RECEIVED JUN 2013 OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185436	A. BUILDING _____ B. WING _____	06/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARC OF OWENSBORO	2885 NEW HARTFORD RD OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted on 06/02/13 through 06/05/13 to determine the facility's compliance with Federal certification requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of a "E".	F 000	**Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.**	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157	**F 157 PHYSICIAN NOTIFICATION** **The facility shall immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is a need to alter treatment significantly.** **Criteria 1:** Resident #5's MD was notified of medication review request on 6/25/13 r/t falls and decline in ADL's. **Criteria 2**: All fall investigations for the past 30 days have been reviewed to determine that each attending MD was notified of fall committee recommendations requiring his/her assistance (i.e., written order, medication review, etc.) r/t changes in residents condition (such as ADL's). **Criteria 3:** The DON and ADON received in-service education on 6/25/13, as provided by the Corporate Nurse Consultant, which included, but was not limited to: MD notification of fall committee recommendations requiring MD assistance, and MD notifications (sent via fax, by phone call or in person) are to be documented in the resident's clinical record. Licensed nursing staff members have received in-service education on 7/5/13, 7/8/13, 7/10/13 and 7/11/13, as provided by the DON and/or ADON, which included, but was not limited to: MD notification of fall committee recommendations requiring MD assistance, and MD notifications (sent via fax, by phone call or in person) are to be documented in the resident's clinical record. Falls team will verify that MD notification is documented in	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 6/28/13

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 157	Continued From page 1 the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to immediately consult with the resident's physician a significant change in the resident's physical status for one resident (#5) in the selected sample of eleven residents. Findings include: A review of the Physician/Legal Representative Notification policy, revised 10/12, revealed the facility would immediately consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status. All notifications and/or attempted notifications would be documented in the nurse's notes. A record review revealed Resident #5 was admitted to the facility on 04/25/13, with diagnoses to include Alzheimer's Disease and Generalized Anxiety Disorder. A review of the initial Minimum Data Set (MDS), dated 05/07/13, revealed the facility assessed the resident as severely cognitively impaired and was independent with transfers and ambulation. The MDS revealed a restraint was not utilized for the	F 157	the nurses' notes as part of the follow-up evaluation. **Criteria 4:** The CQI indicator for the monitoring of MD notification will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON. **Criteria 5:** Target Date 7/12/13	7/12/13

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F 157	Continued From page 2 resident. A review of the Physician's Orders, dated 05/17/13, revealed an order for a urinalysis with culture and sensitivity (C&S). An order for Cipro (antibiotic) 500 milligrams (mg) twice daily for ten days was written 05/19/13. A review of the residents Activities of Daily Living (ADL) Assistance record, dated May 2013, revealed a decline was noted on 05/20/13 in the resident's ability to transfer and ambulate. The resident went from independent to extensive assistance in both tasks. The Physician's Orders, dated 05/21/13, revealed the resident was evaluated by Physical Therapy with treatment to begin for therapeutic exercises, therapeutic activities, and gait training. A review of the Event Report Investigations, dated 05/24/13, 05/25/13, 05/29/13, 05/30/13, and 05/31/13, revealed the resident sustained six falls after the noted decline in ADL's. Observations of Resident #5, on 06/03/13 at 9:30 AM, 10:30 AM, 1:30 PM, and 06/05/13 at 9:00 AM revealed the resident was up in the wheelchair with a pelvic restraint in use. Another observation on 06/04/13 at 9:15 AM, revealed two staff transferred the resident from the wheelchair to the bed utilizing a gait belt. An interview with the Physical Therapist, on 06/04/13 at 2:00 PM, revealed physical therapy was asked to evaluate Resident #5 due to frequent falls. The resident had been on antibiotics for a urinary tract infection (UTI), which	F 157		

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F 157	Continued From page 3 could have contributed to the decline in ADL's; however, the UTI had resolved and the resident did not improve as anticipated. She revealed the Director of Nursing (DON) was made aware of the concern with a request given to review the resident's medications for possible side effects causing an ADL decline. She was not sure if the physician had been notified of the request. An interview with the DON, on 06/05/13 at 11:15 AM, revealed she discussed having the physician review the resident's medications for a possible reduction on 05/24/13; however, she had no documented evidence of faxing the physician. She could not provide evidence where the physician had reviewed the resident's medications. An interview with the Primary Physician, on 06/05/13 at 8:45 AM, revealed he remembered the resident had increased falls and confusion; therefore a urinalysis was ordered. He revealed a decline in ADL's could be contributed to a UTI and would expect to be notified if symptoms did not improve after antibiotic therapy was completed. He could not recall notification of a continued decline with the resident after the UTI resolved. He could not recall being asked to review the resident's medications within the last few days.	F 157		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents	F 226	**F 226 STAFF TREATMENT OF RESIDENTS** **The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.** **Criteria # 1:** Resident #3 (BIMS score of 3) had a stop sign placed on her door on 6/10/13 to	

