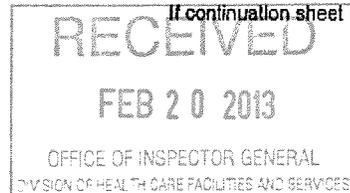


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-NORTHFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222	
(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 371	<p>Continued From page 28</p> <p>Observation of the kitchen, on 01/08/13 at 8:15 AM, revealed the seal between the hand sink and the wall was cracked. There were three (3) dish crates stored on the floor in the dishwashing room. The eye sanitation basin was soiled with a thick whitish substance and small black particles. The outsides of the coffee maker and tea maker were smeared and a whitish substance was present. There were numerous soiled paper signs taped to the walls and tape residue was present in many areas.</p> <p>Observation of the kitchen, on 01/10/13 at 10:30 AM, revealed the tea makers and coffee makers continued to have the same soiling as on 01/08/13. The dish warmer full of plates had a brownish greasy build-up able to be removed and brown and white particles around the openings for the plates.</p> <p>Review of the cleaning schedule for the kitchen, revealed the dish warmer was to be cleaned weekly and other appliances were to be wiped down daily.</p> <p>Interview with the Cook, on 01/10/13 at 10:30 AM, revealed each worker had specific areas to clean. She stated the kitchen needed to be clean to prevent the spread of germs.</p> <p>Interview with the Manager, on 01/10/13 at 10:40 AM, revealed the cleaning schedule times needed to be increased to ensure the kitchen was clean. He stated the kitchen needed to be clean to prevent the spread of disease. He stated he was responsible to ensure the cleanliness of the kitchen.</p>	F 371	<p>The coffee and tea makers were scrubbed and parts have been replaced by the vendor to ensure cleanliness on 1/13/13, the dish washers were in-serviced on using dish rack trolleys on 1/12/13, the eye wash station bowl was replaced 1/18/13, the crack behind the hand sink was repaired on 1/14/13 by Joe Saylor, maintenance supervisor.</p> <p>All paper signs were removed and placed in plastic frames on 1/18/13. The frames were mounted to the wall to hold the required information by Sara Otto. Gaston Diomi added the dish warmer to the daily cleaning schedule as of 1/14/13. The Nutritional Service Manager Gaston Diomi will hold monthly department meetings to ensure compliance with daily, weekly and monthly cleaning schedules. The Nutritional Service Manager, the assistant Nutritional Service Manager will do daily rounds of the kitchen, the Registered Dietician Andrea Baker, and the Executive Director, Dennis McNatt will conduct weekly rounds of the kitchen. The Nutritional Service Manger will compile the information from these rounds and report to the Performance Improvement Committee for the next twelve months. The information will be shared monthly with the dietary staff at the monthly department meeting.</p> <p>The Nutritional Service Manager, Gaston Diomi will present the compiled report to the Performance Committee for twelve months. The Executive Director is overall responsible for compliance.</p>	
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		



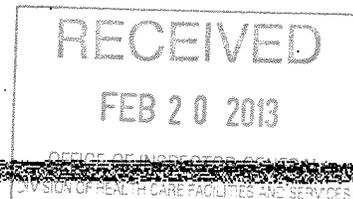
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-NORTHFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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)	(X6) COMPLETION DATE
F 431 SS=D	<p>Continued From page 29</p> <p>LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 431	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F431 Label/Store Drugs & Biologicals It is the practice of Kindred Transitional Care and Rehabilitation - Northfield to see that drugs and biologicals are stored and labeled properly.</p> <p>Audit completed of all medication carts, Treatment carts, and medication rooms to ensure all are labeled and expiration dates are appropriate. Completed on 01/20/2013.</p> <p>Daily auditing of the medication carts, treatment carts, and medication rooms completed every day starting 01/13/2013 and ongoing for the next 30 days, then weekly audits to be completed by Unit Manager to ensure all drugs/biological are labeled and stored correctly. To be done weekly ongoing.</p> <p>The Director of Nursing will review audits with unit manager on a weekly basis and will compile a report for the Performance Improvement Committee for twelve months. The Executive Director is responsible for overall compliance.</p>	2/18/13



