check in with maintenance so work could be monitored for resident safety but she did not recall what the circumstances were at the time of the incident.</p> <p>An interview with Maintenance Director, on 03/22/13 at 9:30 AM, revealed the contractors usually stopped and checked in at the front door; however, he was not familiar with the incident involving Resident #11.</p> <p>An interview with a Unit Manager, on 03/21/13 at 4:40 PM, revealed she recalled Resident #11 had wheeled self into the ladder the contractor was using and the ceiling tile that was sitting on the ladder fell and hit him/her on the leg.</p> <p>An interview with the Administrator, on 03/21/13</p>	F 323			

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

PRINTED: 04/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/22/2013
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NAME OF PROVIDER OR SUPPLIER CALVERT CITY CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029
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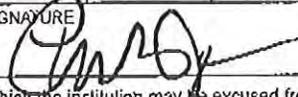
F 323	Continued From page 18 at 1:50 PM, revealed staff was made aware on more than one occasion that someone was to help secure any area where work was going on and that area should have been secured and was not.	F 323		
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PRINTED: 04/05/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185234	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER CALVERT CITY CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029	
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1972.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1972, and upgraded in 2010 with 16 smoke detectors and 3 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1972 and upgraded in 2011.</p> <p>GENERATOR: Type II generator installed in 2011. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted on 03/19/13 and 03/20/13. Calvert City Convalescent Center was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Ninety-Five (95) beds with a census of Ninety-Two (92) on the day of the survey.</p> <p>The findings that follow demonstrate</p>	K 000		

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



TITLE

ADMINISTRATOR

(X6) DATE

5/1/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185234	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER CALVERT CITY CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029		
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K 000	Continued From page 1 noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "F" level.	K 000			
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure smoke detectors were inspected and tested in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of eight (8) smoke compartments, sixteen (16) residents, staff and visitors. The facility is certified for Ninety-Five (95) beds with a census of Ninety-Two (92) on the day of the survey. The facility failed to ensure that the battery powered smoke detectors in each resident room were being properly tested and cleaned. The findings include: Record review, on 03/20/13 at 10:50 AM with the Maintenance Supervisor, revealed there was no documentation of Smoke Detector weekly testing or monthly cleaning of the three (3) battery powered smoke detectors located in the facility. Interview, on 03/20/13 at 10:50 AM with the	K 054	K 054 1. On March 22, 2013 all battery powered smoke detectors were tested and cleaned by the Center's maintenance staff. 2. On March 20, 2013, the Center's Maintenance Supervisor and the Environmental Surveyor for the OIG inspected all smoke detector logs and determined that only three (3) battery powered smoke detectors located in the facility were effected. 3. All battery powered smoke detectors have been placed on a scheduled maintenance program to be tested weekly and cleaned monthly by a member of the facility maintenance personnel. 4. The Quality Assurance Director will monitor compliance by quarterly reviews of Maintenance Smoke Detector cleaning and testing logs and with random on-site testing and inspections of each unit with a member of the Center's maintenance personnel. 5. 3/27/13	3/27/13	

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K 054	Continued From page 2 Maintenance Supervisor, revealed he has checked the detectors but there was no system on checking the detectors. Reference: NFPA 72 (1999 ed.) 7-4.1 Fire alarm system equipment shall be maintained in accordance with the manufacturer ' s instructions. The frequency of maintenance shall depend on the type of equipment and the local ambient conditions. Reference: NFPA 101 (2000 ed.) 4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. 4.6.12.2* Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. 4.6.12.3 Equipment requiring periodic testing or operation to ensure its maintenance shall be tested or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction. 4.6.12.4 Maintenance and testing shall be under the supervision of a responsible person who shall ensure that testing and maintenance are made at	K 054		

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K 054	Continued From page 3 specified intervals in accordance with applicable NFPA standards or as directed by the authority having jurisdiction.	K 054	K 056		
K 056 SS=F	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 observations and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of eight (8) smoke compartments, all residents, staff and visitors. The facility is certified for Ninety-Five (95) beds with a census of Ninety-Two (92) on the day of the survey. The facility failed to ensure the sprinkler heads were not blocked by light fixtures in twenty-two (22) areas, and two (2) areas had sprinkler coverage. The findings include:	K 056 1. Ceiling fans blocking sprinklers in the Main Office, Activities Office, Business Office, and in the Lobby have been removed. The sprinkler head blockage in bathrooms 202, 217, 201, 203, 206, 207, 121, 125, 128, 115, 116, and 110 are being corrected by a certified electrician removing current lighting and installing flush mount lighting. The light fixture in the Soiled Utility Hall 1 has been moved to remove the blockage. The sprinkler heads in the dishwasher room, kitchen, in back of dry storage, the locker room, and the records room are being extended below light fixtures. Sprinkler protection is being added to the laundry corridor and the kitchen hallway next to the freezer. 2. On March 20, 2013, the Center's Maintenance Supervisor and the Environment Surveyor for the OIG inspected all sprinkler heads in the facility identifying areas not properly sprinkler protected and all sprinkler heads with blockage. 3. A maintenance staff in-service was conducted by the Administrator on 4/10/13 on sprinkler head obstruction. The maintenance schedule for the fire alarm system has been changed to include monthly inspections by a member of the Center's Maintenance Staff for sprinkler head blockage to assure NFPA standards are maintained. 4. The Quality Assurance Director will review quarterly the monthly maintenance logs of the fire alarm system to assure compliance. The sprinkler heads will be visually inspected by the Quality Assurance Director and the Administrator each six (6) months to check for sprinkler head obstruction and any areas that does not have sprinkler head protection. 5. 4/22/13	4/22/13		