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F 226	Continued From page 4 and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observations interviews, record reviews and facility policy, it was determined the facility failed to ensure allegations and incidents of potential abuse/neglect were investigated related to three residents (Residents #3, #5 and #12) related to allegations of abuse, and falls from residents wandering. Resident #3 had two falls related to a resident coming into his/her room. findings include: Review of facility policy, titled Resident Abuse and dated 02/13, revealed; "Verbal Abuse" refers to any use of oral, written or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, agility to comprehend or disability. Facility Policy, Entitled Resident Safe Environment with a date of 12/07, states under "High Risk" follow low risk, moderate risk and general observations. (A) Evaluate need for protective devices with team; implement as per restraint/device use policy as needed. (B) Do not leave unattended in shower or bathroom. (C)	F 226	discourage wandering residents from entering his/her room and has had no further falls r/t pushing resident wheelchairs out of his/her room. Resident #5 (BIMS score of 3) is unable to recall details of the fall that occurred on 5/07/13. Resident A (BIMS score of 4) is unable to recall details of Resident #5's fall that occurred on 5/07/13. The male resident (he was unable to complete the BIMS interview) witnessed to be at the other end of the hall at the time of the fall is unable to recall any events from 5/07/13. Resident #5 has had no further falls with allegations of other residents being involved. Resident #12: The administrator initiated an investigation on 6/5/13 after an OIG team member reported to him an allegation of 'mental abuse' involving Resident #12. Resident #12 (BIMS score of 10) was interviewed on 6/5/13 by the MDS Coordinator; the resident denied any feelings of mental abuse r/t statements made by CNA #7. The administrator interviewed CNA #6 and LPN #4 on 6/5/13; neither employee used the term 'abuse' or 'mental abuse' when describing the event. The administrator completed his investigation for alleged mental abuse on 6/5/13 and found no evidence of mental abuse. **Criteria # 2:** All residents have the potential to be affected by this alleged deficient practice of investigating allegations of 'mental abuse'. All unwitnessed fall investigations from the past 30 days was completed by the DON and ADON on 6/26/13to determine if further investigating for potential abuse should be done. **Criteria # 3:** Administrative nursing staff and Social Service staff received in-service education on (date), as provided by the Administrator, which included, but was not limited to: (1) doing a thorough investigation of any falls, unwitnessed by staff, to rule out potential abuse; and (2) the facility's abuse policy and procedure. Charge nurses received in-service education on 7/5/13, 7/8/13, 7/10/13 and 7/11/13, as provided by the DON/ADON, which included, but was not limited to: (1) doing a thorough investigation of any falls,	

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F 226	Continued From page 5 Evaluate need for room near nursing station; relocate resident as needed. (D) Place "HIGH RISK" indicators on the care plan, chart and MAR. (E) Visually observe every hour (unless with visitors). Record Review revealed that Resident #3 was admitted to the facility on 08/14/08 with diagnoses to include; Senile Dementia, Alzheimer's Disease, Congestive Heart Failure, Generalized Anxiety, and Anemia. Review of Significant Change Minimum Data Set (MDS) assessment, dated 05/03/13, revealed the facility assessed the resident with severe cognitive impairment. Review of Event Report Investigations, dated 08/11/12 and 12/26/12, revealed Resident #3's falling was related to another resident wandering into Resident #3's room, and on 05/21/13 Resident #3 fell related to bed alarm not working properly that had been placed as an intervention from a fall on 1/25/13. A interview on 06/04/13 at 2:50 PM, and 06/05/13 at 12:10 PM, with Minimum Data Set Assessment Coordinator (MDS), revealed the facility does not do an investigation to determine cause if nothing is suspected, and she usually does not go back and look at each section after she puts the information in the care plans, and that the floor staff should be familiar with the high risk level related to falls. A interview on 06/05/13 at 11:20 AM, 12:00 PM, and 12:50 PM, with Director of Nursing revealed that there was no witness to Resident #3's falls on 08/11/12 and 12/26/12; or Resident #9's falls on 02/08/13 and 05/21/13. The DON further	F 226	unwitnessed by staff, to rule out potential abuse; and (2) the facility's abuse policy and procedure. **Criteria # 4:** The QA Indicator tool for the monitoring of compliance with the facility's Abuse policy shall be utilized monthly X 2 months and then annually and prn as per established QA calendar under the supervision of the Administrator. **Criteria # 5:** Target Date 7/12/13	7/12/13

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F 226	Continued From page 6	F 226		

stated the morning meeting goes over falls to discuss what happened and to decide on what interventions to implement, and to discuss if the falls were related to the resident's dementia. The DON said she use to check batteries in the alarms but she hadn't done this in a while, but it was her responsibility to do so. Additionally, the DON stated she didn't do any investigation because Residents #3 and #9 have dementia, and "you can't provide one on one, in an ideal world you would have two people providing care and one touring but we don't always have staff that can provide that constant supervision."

A interview on 06/05/13 at 12:38 PM, with Corporate Nurse revealed that the facility has no policy related to supervision.

A Record Review of Resident #3's Care Plan dated 05/08/13 and entitled, At Risk for Falls, states, "Apply Sensor alarms to alert staff of unattended transfer attempts, check for proper function each time applied, and Falls Committee to review care plan when a fall or 'near fall' occurs and attempt to determent the root cause. Rule out systemic problems. Alter/remove any potential causes if possible. Notify direct care staff of changes and high risk fall status per facility protocol."

Review of Certified Nurse Aide (CNA) care plan dated 06/13 revealed that Resident #3 has a personal safety alarm when in bed.