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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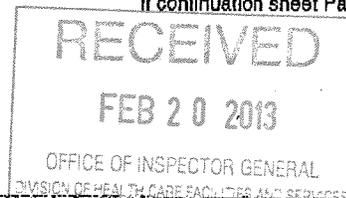
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-NORTHFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222
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F 431	<p>Continued From page 30</p> <p>Based on observation, interview and policy review, it was determined the facility failed to remove sixteen (16) of sixty-one (61) expired needles and sterility compromised needles from resident stock supplies on the North Hall Medication room. In addition, there was one (1) of one (1) Urethral Catheter Kit that had expired.</p> <p>The findings include:</p> <p>Upon request of the facility's policy for expired items, the facility provided the Policy for Medications with Special Expiration Date Requirements, revised 10/31/09, which did not address these items in question.</p> <p>Observation, of the North Medication Room, on 01/09/13 at 11:00 AM, revealed twelve (12) of sixty-one (61) needles expired on 02/2011, one (1) of sixty-one (61) needles expired on 02/2009, two (2) of sixty-one needles were opened and sterility was broken. One (1) of one (1) Urethral Catheter Kit expired 09/2012.</p> <p>Interview, with Licensed Practical Nurse #4, on 01/09/13 at 11:00 AM, reported she stocks the medication room on North Hall and stocks it when the supplies arrive. She reports she cleans the room as it is needed.</p> <p>Interview, with the Director of Nurses, on 01/10/13 at 11:12 AM, revealed each Unit Manager was responsible to clean the medication room and check supplies for an expiration date when supplies were ordered or stocked. She reported she did not track each Unit Manger In</p>	F 431		
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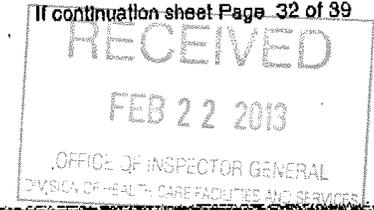


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F 431	Continued From page 31. that area. She reported she did not have policy to address when to clean the medication rooms.	F 431		
F 441 SS=E	<p>Upon request of the facility's policy for expired items, the facility provided the Policy for Medications with Special Expiration Date Requirements, revised 10/31/09, which did not address these items in question.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F441 Infection Control, Prevent Spread, 2/18/13. Linens It is the practice of Kindred Transitional Care and Rehabilitation - Northfield to assure proper infection control is demonstrated by staff. Performance improvement was completed with LPN#3 for not washing hands on 01/09/2013. One on one education was completed with staff member by SDC on 01/09/2013. . The medication and treatment carts were immediately deep cleaned and sanitized on 01/09/2013 by the unit managers. The medication rooms were deep cleaned and sanitized by the unit managers on 01/09/2013.</p>	



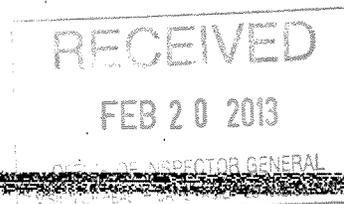
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-NORTHFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222
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F 431	Continued From page 31 that area. She reported she did not have policy to address when to clean the medication rooms.	F 431		
F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F441 Infection Control, Prevent Spread, 2/18/13 Linens It is the practice of Kindred Transitional Care and Rehabilitation - Northfield to assure proper infection control is demonstrated by staff.</p> <p>All nursing staff education on hand washing and infection control completed on 01/29/2013. All staff checked off on appropriate hand washing techniques.</p> <p>All nursing staff education completed on removal of gloves with hand washing and medication pass. Education also completed on cleaning medication and treatment carts at the end of each shift. Education completed on 01/29/2013.</p>	



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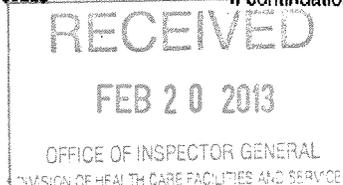
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185170	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-NORTHFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222	
(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 441	Continued From page 32 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to consistently implement their infection control program in regards to handwashing, suction equipment, and cleaning of the medication rooms. The facility staff did not practice appropriate hand hygiene after removal of gloves for two (2) of five (5) glove changes during the use of the blood glucose monitoring. The medication and treatment carts on two (2) of two (2) units were soiled inside and outside and both (2) medication rooms had soiled cabinets and storage areas. In addition, one (1) of sixteen (16) sampled residents and eight (8) unsampled residents used suction equipment for his/her care. The facility staff did not clean or change Resident #5's suction equipment for two (2) days. The findings include: 1. Review of the facility's Hand Hygiene/Handwashing Policy, revised 08/31/11, page three (3), section eight (8)(h) revealed staff were to decontaminate their hands after removing their gloves.	F 441	The suction equipment was removed from the room of resident #5 and was immediately cleaned and new canisters, catheters placed on machine. All suction equipment will be monitored by the Respiratory Therapist for cleaning, and replacing on a daily basis. Nursing staff to monitor after each use as well. All nursing staff education on hand washing, cleaning of equipment and infection control completed on 01/29/2013. All staff checked off on appropriate hand washing techniques. By the SDC completed education with all employees. All staff demonstrated competency by re-verbalization, testing, and demonstration. All nursing staff education completed on removal of gloves with hand washing and medication pass. Education also completed on cleaning medication and treatment carts at the end of each shift. Dating and Labeling equipment education also completed. Education completed on 01/29/2013 by the SDC. All staff showed competency through demonstration and testing. Unit managers and DNS to monitor on a daily basis medication rooms for cleanliness. Started 01/13/2013 and daily for the next 30 days. Then to be completed weekly by Unit Managers ongoing. The Director of Nursing Services and Unit Managers are to monitor on a daily basis and education to be ongoing with nurses.	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-NORTHFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222		
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F 441	<p>Continued From page 32 hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to consistently implement their infection control program in regards to handwashing, suction equipment, and cleaning of the medication rooms. The facility staff did not practice appropriate hand hygiene after removal of gloves for two (2) of five (5) glove changes during the use of the blood glucose monitoring. The medication and treatment carts on two (2) of two (2) units were soiled inside and outside and both (2) medication rooms had soiled cabinets and storage areas. In addition, one (1) of sixteen (16) sampled residents and eight (8) unsampled residents used suction equipment for his/her care. The facility staff did not clean or change Resident #5's suction equipment for two (2) days.</p> <p>The findings include:</p> <p>1. Review of the facility's Hand Hygiene/Handwashing Policy, revised 08/31/11, page three (3), section eight (8)(h) revealed staff were to decontaminate their hands after removing their gloves.</p>	F 441	<p>Unit managers and DNS to monitor on a daily basis medication rooms for cleanliness. Started 01/13/2013 and daily for the next 30 days. Then to be completed weekly by Unit Managers ongoing.</p> <p>The Director of Nursing or Assistant Director of Nursing will monitor through direct observation and review of Infection Control logs to assure proper infection control technique is utilized including hand washing. This data will be reviewed and analyzed at the Performance Improvement committee for twelve months. The Executive Director is responsible to ensure compliance.</p>		