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K 058	<p>Continued From page 4</p> <p>Observations, on 03/20/13 between 8:40 AM and 12:00 PM with the Maintenance Supervisor, revealed the sprinkler heads located in resident bathrooms #202, #217, #201, #203, #206, #207, #121, #125, #128, #115, #116, and #110 were blocked by light fixtures, within 1 foot of the sprinkler head, extending below the sprinkler heads. Further observation revealed the sprinklers were blocked by light fixtures in the soiled utility hall 1, dishwasher room, Kitchen, back of dry storage, locker room, and the records room. Further ceiling fans were blocking sprinklers in the Main office, Activities office, Business office, and the far sprinkler head in the Lobby.</p> <p>Interview, on 03/20/13 between 8:40 AM and 12:00 PM with the Maintenance Supervisor, revealed he was unaware that the light fixtures could block the spray pattern of the sprinkler head.</p> <p>Observation, on 03/20/13 at 10:45 AM with the Maintenance Supervisor, revealed the corridor storage area next to laundry and the small hallway next to the freezer did not have sprinkler protection.</p> <p>Interview, on 03/20/13 at 10:45 AM with the Maintenance Supervisor, revealed he was unaware that the areas were not properly sprinkler protected.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of</p>	K 058		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 056	Continued From page 5 Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP) <table border="0"> <thead> <tr> <th style="text-align: left;">Distance from Sprinklers to above Bottom of Side of Obstruction (A)</th> <th style="text-align: left;">Maximum Allowable Distance of Deflector Obstruction (in.) (B)</th> </tr> </thead> <tbody> <tr><td>Less than 1 ft</td><td>0</td></tr> <tr><td>1 ft to less than 1 ft 6 in.</td><td>2 1/2</td></tr> <tr><td>1 ft 6 in. to less than 2 ft</td><td>3 1/2</td></tr> <tr><td>2 ft to less than 2 ft 6 in.</td><td>5 1/2</td></tr> <tr><td>2 ft 6 in. to less than 3 ft</td><td>7 1/2</td></tr> <tr><td>3 ft to less than 3 ft 6 in.</td><td>9 1/2</td></tr> <tr><td>3 ft 6 in. to less than 4 ft</td><td>12</td></tr> <tr><td>4 ft to less than 4 ft 6 in.</td><td>14</td></tr> <tr><td>4 ft 6 in. to less than 5 ft</td><td>16 1/2</td></tr> <tr><td>5 ft and greater</td><td>18</td></tr> </tbody> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).</p>	Distance from Sprinklers to above Bottom of Side of Obstruction (A)	Maximum Allowable Distance of Deflector Obstruction (in.) (B)	Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	16 1/2	5 ft and greater	18	K 056		
Distance from Sprinklers to above Bottom of Side of Obstruction (A)	Maximum Allowable Distance of Deflector Obstruction (in.) (B)																									
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4 ft 6 in. to less than 5 ft	16 1/2																									
5 ft and greater	18																									
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.	K 076																								

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K 076	<p>Continued From page 6</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility is certified for Ninety-Five (95) beds with a census of Ninety-Two (92) on the day of the survey. The facility failed to ensure oxygen storage over 300 cu ft. was stored 5 feet away from any combustibles and ignition sources located five (5) feet from the floor.</p> <p>The findings include:</p> <p>Observation, on 03/20/13 at 11:20 AM with the Maintenance Supervisor, revealed nineteen (19) oxygen tanks in the 100 hall med room. The oxygen tanks were being stored within five (5) feet of combustible items and ignition sources were not located over five (5) feet from the floor.</p> <p>Interview, on 03/20/13 at 11:20 AM with the Maintenance Supervisor, revealed he was unaware that over 12 e-cylinders stored in a smoke compartment had requirements on storage.</p>	K 076	<p>K076</p> <ol style="list-style-type: none"> On 3/21/13, all oxygen storage bottles exceeding the maximum twelve (12) bottles in the 100 Hall Med Room were transferred to the maintenance building storage area. On 3/20/13, an inspection of the oxygen storage areas for the East Wing (100) and West Wing (200) was conducted by the Center's Maintenance Supervisor and the Environmental Surveyor for the OIG to determine compliance for oxygen storage and it was found that the East Wing (100 Hall Med Room) storage was not in compliance. In the 100 Med Room and 200 Med Room where medical gas cylinders are stored, the cylinder storage racks have been modified to hold only twelve (12) cylinders. The nursing staff will be in-serviced on April 19, 2013 by the Center's Maintenance Supervisor on medical gas storage requirements. The QA Director will monitor quarterly the 100 Med Room and 200 Med Room storage to assure no more than the maximum twelve (12) bottles are in storage in each room. 4/20/13 	4/20/13

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K 076	<p>Continued From page 7</p> <p>Reference: NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1/2 hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet</p>	K 076		

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K 076	Continued From page 8 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.	K 076			