A record review revealed Resident #5 was admitted to the facility on 04/25/13 with diagnoses to include Alzheimer's Disease and Generalized Anxiety Disorder. A review of the initial MDS,

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F 226	Continued From page 7 dated 05/07/13, revealed the facility identified Resident #5 as severely cognitively impaired. A review of the Event Report Investigation, dated 05/07/13, revealed another resident reported Resident #5 was knocked down on the floor by "a man." The investigation indicated a recommended intervention of physical therapy to screen the resident; however, it did not address the allegation of "a man" knocking the resident down. An interview with LPN #5, on 06/05/13 at 10:00 AM, revealed she was the nurse investigating the fall on 05/07/13. Resident #A reported Resident #5 had been pushed and fell. When I found the resident, he/she was on the floor and stated a "man" had pushed him/her. There was one male resident in sight; however, he would not have been able to get so far up the hall after pushing Resident #5 onto the floor. Additionally, LPN #5 revealed that male resident was not "normally aggressive." She revealed no interview with the male resident was attempted. She further revealed Resident #A changed the story after asking for a second time, stating Resident #5 tripped and fell. She did not complete a written investigation on the allegation. An interview with the DON, on 06/05/13 at 11:15 AM, revealed she remembered the discussion of the fall that occurred on 05/07/13. She revealed both residents, Resident #A and Resident #5 had dementia; therefore, it was discussed whether or not the allegation actually occurred. She stated	F 226		

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F 226	Continued From page 8 there "possibly" should have been an investigation on the incident. An interview with the Administretor, on 06/05/13 at 12:00 PM, revealed he could not recall the particular incident involving Resident #5. He expected the incident be investigated with the fall. A record review revealed Resident #12 was admitted to the facility on 03/07/12 with diagnoses to include Congested Heart Failure (CHF) and Senile Dementia. A review of the quarterly Minimum Data Set (MDS), dated 05/22/13, revealed the facility identified the resident as moderately cognitively impaired. An interview with CNA #6, on 06/03/13 at 10:45 AM, revealed Resident #12 reported to him an allegation of "mental abuse" about two months ago. He revealed another CNA eliegedly told the resident he/she used the bathroom "too much." CNA #6 revealed he reported the allegation to LPN #4; however, he was unsure of what happened afterwards. An interview with LPN #4, on 06/03/13 at 11:10 AM, revealed she received a report that a CNA from a different shift told the resident he/she went to the bathroom "a lot"; however, she did not consider it abuse. She did not investigate the incident. An interview with Resident #12, on 06/03/13 at 1:00 PM, revealed CNA #7 told him/her "You go	F 226		

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F 226	Continued From page 9 to the bathroom too often." The resident revealed he/she assumed CNA #7 just did not want to take him/her. An interview with CNA #7, on 06/05/13 at 11:00 AM, revealed the incident happened about a month and a half ago. She revealed Resident #12 told her he/she was having to go more often to the bathroom as his/her fluid restrictions had been lifted. CNA #7 stated she told the resident she could tell because they were having to take him/her to the bathroom every hour, which was unusual. She revealed various staff members were reporting she was going to "get in trouble" for telling the resident he/she was going to the bathroom too often. She reported immediately to the Director Of Nursing (DON) as the allegation was not true. An interview with the DON, on 06/05/13 at 11:15 AM, revealed CNA #7 came to her and reported rumors that she was "not very nice" with Resident #12; however, she was just joking. She could not remember when the report was made. She revealed an investigation was not initiated; however, there "probably" should have been. An interview with the Administrator, on 06/05/13 at 12:00 PM, revealed he was not aware of the situation involving Resident #12 until reported by the state surveyor, on 06/03/13. He revealed the facility was to investigate any allegation of abuse; however, he did not feel this situation was considered abuse. He revealed it should have	F 226		

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F 226	Continued From page 10 been investigated as a "grievance."	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, interviews and facility policy, it was determined the facility failed to promote dignity for one resident (Resident #6), in a selected sample of eleven (11). The facility failed to ensure an environment that promoted dignity for Resident #6 while resident was eating lunch. Resident #6 was eating lunch in his/her room while feces was present on the floor and in resident's closet. Findings Include: A record review revealed Resident #6 was admitted to the facility on 10/17/11 with diagnoses to include: Cholecystitis, Abdominal Pain, and Disease of gallbladder. Review of the quarterly Minimum Data Set (MDS) dated 03/15/13, revealed the facility identified the resident as moderately cognitively impaired. An observation and interview on 06/02/13 at 12:05 PM, with a family member revealed that a Certified Nurse Aide (CNA) #4 was informed of the feces on floor in residents room at approximately 11:30 AM on 06/02/13. An	F 241	**F 241 DIGNITY AND RESPECT OF INDIVIDUALITY** **The facility shall promote care for the 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.** **Criteria # 1:** The floor in Resident #6's room is free of offensive odors and/or debride while eating. **Criteria # 2:** All residents eating meals in their rooms have the potential to be affected by this alleged deficient practice. **Criteria # 3:** Nursing and Housekeeping staff members have received in-service education on timeliness of cleaning up offensive debride in resident rooms, especially during meals as provided by the DON and/or ADON on 7/5/13, 7/8/13, 7/10/13 and 7/11/13. **Criteria # 4:** The QA indicator tool for the monitoring of dignity during meal service shall be utilized Weekly X 4 weeks, then monthly X 2 months and then quarterly as per established QA calendar under the supervision of the DON. **Criteria # 5:** Target Date 7/12/13	7/12/13