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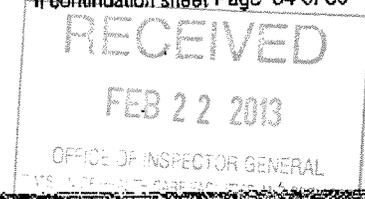
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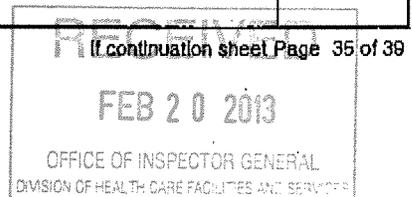
F 441	<p>Continued From page 33</p> <p>Review of the facility's Infection Control Work Practices, revised 04/28/10, revealed the employee was to wash their hands with soap and water immediately or as soon as feasible after the removal of gloves or other personal protective equipment.</p> <p>Observation of Licensed Practical Nurse (LPN) #3 during a blood glucose check, on 01/09/13 at 4:15 PM, revealed of the five (5) glove changes the nurse failed to perform hand hygiene after removal of the gloves on two (2) occasions.</p> <p>Interview with LPN #3, on 01/09/13 at 11:45 AM and at 4:40 PM, revealed hand washing with soap and water was done after three (3) to five (5) glove changes and alcohol based gel after each glove change. She reported she used alcohol based hand gel after each glove change. She stated she did not know why she did not do hand hygiene after each glove change.</p> <p>2. Observation of the North Hall Medication Room, on 01/09/13 at 11:00 AM, revealed four (4) of four (4) drawers had loose brown particles and what appeared to be hair in the needle storage basket. The sink had white and brown stains around the sink faucet.</p> <p>Observation of the North Hall Medication Room, on 01/09/13 at 4:50 PM, revealed all drawers had loose brown particles and the storage cabinets were soiled. Residents' supplies were stored in the soiled drawers.</p> <p>Observation of the South Hall Medication and Treatment Carts, on 01/10/13 at 10:10 AM, revealed Betadine colored stains with spillage into</p>	F 441	<p>The Director of Nursing and The Assistant Director of Nursing will monitor through direct observation and review of equipment and medication room to assure proper infection control technique is utilized including hand washing. This data will be reviewed and analyzed at the Performance Improvement committee for three months and then quarterly. The Executive Director is responsible to ensure compliance.</p>	
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F 441	<p>Continued From page 34</p> <p>the bottom drawers of the Treatment Cart. The Medication Cart for rooms one (1) through thirty-two (32) was soiled at the trash can receptacle.</p> <p>Interview with LPN #3, on 01/09/13 at 11:45 AM and at 4:40 PM, revealed each medication cart was cleaned by the nurse on the shift she/he used the cart.</p> <p>Interview, with LPN #4, on 01/09/13 at 11:00 AM, reported she monitored the medication room when she ordered supplies and stock. She stated she cleaned the medication room as it was needed.</p> <p>Interview, with Registered Nurse (RN) #1, on 01/09/13 at 4:50 PM, revealed he monitored the medication room when he ordered supplies and stock.</p> <p>Interview, with the Director of Nurses, on 01/10/13 at 11:12 AM, revealed each nurse was responsible to clean the Medication and Treatment Carts during each shift, and if they saw any spillage, it should be cleaned at that time. She reported each Unit Manager was responsible to clean the medication drawers and supplies when supplies are ordered or stocked. She stated she did not track each Unit Manager in that area. She reported she did not have a policy to address when to clean the medication rooms or carts.</p> <p>3. Review of the facility's policy regarding Suction Machine, Care and Use Of, Revised 08/31/12,</p>	F 441			



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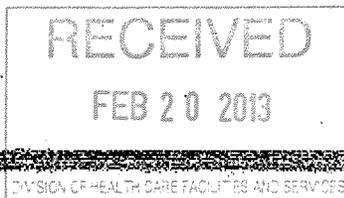
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-NORTHFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222	
(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 441	<p>Continued From page 35</p> <p>revealed appropriate handling and care of suction machines prevented contamination, spread of infection and maintained the equipment in good working order.</p> <p>Review of the Respiratory Equipment Change and Cleaning Guide, Revised 08/31/11, revealed the suction catheter was to be rinsed after use and have a date and label with the residents room number on it.</p> <p>Observation, on 01/08/13 at 10:56 AM, revealed a suction machine in the room of Resident #5, with the products of suctioning in the machine, tubing with products of suctioning present and the Yankauer suction catheter uncovered hanging behind the suction machine. The suction catheter was not labeled or dated. Continued observation, on 01/09/13 at 9:30 AM, revealed no change in the suction equipment from the previous day.</p> <p>Interview, on 01/09/13 at 10:40 AM, with Licensed Practical Nurse (LPN) #1 revealed the suction machine was to be covered with a bag. She also revealed the suction catheter was to be covered or discarded. She revealed there was an oxygen equipment company that came to the facility weekly to change out the equipment. She also revealed for infection control purposes that the suction catheter should be cleansed and put in a package.</p> <p>Interview, on 01/09/13 at 10:45 AM, with the Director of Nursing (DON) revealed the suction catheter for the suction machine was to be in a plastic bag when not in use. In addition, she stated the suction cannister should have been</p>	F 441		

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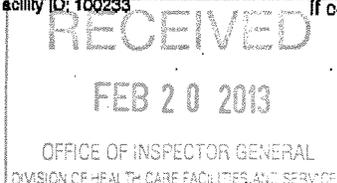
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F 441	Continued From page 36 emptied every twenty-four (24) hours. The reason was so the cannister would be clean. Interview, on 1/09/13 at 10:50 AM, with LPN Weekend Supervisor #2 revealed the suction catheter should be stored under the bag with the suction machine. She gave infection control as the reason for appropriate storage of the suction equipment. She revealed if the suction catheter was not stored appropriately, you may expose the resident to anything the catheter was exposed to.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to provide a functional environment for eight (8) of twenty-five (25) resident rooms with over the bed light strings. Five (5) of twenty-five (25) resident rooms was cluttered and had boxes stored on the floor in the resident's room. The facility failed to provide a comfortable, safe environment for the residents in one (1) of two (2) Day Rooms with observation of a window that had loose, crumbly wood exposed to outside elements. The findings include: Upon request, of the Policy and Procedure for the Facility, from the Director of Maintenance, on	F 465	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	2/18/13
			F465 Safe/Functional/Sanitary/Comfortable Environment It is the practice of Kindred Transitional Care and Rehabilitation – Northfield to improve a safe environment for residents. The Maintenance Director was in serviced on 2/4/13 by the Executive Director of proper use of PM's and daily rounds to ensure building upkeep. A weekly check off for windows was developed on 2/12/13 and will be utilized by the maintenance and housekeeping departments. The maintenance Director will collect the check offs weekly and ensure that all windows are in working condition. Any issues will be addressed, corrected and reported to the Executive Director for inclusion in the PI report on a safe environment for residents.	



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F 465	<p>Continued From page 37</p> <p>01/17/13, revealed he did not have a policy on the up keep of the building. He stated corporate did not require a preventative maintenance of the building and he did not have a check off for the windows.</p> <p>Observation of resident rooms 15, 17, 18, 50 B, 52 B, 53 A, 54 B and 60 A, on 01/08/13 at 8:15 AM, during facility tour, revealed missing over the bed light strings. Observation during a facility tour of resident rooms 15, 17, 18, 50 B, 52 B, 53 A, 54 B and 60 A, on 01/10/13 at 1:00 PM, revealed the over the bed light strings remained missing.</p> <p>Observation, on 01/08/13 at 8:30 AM, during initial tour, revealed cluttered rooms and boxes stored on the floor in resident rooms 36 B, 39 B, 43 B, 47 A, 48 A/B and 51 B.</p> <p>Observation, of the North Day Room, on 01/08/13 at 8:30 AM and on 01/10/13 at 8:35 AM, revealed one window was cloudy and the wood sash had loose wood particles. The wood trim that held the glass window in place had lost the coat of paint, and cool air was felt through the wood. Daylight was seen through the window sash.</p> <p>Interview, with the Director of Maintenance, on 01/10/13 at 8:40 AM, reported he was not aware of any window damage in the North Day Room. He reported, he did not have any tracking mechanism in place to ensure areas of the facility were routinely checked. He stated, he did not have any preventive maintenance checklist for the building.</p> <p>Interview, with the Director of Housekeeping, on</p>	F 465	<p>Rooms 15,17, 18, 50B, 52B, 53A, 54B, 60A all have strings attached to overhead lights as of 1/14/13. This was completed by the maintenance director. The maintenance director on daily rounds will check for overbed light strings and replace as needed. Rooms 36B, 39B, 43B, 47A, 48A, 48B and 51B have been decluttered by maintenance, housekeeping and nursing staff on 1/14/13. A letter was given to residents and sent to responsible parties on 1/31/13 stressing the need to assist the center in controlling items in resident rooms. All resident rooms with clutter were addressed by social services 1/14/13 and will be addressed as needed each month and at resident council for twelve months.</p> <p>The window in the north day room was immediately covered with plastic on 1/10/13 and was covered under warranty and was replaced on 2/15/13.</p> <p>All residents had the potential of being affected by the environment. The Maintenance Director, Joe Saylor completes daily rounds using the PM daily check, based on visual observations. Weekly the Executive Director, Dennis McNatt will also do rounds with the Maintenance Director, Joe Saylor. All finding will be logged and any areas needing attention will be addressed immediately with the direction of the Maintenance Director, Joe Saylor.</p>