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F 226	Continued From page 10 been investigated as a "grievance."	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, interviews and facility policy, it was determined the facility failed to promote dignity for one resident (Resident #6), in a selected sample of eleven (11). The facility failed to ensure an environment that promoted dignity for Resident #6 while resident was eating lunch. Resident #6 was eating lunch in his/her room while feces was present on the floor and in resident's closet. Findings Include: A record review revealed Resident #6 was admitted to the facility on 10/17/11 with diagnoses to include: Cholecystitis, Abdominal Pain, and Disease of gallbladder. Review of the quarterly Minimum Data Set (MDS) dated 03/15/13, revealed the facility identified the resident as moderately cognitively impaired. An observation and interview on 06/02/13 at 12:05 PM, with a family member revealed that a Certified Nurse Aide (CNA) #4 was informed of the feces on floor in residents room at approximately 11:30 AM on 06/02/13. An	F 241	**F 241 DIGNITY AND RESPECT OF INDIVIDUALITY** **The facility shall promote care for the 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.** **Criteria # 1:** The floor in Rosident #5's room is free of offensive odors and/or debride while eating. **Criteria # 2:** All residents eating meals in their rooms have the potential to be affected by this alleged deficient practice. **Criteria # 3:** Nursing and Housekeeping staff members have received in-service education on timeliness of cleaning up offensive debride in resident rooms, especially during meals as provided by the DON and/or ADON on 7/5/13, 7/8/13, 7/10/13 and 7/11/13. **Criteria # 4:** The QA indicator tool for the monitoring of dignity during meal service shall be utilized Weekly X 4 weeks, then monthly X 2 months and then quarterly as per established QA calendar under the supervision of the DON. **Criteria # 5:** Target Date 7/12/13	7/12/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185436	A. BUILDING _____ B. WING _____	06/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARC OF OWENSBORO	2885 NEW HARTFORD RD OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 11 observation in the residents room revealed there was feces in the closet, and a foot print of feces on the carpet approximately three (3) feet from where the resident was eating lunch. An interview on 06/02/13 at 12:55 PM, with a housekeeper revealed the family member informed her of the feces in the residents room at 12:45 PM after no one had come to clean it up. The housekeeper further stated at 1:20 PM that she had just finished cleaning the room. An interview on 06/02/13 at 1:23 PM, with Resident #6's family member, revealed that the residents room had just been cleaned by the housekeeper. An interview on 06/04/13 at 11:10 AM, with CNA #4, revealed Resident #6's family told her about something being on the floor in the resident s room. CNA #4 further stated that she did not inform anyone of this Issue after being told by the family. An interview on 06/05/13 at 12:15 PM, with Licensed Practical Nurse (LPN) #1, revealed that she expected feces to be cleaned up immediately or staff to find someone to clean it up. An interview on 06/05/13 at 12:38 PM, with the Corporate Registered Nurse (RN), revealed the facility did not have a policy on dignity but followed the employee handbook. Employee Handbook Information entitled Resident's Bill of Rights under the heading of Resident Rights revealed "Nursing facility	F 241		

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	185436	A. BUILDING _____ B. WING _____	06/05/2013

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F 241	Continued From page 12 residents generally require a greater deal of dignity, privacy, and choice to sustain them. Our residents tend to thrive when their sense of integrity and self-esteem are kept intact, corresponding response to provide an environment which fosters basic personal integrity. It is in this spirit that the Resident Bill of Rights serves as a mechanism to guide and sustain our efforts in attaining and maintaining an individual's dignity while he or she is a resident in our facility."	F 241		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and facility policy, it was determined the facility failed to ensure physician orders were followed for one resident (Resident #9), in a selected sample of eleven (11). The facility failed to ensure Resident #9's geri-sleeves were applied according to physician orders. Findings Include: A record Review revealed that Resident #9 was admitted to the facility on 12/27/11, with diagnoses to include Hypertension, Orthostatic Hypotension, B-12 Deficiency, Hyperlipidemia, Senile Dementia, Hypothyroidism, and Paralysis Agitans. Review of quarterly Minimum Data Set	F 281	**F 281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS** **The services provided or arranged by the facility shall meet professional standards of quality.** **Criteria #1:** Resident # 9's geri-sleeves were discontinued on 6/4/13 due to resident choosing not to wear them; and was at risk for self inflicted injuries when removing them him/herself. **Criteria #2:** An audit of resident care plans was completed on 6/27/13 by Staff Development Coordinator to identify any residents that may need revisions in physician orders due to choosing not to comply. **Criteria #3:** All licensed nurses received in-service education on 7/5/13, 7/8/13, 7/10/13 and 7/11/13 as provided by the DON and/or ADON on obtaining physician order to d/c protective equipment when a resident repetitively chooses not to wear it; and conveying that information to the care plan team so that an alternative can be considered if necessary. **Criteria #4:** The CQI indicator for monitoring use of protective equipment in accordance with physician orders shall be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON. **Criteria #5:** Target Date 7/12/13	7/12/13