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F 465	<p>Continued From page 38</p> <p>01/10/13 at 8:55 AM, reported his staff was responsible for cleaning the North and South Day Rooms. He stated, he was not aware of any window damage in the North Day Room. He reported, he did not have any tracking mechanism in place to ensure items of concern were reported.</p> <p>Interview, with the Director of Nurses, on 01/10/13 at 8:59 AM, reported she was not aware of the rotted window in the North Day Room; however, she did have a Maintenance binder at the North Nurses Station. She stated, the nurses document any repair needs for the unit in that binder. She stated the Maintenance staff check it everyday for repairs.</p> <p>Interview, with the Administrator, on 01/10/13 at 9:05 AM, reported he was not aware of the rotted window in the North Day Room. He stated, he had noticed the window was cloudy, but was not aware the window had rotted. He verbalized, if they had know the window was rotten, they would have called someone in to fix it. However, review of the Maintenance Binder located at the North Nurses Station, revealed staff documented window wood dry rot, dated 10/17/12. This job was signed off as completed by the Maintenance staff.</p>	F 465	<p>In service completed for all staff in the entire building to ensure that all staff is aware of the maintenance log book on both units. Education was completed by Jamie Humphrey RN SDC and the Maintenance Director, Joe Saylor on 1/31/13. The maintenance director, Joe Saylor will collect the log each morning and bring it to the morning stand up meeting to give an update on repairs and gather new items that need repair.</p> <p>The Maintenance Director will report the findings from the unit maintenance log books and the information gathered during scheduled rounds for twelve months and present the findings to the Executive Director to report at the Performance Improvement committee for twelve months.. The Executive Director is the responsible for overall compliance.</p>		

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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: 1986</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One Story, Type III (000)</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system. (2- risers)</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 01/08/13. Kindred Transitional Care and Rehab was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one hundred twenty (120) beds with a census of seventy eight (78) 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		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Dennis McNeil TITLE: Executive Director (X6) DATE: 2/14/13

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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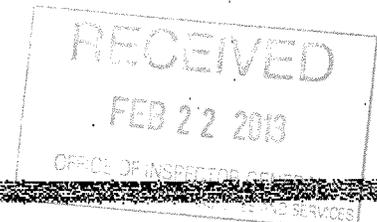
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K 000	Continued From page 1	K 000			
K 029 SS=D	Deficiencies were cited with the highest deficiency identified at F level. NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029			
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty (120) beds with a census of seventy eight (78) on the day of the survey. The facility failed to provide a self-closing devices for doors protecting hazardous areas. The findings include: Observation, on 01/08/13 at 2:34 PM, with the				

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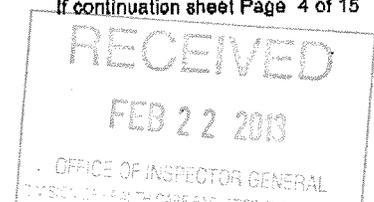
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K 029	<p>Continued From page 2</p> <p>Maintenance Supervisor revealed the North Hall Storage room had hazardous storage and did not have self-closing device to keep the door closed.</p> <p>Interview, on 01/08/13 at 2:34 PM, with the Maintenance Supervisor revealed they were not aware the door to this room was required to be self-closing.</p> <p>Interview, on 01/08/13 at 2:34 PM, with the Administrator revealed they were not aware the door to this room was required to be self-closing.</p> <p>8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided</p>	K 029	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>K29 Life Safety Code Standard It is the practice of Kindred Transitional Care and Rehabilitation - Northfield to have self closing devices for doors protecting hazardous areas. 2/18/13</p> <p>The residents in 1 of 7 smoke compartments had the potential to be affected by the non self closing door in the North hall storage room. The self closure was installed on 1/15/13 in the storage closet (north). All doors requiring self closure were checked by the maintenance director 2/4/13.</p> <p>The Maintenance Director and the staff were educated on the regulation regarding K29 and requirements of self-closing doors on appropriate rooms. The Executive Director was educated on the proper use of self closing doors on appropriate rooms and Tag K29. Education was completed by the area Maintenance Supervisor on 01/30/2013. The Executive Director and Maintenance staff demonstrate competency by re-verbalization of education.</p> <p>The maintenance director on daily rounds will check doors that self close for proper operation and recorded for monthly safety meeting for twelve months.</p>



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K 029	Continued From page 3 with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029	The maintenance director will present this report to the Executive Director for submission to the Performance Improvement committee for twelve months. The Executive Director is overall responsible for compliance.	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by:	K 046		



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K 046 Continued From page 4

Based on staff interview and testing of emergency lighting record review, it was determined the facility failed to test emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty (120) beds with a census of seventy eight (78) on the day of the survey. The facility failed to provide documentation that battery emergency lighting was tested annually for 1 1/2 hours.

The findings include:

Testing of emergency lighting record review, on 01/08/13 at 12:16 PM, with the Maintenance Supervisor revealed the facility did not have documentation that the battery emergency lighting in the facility was tested for 1-1/2 hours within the last year.

Interview, on 01/08/13 at 12:16 PM, with the Maintenance Supervisor revealed he was not aware the annual test for the battery emergency light for 1-1/2 hours had to be documented.

Interview, on 01/08/13 at 3:40 PM, with the Administrator revealed they were not aware of the requirement for emergency battery light testing.

Reference: NFPA 101 (2000 edition)
7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10

K 046

This Plan of Correction is the center's credible allegation of compliance.

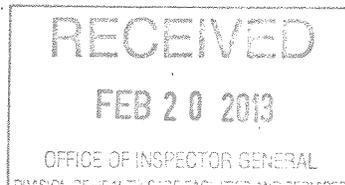
Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

K46 Emergency lighting 2/18/13

It is the practice of Kindred Transitional Care and Rehabilitation - Northfield to test emergency lighting.

All residents could have had potential issues with the lack of documentation of a 1 1/2 hour testing of emergency lighting in the last year. All emergency lighting was tested on 1/16/13 and is operating properly. The Executive Director in serviced the Maintenance Director on NFPA 7.9.3 Periodic Testing of Emergency Lighting Equipment on 2/8/13.

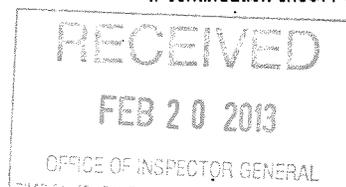
The Maintenance staff was educated by the Executive Director on 02/08/2013. Competency of education was verified through Re-verbalization of understanding of policy on testing emergency lighting. The maintenance director will ensure the 1 1/2 is on the PM's and checked yearly. The results of the checks will be documented and presented to the safety meeting. The maintenance director will present this report to Performance Improvement committee in February. The Executive Director is overall responsible for compliance.



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K 046	Continued From page 5 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are	K 050		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

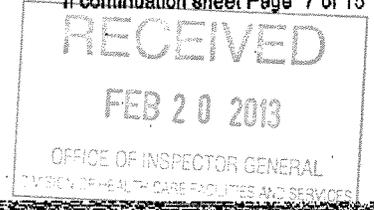
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185179	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/08/2013
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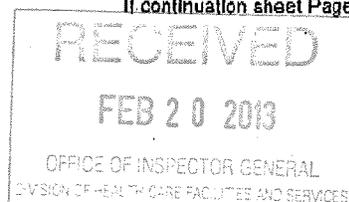
K 050	<p>Continued From page 6</p> <p>qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined 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 seven (7) of seven (7) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty (120) beds with a census of seventy eight (78) on the day of the survey. The facility failed to ensure the fire drills were conducted at unexpected times.</p> <p>The findings include:</p> <p>Fire Drill review, on 01/08/13 at 11:42 AM, with the Maintenance Supervisor revealed the facility failed to conduct fire drills at unexpected times on all shifts.</p> <p>Interview, on 01/08/13 at 11:49 AM, with the Maintenance Supervisor revealed they were not aware the fire drills were not being conducted as required.</p> <p>Interview, on 01/08/13 at 3:40 PM, with the Administrator revealed they were not aware of the requirements for conducting fire drills.</p>	K 050	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>K50 NFPA 101 Life Safety Code Standard 2/22/13 It is the practice of Kindred Transitional Care and Rehabilitation - Northfield to conduct fire drills quarterly on each shift.</p> <p>All residents had the potential of being affected by the lack of documentation on quarterly fire drills. The maintenance director will follow the PM schedule and conduct monthly fire drills on each shift at staggered times for the next 12 months. The Executive Director in serviced the maintenance Director on 2/8/13 on the importance of staggering the drills to ensure staff awareness.</p> <p>The maintenance director will conduct fire drills and document as part of his monthly PM program and report findings at the safety committee meeting for twelve months.</p> <p>The maintenance director will present the report to the Executive Director for presentation to the Performance Improvement committee for twelve months. The Executive Director is overall responsible for compliance.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/23/2013
FORM APPROVED
OMB NO. 0938-0391