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F 281	Continued From page 13 assessment (MDS) dated 5/3/13 revealed the resident to be moderately cognitively impaired. An observation on 06/04/13 at 10:54 AM, and at 2:58 PM, revealed Resident #9 did not have on bilateral arm protectors (geri sleeves). A review of Physician Telephone Orders dated 01/26/13, revealed a order for Resident #9 to have "arm protectors to bilateral arms at all times." Further review of Physician Orders dated June 2013, revealed under Safety Device heading "Arm Protectors to bilateral arms at all times." An interview on 06/04/13 at 3:10 PM, with a Licensed Practical Nurse (LPN) #2 revealed that Resident #9 did not have on his/her geri-sleeves. An interview on 06/05/13 at 11:20 AM, with Director of Nursing (DON), revealed that physician orders should be carried out and transposed to care plans, but sometimes this does not get carried over monthly. DON further stated that it was ultimately her responsibility to make sure that it was done.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 282	**F 282 SERVICES PROVIDED BY QUALIFIED PERSONS/PER CARE PLAN** **The services provided or arranged by the facility shall be provided by qualified persons in accordance with each resident's written plan of care.** **Criteria #1:** Resident # 1's hand protectors were discontinued on 6/4/13 due to resident choosing not	

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	185436	A. BUILDING _____ B. WING _____	06/05/2013

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F 282	Continued From page 14 by: Based on observations, interviews, record reviews and facility policy, it was determined that the facility failed to ensure care plans were implement related to protective devices for two (2) residents (Resident #1 and Resident #9), in a selected sample of eleven (11). The facility failed to ensure bilateral hand protectors and heel protectors for Resident #1, and bilateral arm protectors for Resident #9 were implemented according to care plan and doctor orders. Findings Include: A record review revealed Resident #1 was admitted to the facility on 03/29/10, with diagnoses to include generalized anxiety disorder, depression, ischemia heart disease, senile dementia, dementia with agitation, depression, depression with agitation, depression, and SBD (skin break down). A review of the Minimum Data Set (MDS) assessment dated 03/08/13, revealed the resident was identified as severely cognitively impaired. An observation on 06/02/13 at 12:32 PM, revealed Resident #1 sitting in geri chair with no bilateral hand protectors on, and one sock on right foot and no heel protectors on. Further observations of Resident #1 revealed on 06/03/13 at 11:55 AM, and 2:00 PM, and on 06/04/13 at 10:00 AM, 10:55 AM, and on 06/05/13 at 10:50 AM, revealed Resident #1 sitting in Geri chair with no hand or heel protectors on. An interview on 06/04/13 at 10 :15 AM, with a	F 282	to wear them; and was at risk for self inflicted injuries when removing them him/herself; resident continues to remove heel protectors at times, staff monitors for proper application when providing care. Resident #9 geri-sleeves were discontinued on 6/4/13 due to resident choosing not to wear them; and was at risk for self inflicted injuries when removing them him/herself. **Criteria #2:** An audit of all comprehensive care plans and CNA Care Plan Records was completed on 6/27/13 by Staff Development Coordinator to determine that they accurately reflected each resident's current use of protective equipment/safety devices. Residents with orders and care plan for protective equipment/safety devices were checked on 6/27/13 by Staff Development Coordinator to determine that equipment/devices were being used properly. **Criteria #3:** All nursing staff members received in-service education on 7/5/13, 7/8/13, 7/10/13 and 7/11/13 as provided by the DON and/or ADON that included but was not limited to: (1) implementation and monitoring of protective equipment/safety devices (i.e., geri-sleeves, hand protectors, heel protectors, etc.) in accordance with resident's written plan of care, (2) checking for proper placement of protective equipment/safety devices, and (3) obtaining physician order to discontinue protective equipment/safety devices when a resident repetitively chooses not to wear/use equipment/device. **Criteria #4:** The CQI indicator for the monitoring of care be provided by qualified persons in accordance with each resident's written plan of care shall be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON. **Criteria #5:** Target Date 7/12/13	7/12/13

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	185436	A. BUILDING _____ B. WING _____	06/05/2013

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F 282	Continued From page 15 Certified Nurse Aide (CNA) #3, revealed Resident #1 did not have on any heel protectors or bilateral hand protectors. An interview on 06/04/13 at 10:55 AM, 11:10 AM and 3:10 PM with Licensed Practical Nurse #2 revealed Resident #1 should have all protective garments on, and it was documented on the Certified Nurse Aide (CNA) Care Plan, and they were trying to find some heel protectors to put on Resident #1. Review of CNA care plan dated 06/13 revealed under heading of skin, heel protectors and bilateral hand protectors were documented as being ordered for the resident. A review of May and June 2013 Physician orders reveal that bilateral hand protectors are to be on Resident #1 when up in Geri chair and heel protectors are to be on resident at all times. A review of care plan entitled, Potential for Pressure Ulcer Development dated 4/20/13, and care plan initiated 11/12/12 entitled, At risk for falls/injury revealed that Resident #1 was to "use heel protectors at all times" and "Keep bilateral hand protectors on when up in geri chair." 2. A record Review revealed that Resident #9 was admitted to the facility on 12/27/11, with diagnoses to include Orthostatic Hypotension, B-12 Deficiency, Hyperlipidemia, Senile Dementia, and Paralysis Agitans. Review of the quarterly Minimum Data Set (MDS) assessment dated 5/3/13, revealed the resident was identified as moderately cognitively impaired	F 282		