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K 050	Continued From page 7	K 050		
K 056 SS=D	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. 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 the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty (120) beds with a census of seventy eight (78) on the day of the survey. The findings include:	K 056 <i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> K56 NFPA Life Safety Code Standard 2/18/13 It is the practice of Kindred Transitional Care and Rehabilitation - Northfield to have required sprinkler systems in the center. Resident in 1 of 7 smoke compartments could have been affected by the lack of sprinklers in the O2 storage room and the locker area. The sprinklers for the O2 storage room and the locker area were added to the system on 1/10/13. The Executive Director in serviced the Maintenance Director on 2/8/13 about sprinkler system requirements. The maintenance director on weekly rounds will check for any areas that have changed or may require additional sprinkler heads. This will be documented and reported to the monthly safety meeting for twelve months.		



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

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K 056 Continued From page 8

Observation, on 01/08/13 at 1:52 PM, with the Maintenance Supervisor revealed a closet located in the oxygen storage room, and the locker area located in the service hall did not have sprinkler coverage.

Interview, on 01/08/13 at 1:52 PM, with the Maintenance Supervisor revealed he was not aware the areas did not have sprinkler coverage and confirmed the observation.

Interview, on 01/08/13 at 3:46 PM, with the Administrator revealed they were not aware of the areas not having complete sprinkler coverage.

Reference: NFPA 13 (1999 Edition) 5-13 8.1

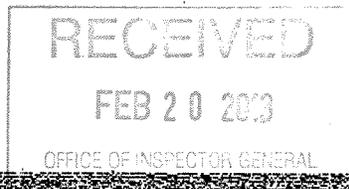
Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.

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:

K 056 The maintenance director will present this report to the Executive Director for presentation to the Performance Improvement committee for twelve months. The Executive Director is overall responsible for compliance.



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

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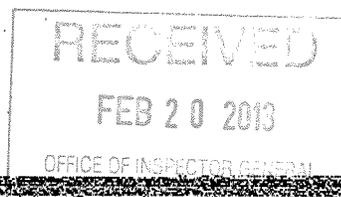
K 056 Continued From page 9
(1) Sprinklers installed throughout the premises
(2) Sprinklers located so as not to exceed maximum protection area per sprnkler
(3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.

K 056

Reference: NFPA 13 (1999 ed.)
5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of 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)

Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)	Maximum Allowable Distance of Deflector Obstruction (in.)
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

For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m.



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

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K 056 Continued From page 10
Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.)
5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.

K 056

K 073 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F
No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4

K 073

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

K73 NFPA 101 Life Safety Code Standard 2/18/13
It is the practice of Kindred Transitional Care and Rehabilitation - Northfield to have a policy to ensure combustible decorations were used in accordance with NFPA standards.

This STANDARD is not met as evidenced by:
Based on interview and policy review, it was determined the facility failed to have a policy to ensure that combustible decorations in the facility were used in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty (120) beds with a census of seventy eight (78) on the day of the survey.

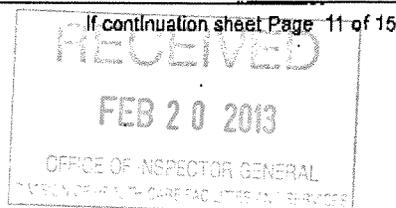
The findings include:

Policy review, on 01/08/13 at 12:16 PM, with the Maintenance Supervisor revealed the facility did not have a policy for treating combustible decorations in the facility with flame retardant material.

Interview, on 01/08/13 at 12:16 PM, with the Maintenance Supervisor revealed the facility did not have a policy or system in place to ensure the decorations were treated with a flame retardant material.

All residents had the potential of being affected by the lack of a policy on flammable materials. Kindred Healthcare has developed a policy as of 1/15/13 dealing with combustible decorations. Residents and responsible parties were notified by letter on 1/31/13. The staff was serviced on 2/4/13 by Maintenance director and he will include this information in the presentation to the new hire orientation.

The center will issue a letter on 1/31/13 to all residents and responsible parties with the policy on flammable materials in the center. The maintenance director and Executive



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

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K 073 Continued From page 11
Interview, on 01/08/13 at 3:45 PM, with the Administrator revealed the facility's corporate office had instructed the facility not to treat combustible decorations with flame retardant due to they could not be sure if the flame retardant was actually flame retardant.

Reference: NFPA 101 (2000 Edition).

21.7.5.4

Combustible decorations shall be prohibited unless they are flame-retardant.
Exception: Combustible decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present.

K 130 NFPA 101 MISCELLANEOUS
SS=D
OTHER LSC DEFICIENCY NOT ON 2786

This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to maintain the hazardous areas in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty (120) beds with a census of seventy eight (78) on the day of the survey.