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F 282	Continued From page 16 An observation on 06/04/13 at 10:54 AM, and 2:58 PM, revealed Resident #9 did not have bilateral arm protectors (geri sleeves) on. A review of Physician Telephone Orders dated 01/26/13, revealed Resident #9 to have "Arm protectors to bilateral arms at all times." Further review of Physician Orders dated June 2013, reveal under Safety Device heading " Arm Protectors to bilateral arms at all times." A review of Resident #9's Comprehensive Care Plans dated 5/9/13 revealed problems to include; "at risk for altered nutrition, altered thought process and impaired communication, potential for pressure ulcer development, at risk for side effects related to use of anticoagulants, activities of daily living (ADL) and self care performance deficit, at risk for fall/injury. Furthermore, the Certified Nurse Aide (CNA) Care Plan dated 6/13 revealed the physician order for the bilateral arms protectors had been omitted from the CNA care plan. A interview on 06/04/13 at 3:10 PM, with Licensed Practical Nurse (LPN) #2 revealed that Resident #9 did not have on geri-sleeves. A interview on 06/05/13 at 11:20 AM, and 12:00 PM, with Director of Nursing (DON) revealed that physician orders should be carried out and transposed to care plans, and sometimes this does not happen. DON further stated that it was ultimately her responsibility to make sure that it was done. A interview on 06/05/13 at 12:15 PM, with LPN #1, revealed that she expected CNA's to follow	F 282		

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F 282	Continued From page 17 CNA care plans for protective devices and for the physician orders to be transcribed to the care plans and updated as the residents needs changed. A interview on 06/05/13 at 12:38 PM, with Corporate Nurse revealed that there was no policy related to following care plan.	F 282		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy it was determined the facility failed to provide a prescribed diet for one resident (Resident #7) in the selected sample of eleven. The facility failed to provide the resident with the prescribed mechanically altered diet as ordered by the physician. Findings Include: A record Review reveals that Resident #7 was admitted to the facility on 10/10/12, with diagnoses to include Acute but ill-defined Cerebral Vascular Disease, Abnormal gait, Hypertension, Cerebral Vascular Accident, Dementia, Seizure Disorder, and Dysphagia (difficulty swallowing, talking). A review of the Minimum Data Set (MDS) dated 10/22/12, revealed the facility identified the resident as severely cognitively impaired.	F 367	**F 367 THERAPEUTIC DIETS** **Therapeutic diets must be prescribed by the attending physician** **Criteria #1:** Resident #7 is receiving her meats ground with all meals. **Criteria #2:** All resident receiving ground meats have the potential to be affected by this alleged deficient practice. **Criteria #3:** The dietary department has discontinued the practice of serving crisp bacon that is to be crumbled by staff for residents that are to receive a therapeutic diet with ground meats. Dietary staff members have received educational in-servicing on following prescribed therapeutic diets on 7/10/13) as provided by the certified dietary manager (CDM). **Criteria #4:** The CQI indicator for the monitoring of tray accuracy in following therapeutic diets will be utilized weekly X 4 weeks, then monthly as per the established CQI calendar under the supervision of the CDM. **Criteria #5:** Target Date 7/12/13	7/12/13

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F 367	Continued From page 18	F 367		

A record review of the facility's dietary policy as description of Dysphagia Mechanical Altered (level 2) diet. "This diet is used for people who have difficulty chewing regular textured foods. Foods that are difficult to chew are chopped, ground, shredded and/or cooked to make them easier to chew and swallow (Dorner, p. 25). Foods allowed "Meats ground or chopped to less than ¼ inch cubes, foods to avoid; Dry, tough meat, or any other whole pieces of meat (Dorner, p. 26)."

An observation 06/03/13 at 8:22 AM, revealed Resident #7 sitting in wheelchair at a table in the Dining Room eating breakfast with 3 strips of bacon on his/her plate.

Further observation on 06/05/13 at 8:20 AM, revealed Resident #7 sitting in the dining room in a wheelchair at the table with a breakfast plate in front of him/her with one strip of bacon, scrambled eggs, toast with jelly, coffee, orange juice and partially eaten banana, also observed on table beside plate was a handful of chewed food.

An interview on 06/03/13 at 8:24 AM, with a Licensed Practical Nurse (LPN) #3, revealed this was the usual breakfast for Resident #7.

An interview on 06/05/13 at 8:20 AM, with Dietary Manager revealed Resident #7 prefers bacon so the "resident receives 2 strips of bacon, which we cooked crispy and will break apart, it is considered mechanical soft."

An interview on 06/05/13 at 9:19 AM, with Speech

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F 367	Continued From page 19 Therapist (ST) revealed ST performed an evaluation on Resident #7 on 05/30/13, and the justification for skilled services was "to increase safety and efficiency of swallowing, recommendations post evaluation, mechanical soft textures." An interview per telephone on 06/05/13 at 10:20 AM, with the Registered Dietician (RD) revealed mechanical soft with ground meat requires that solid meat is ground up with a grinder in the kitchen and that a strip of bacon is not considered a ground meat. A interview on 06/05/13 at 12:09 PM, with the Director of Nurses (DON) revealed strips of bacon are not considered ground meat. A record Review of the Physician Telephone order dated 5/30/13 revealed an order to change Resident #7's diet to Mechanical soft with ground meat. A review on 06/04/13 at 8:33 AM, revealed Resident #7's diet meal ticket to say Mechanical soft w/ground meat. A record review of Resident #7's Comprehensive Care Plan dated 05/30/13 revealed change diet to mech soft with ground meat.	F 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185436	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01. PLAN APPROVAL: 1990. SURVEY UNDER: 2000 Existing. FACILITY TYPE: SNF/NF. TYPE OF STRUCTURE: One (1) story, Type III (200). SMOKE COMPARTMENTS: Five (5) smoke compartments. FIRE ALARM: Complete fire alarm system installed in 1990, with 85 smoke detectors and 5 heat detectors. SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1990. GENERATOR: Type II generator installed in 1990. Fuel source is Diesel. A standard Life Safety Code survey was conducted on 06/04/13. Wellington Parc of Owensboro was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Forty-Four (44) beds with a census of Forty-Two (42) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from	K 000	Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 6/28/13

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

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K 000	Continued From page 1 Fire). Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for Forty-Four (44) beds with a census of Forty-Two (42) on the day of the survey. The facility failed to ensure four (4) egress doors had the proper signage for delayed egress doors. The findings include: Observation, on 06/04/13 at 1:45 PM with the Administrator and Maintenance Director, revealed four (4) glass egress doors equipped with a clear background delayed egress sign. Interview, on 06/04/13 at 1:45 PM with the	K 038	K038 – Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1 19.2.1 Criteria 1 –The facility is requesting approval under NFPA 101 19.2.2.2.4 Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. Upon review and approval of the deputy State Fire Marshal, and based on the facility resident population, for the safety of the residents, the delayed egress has been changed on all exit doors and the delayed egress signs have been removed on the exit doors. Criteria 2 – All exit doors have been changed from delayed egress to a special locking arrangement and have had the delayed egress signs removed. Criteria 3 – All staff have received in-service education on 7/10/13 by the Administrator to assure that they can readily unlock all exit doors at all times. Criteria 4 – The Administrator will use the CQI Indicator, ES-3 monthly X 2 then quarterly thereafter to assure that exit access is arranged so that exits are readily accessible at all times. Criteria 5 -	7/12/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185436	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARC OF OWENSBORO	2886 NEW HARTFORD RD OWENSBORO, KY 42303

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K 038	Continued From page 2 Administrator and Maintenance Director, revealed they were unaware the doors were required to have signage with a contrasting background. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in	K 038		

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K 038	Continued From page 3 accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.	K 038		

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K 038	Continued From page 4 (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS NFPA 101 LIFE SAFETY CODE STANDARD	K 038		
K 056 SS=F	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, record review, 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 five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for Forty-Four (44) beds with a census of Forty-Two (42) on the day of the survey. The facility failed to ensure	K 056	K056 – 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. Criteria 1 – The areas identified during the survey where the sprinkler heads were blocked by the light fixtures and skylights that were not sprinklered have been corrected by the facility sprinkler service contractor. Criteria 2 – All areas of the facility have been inspected by the Administrator and the sprinkler service contractor to assure there are no other areas not properly covered by our sprinkler system. Criteria 3 – The Maintenance Director has received in-service education on 7/10/13 by the Administrator to assure there are no areas in the building that are not properly covered by our sprinkler system. Criteria 4 – The CQI Indicator, ES-3 which includes assuring that there is proper sprinkler coverage in all areas of the building shall be completed by the Administrator monthly X 2, then quarterly thereafter. Criteria 5	7/12/13

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	185436	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/04/2013

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K 056	Continued From page 5 sprinkler heads were not blocked by light fixtures and located in the areas for the skylights. The findings include: Sprinkler record review, on 06/04/13 at 1:15 PM with the Administrator and Maintenance Director, revealed sprinkler heads located throughout the facility were blocked by light fixtures, within 1 foot of the sprinkler head, extending below the sprinkler heads. This was also noted on the April 2013 quarterly sprinkler report. Observation revealed skylight areas in the facility that did not have proper sprinkler protection. Interview, on 06/04/13 at 1:15 PM with the Administrator and Maintenance Director, revealed the facility had a bid from the sprinkler company to complete the work noted. The bid had not been accepted at the time of the survey to complete the work. 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) Maximum Allowable Distance Distance from Sprinklers to of Deflector above Bottom of	K 056		

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K 056	Continued From page 6 Side of Obstruction (A) (B — Obstruction (in.) Less than 1 ft — 0 1 ft to less than 1 ft 6 in. — 21/2 1 ft 6 in. to less than 2 ft — 31/2 2 ft to less than 2 ft 6 in. — 51/2 2 ft 6 in. to less than 3 ft — 71/2 3 ft to less than 3 ft 6 in. — 91/2 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 — 161/2 5 ft and greater — 18 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). 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 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on sprinkler record review, and interview it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for Forty-Four (44) beds with a census of Forty-Two (42) on the day of the survey. The	K 062	K062 – Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. Criteria 1 – The facility sprinkler service contractor inspected sprinkler check valve on 6/27/13 and determined the backflow device to be testable and the backflow test was completed on 6/20/13. Criteria 2 – There are no other check valves or backflow devices to be inspected by the sprinkler service contractor. Criteria 3 – The Maintenance Supervisor received in-service education from the Administrator on 6/27/13 to assure the sprinkler check valve will be properly inspected and the backflow test competed per the NFPA 101 life safety code. Criteria 4 – The CQI Indicator, ES-3 which insures that the sprinkler inspections are properly conducted on a timely basis by our sprinkler service contractor	

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	185436	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/04/2013