The findings include:

Observation, on 01/08/13 at 1:47 PM, with the

K 073 Director will ensure during weekly rounds that rooms do not contain flammable materials. The rounds will be documented and reported to the safety committee for 12 months. Facility Angel rounds on 2/4/13 had information added to rounds about combustible materials in resident rooms to be reported to the morning meeting on a weekly basis.

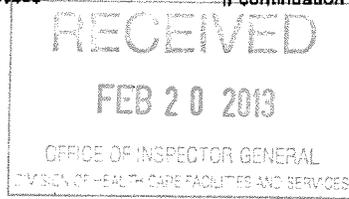
The maintenance director will present the results of his rounds to the Executive Director who will submit to the Performance Improvement committee for 12 months. The Executive Director is overall responsible for compliance.

K 130 This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

K130 NFPA 101 Miscellaneous 2/18/13
It is the practice of Kindred Transitional Care and Rehabilitation - Northfield to maintain the build up of lint in the dryers

All residents had the potential to be affected by this build up of lint in the dryer compartments. The top and bottom were cleaned completely on 1/8/13. The housekeeping supervisor in serviced all housekeeping staff on proper technique for cleaning dust from dryers on 2/4/13.



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

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K 130 Continued From page 12
Maintenance Supervisor revealed a heavy build-up of lint in the top and bottom of the dryers located in the Laundry Room.

Interview, on 01/08/13 at 1:47 PM, with the Maintenance Supervisor revealed the lint was cleaned on a regular basis but confirmed that it should be done more frequently.

Interview, on 01/08/13 at 3:47 PM, with the Administrator revealed they were aware of the requirements for keeping the dryers cleaned, but not aware the lint build-up was so excessive.

K 130 The maintenance director with housekeeping supervisor will check during weekly rounds that the dryer lint cleaning schedule is being followed. This will be recorded and reported to the safety committee for twelve months.

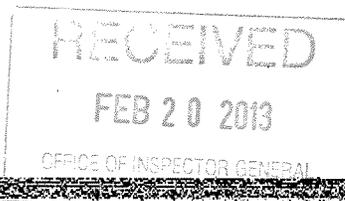
The maintenance director will present this report to the Executive Director to submit to the Performance Improvement committee for twelve months. The Executive Director is overall responsible for compliance.

NFPA 101 (2000 Edition) 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.

K 147 SS=D NFPA 101 LIFE SAFETY CODE STANDARD
Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

K 147

This STANDARD is not met as evidenced by:



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

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K 147 Continued From page 13
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 two (2) of seven (7) smoke compartments, residents, staff, and visitors. The facility is certified for one hundred twenty (120) beds with a census of seventy eight (78) on the day of the survey.

The findings include:

Observations, on 01/08/13 between 10:00 AM and 2:30 PM, with the Maintenance Supervisor revealed:

- 1) A microwave plugged into a power strip located in the Administrators Office.
- 2) A refrigerator plugged into an extension cord located in the Activities storage room.
- 3) An extension cord in use located in room #40.

Interview, on 01/08/13 between 10:00 AM and 2:30 PM, with the Maintenance Supervisor revealed they were aware of the proper use of power strips and extension cords but it was hard to monitor.

Interview, on 01/08/13 at 3:48 PM, with the Administrator revealed they were aware of the proper use of power strips and extension cords.

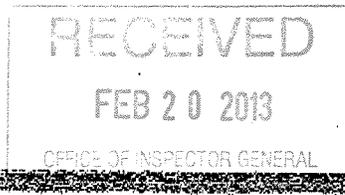
Reference: NFPA 101 (2000 Edition)

9.1.2 Electric.

K 147 *This Plan of Correction is the center's credible allegation of compliance.*

Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

K147 NFPA Life Safety Code Standard 2/18/13
It is the practice of Kindred Transitional Care and Rehabilitation - Northfield to ensure electrical wiring is maintained in accordance with NFPAS standards
All residents had the potential to be affected by improper power strips and extension cords. The power strip in the administrators office for a microwave oven was removed on 1/8/13, the refrigerator in the activity storage room had an outlet installed by a electrician on 1/10/13, and the extension cord was removed. Room #40's extension cord was removed from the lift chair and plugged into a wall outlet direct on 1/8/13
The Maintenance director on weekly rounds will check rooms, offices, and common areas for improper power strips or extension cords. A letter was sent to residents and responsible parties about not using extension cords or power strips. This letter was sent out on 01/31/13. A notice was posted in the employee breakroom and on the information boards by the time clock to inform staff about the improper use of extension cords and power strips in offices, resident rooms, and other areas of the center. The Maintenance director will document his findings from weekly rounds and report to the safety committee for twelve months.



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

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-NORTHFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222
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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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K 147 Continued From page 14
Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.

Reference: 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:
(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

Reference: NFPA 99 (1999 edition)
3-3.2.1.2 D
Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.

K 147 *This Plan of Correction is the center's credible allegation of compliance.*

Preparation and/or 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 deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

The maintenance director will report the findings to the Executive Director who will submit the findings to the Performance Improvement committee the findings for twelve months. The Executive Director is overall responsible for compliance