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K 062	Continued From page 7 facility failed to ensure the check valve in the sprinkler system was inspected within the past five (5) years and the backflow device was testable. The findings include: Sprinkler record review, on 06/04/13 at 1:15 PM with the Administrator and Maintenance Director, revealed the facility failed to provide documentation that the check valve for the sprinkler system had been inspected within the last 5 years. This was listed on the quarterly sprinkler check in April of 2013. Further observation revealed the sprinkler company report noted the backflow device was intestable because it was missing the #1 test port. Interview, on 06/04/13 at 1:15 PM with the Administrator and Maintenance Director, revealed they had received a bid to complete the work that was noted on the sprinkler report. The bid had not been approved to complete the work. Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected,	K 062	will be completed by the Administrator monthly X 2 then quarterly thereafter. Criteria 5 -	7/12/13

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K 062	Continued From page 8 tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1	K 062		

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K 062	Continued From page 9 Obstruction investigation Maintenance 5 years or as needed Chapter 10 Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Component Activity Frequency Reference Control Valves Sealed Inspection Weekly 9-3.3.1 Locked Inspection Monthly 9-3.3.1 Exception No. 1 Tamper switches Inspection Monthly 9-3.3.1 Exception No. 1 Alarm Valves Exterior Inspection Monthly 9-4.1.1 Interior Inspection 5 years 9-4.1.2 Strainers, filters, orifices Inspection 5 years 9-4.1.2 Check Valves Interior Inspection 5 years 9-4.2.1 Preaction/Deluge Valves Enclosure (during cold weather) Inspection Daily/weekly 9-4.3.1 Exterior Inspection Monthly 9-4.3.1.2 Interior Inspection Annually/5 years 9-4.3.1.3 Strainers, filters, orifices Inspection 5 years 9-4.3.1.4 Dry Pipe Valves/Quick-Opening Devices Enclosure (during cold weather) Inspection Daily/weekly 9-4.4.1.1 Exterior Inspection Monthly 9-4.4.1.3 Interior Inspection Annually 9-4.4.1.4 Strainers, filters, orifices Inspection 5 years 9-4.4.1.5 Pressure Reducing and Relief Valves Sprinkler systems Inspection Quarterly 9-5.1.1 Hose connections Inspection Quarterly 9-5.2.1	K 062		

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K 062	Continued From page 10 Hose racks Inspection Quarterly 9-5.3.1 Fire pumps Casing relief valves Inspection Weekly 9-5.5.1, 9-5.5.1.1 Pressure relief valves Inspection Weekly 9-5.5.2, 9-5.5.2.1 Backflow Prevention Assemblies Reduced pressure Inspection Weekly/monthly 9-6.1 Reduced pressure detectors Inspection Weekly/monthly 9-6.1 Fire Department Connections Inspection Quarterly 9-7.1 Main Drains Test Annually 9-2.6, 9-3.4.2 Waterflow Alarms Test Quarterly 9-2.7 Control Valves Position Test Annually 9-3.4.1 Operation Test Annually 9-3.4.1 Supervisory Test Semiannually 9-3.4.3 Preaction/Deluge Valves Priming water Test Quarterly 9-4.3.2.1 Low air pressure alarms Test Quarterly 9-4.3.2.10 Full flow Test Annually 9-4.3.2.2 Dry Pipe Valves/Quick-Opening Devices Priming water Test Quarterly 9-4.4.2.1 Low air pressure alarm Test Quarterly 9-4.4.2.6 Quick-opening devices Test Quarterly 9-4.4.2.4 Trip test Test Annually 9-4.4.2.2 Full flow trip test Test 3 years 9-4.4.2.2.1 Pressure Reducing and Relief Valves Sprinkler systems Test 5 years 9-5.1.2 Circulation relief Test Annually 9-5.5.1.2 Pressure relief valves Test Annually 9-5.5.2.2 Hose connections Test 5 years 9-5.2.2 Hose racks Test 5 years 9-5.3.2 Backflow Prevention Assemblies Test Annually 9-6.2	K 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 062	Continued From page 11 Control Valves Maintenance Annually 9-3.5 Preaction/Deluge Valves Maintenance Annually 9-4.3.3.2 Dry Pipe Valves/Quick-Opening Devices Maintenance Annually 9-4.4.3.2	K 062		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of	K 066	K066 – Smoking regulations are adopted and followed. Criteria 1 – The area around the employee smoking area has been cleaned of all cigarette butts. Criteria 2 – There were no other areas affected by this deficiency. Criteria 3 – All staff received in-service education on 7/10/13 by the Administrator informing them of the facility policy to use only approved ashtrays. Criteria 4 – The CQI Indicator, ES-3 will be used by the Administrator to assure that only approved ashtrays are used in designated smoking areas. Criteria 5 -	7/12/13

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K 066	Continued From page 12 approved ashtrays at an entrance, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for Forty-Four (44) beds with a census of Forty-Two (42) on the day of the survey. The facility failed to ensure the smoker poles were being utilized at the facility smoking area. The findings include: Observation, on 06/04/13 at 2:45 PM with the Administrator and Maintenance Director, revealed the smoking area had the approved smoker poles but over two dozen cigarette butts were on the ground in the gravel area between the smoking area and the facility. Interview, on 06/04/13 at 2:45 PM with the Administrator and Maintenance Director, revealed they were not aware the cigarette butts were being thrown on the ground in the gravel area. Reference: NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.	K 066		

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K 066	Continued From page 13 Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066		