

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

PRINTED: 07/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2013
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NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 425 ISLAND FORD ROAD MADISONVILLE, KY 42431
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS A recertification/abbreviated (KY #20360) survey was conducted on 06/26/13 through 06/28/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of a "D". KY #20360 was substantiated with no deficiencies cited.	F 000	Preparation and execution of this plan of Correction does not constitute an admission of 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 solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge deficiencies below is not an admission that the alleged facts occurred as presented in the statements.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	<u>F 164 D PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</u> <i>Residents Found to Have Been Affected</i> Licensed Practical Nurse (LPN) #1 was educated on the Dignity/Respect Policy by the Director of Nursing on 06/28/13. Licensed Practical Nurse (LPN) #2 received in-service education on the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X9) DATE *07/29/2013*

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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NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 ISLAND FORD ROAD MADISONVILLE, KY 42431	
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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure personal privacy during resident care for two (2) residents (#1, #8) in the selected sample of nineteen (19) residents. Review of the Dignity/Respect policy, revised 10/04/11, revealed appropriate measures would be taken to assure that residents were treated in a courteous and dignified manner. Drape properly during care and procedures to avoid exposure and embarrassment. Use curtains or screens during care and procedures. 1. Observation of Resident #8, on 06/27/13 at 1:50 PM, revealed Licensed Practical Nurse (LPN) #1 removed the resident's shirt and bra for a skin assessment; however, she did not close the window blinds in the room. The facility's courtyard could be viewed from the windows. Record review revealed Resident #8 was admitted to the facility on 02/05/13 with diagnoses to include Alzheimer's Disease, Dementia, and Anxiety. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/10/13, revealed the facility identified the resident as moderately cognitively impaired. An interview with Resident #8, on 06/28/13 at 9:00 AM, revealed he/she would feel more comfortable with the window blinds closed during care as it would be an "invasion of privacy" if	F 164	Dignity/Respect Policy by the Director of Nursing on 06/28/13. <i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected by F 164. Systemic and Monitoring actions listed below will include all residents who have the potential to be affected. All residents were interviewed on July 17 - 19, 2013 to solicit any concerns relating to dignity. <i>Systemic Changes</i> All licensed nurses were educated on the Dignity/Respect Policy by the Director of Nursing on July 1-2, 2013. All nursing department personnel were educated on the Dignity/Respect Policy on July 1-19, 2013. On July 18, 2013 the Social Services Department conducted random audits three times each week to determine compliance with personal privacy. <i>Monitoring</i> The Administrator will review all concerns with the Social Services Director at the daily Continuous Quality Improvement (CQI) meeting to verify that the Dignity/Respect Policy is followed. The QAA Committee will meet weekly beginning July 15, 2013 for a	

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NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 426 ISLAND FORD ROAD MADISONVILLE, KY 42431		
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F 164	Continued From page 2 someone could see in his/her room. An interview with LPN #1, on 06/27/13 at 1:55 PM, revealed she should have ensured the blinds were closed before starting the skin assessment. Interview with the Director of Nursing (DON), on 06/28/13 at 2:50 PM, revealed she expected staff to close the window blinds during resident care. 2. Observation during a skin assessment, on 06/27/13 at 2:45 PM, revealed Resident #1 was left naked on the bed and was not provided any covering while LPN #2 left the room to obtain supplies and to wash/glove hands during care. Record Review revealed Resident #1 was admitted to the facility on 11/08/12 with diagnoses to include Anxiety and Depressive Disorder. A review of the quarterly MDS assessment, dated 06/20/13, revealed the facility assessed Resident #1's cognition as cognitively intact. Interview with Resident #1, on 06/28/13 at 10:45 PM, revealed "it bothered him/her to be left naked during care". Interview with LPN #2, on 06/27/13 at 3:00 PM, revealed she should have covered Resident #1 when leaving the room during the skin assessment. Interview with the DON, 06/28/13 at 9:19 AM, revealed the LPN should have covered Resident #1 when she left the room.	F 164	minimum of four weeks and until regulatory compliance is achieved. Completion Date: July 20, 2013	7/20/13	
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281			

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F 281 SS=D	Continued From page 3 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 observation, interview, and record review, and facility policy and procedure review it was determined the facility failed to ensure a physician order for oxygen (O2) was followed for one (1) resident (#1), in the selected sample of nineteen (19) residents. Findings include: A review of the facility's policy, entitled Concord Health Systems Oxygen Policy and Procedure, last revised 04/04/12, revealed the purpose of oxygen was to supplement oxygen supply when insufficient oxygen is being carried by the blood to the tissues and to check physician's order for liter flow and method of administration. Record Review revealed Resident #1 was admitted to the facility on 11/06/12 with diagnoses to include Wheezing, Shortness of Breath, and Unspecified Disease of Respiratory System. A review of the quarterly Minimum Data Set (MDS) assessment, dated 06/20/13, revealed the facility assessed Resident #1's cognition as cognitively intact. A review of the physician order, dated 05/30/13, revealed staff should provide continuous O2 at	F 281	<u>F 281 D SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</u> <i>Residents Found to Have Been Affected</i> Resident #1 is receiving oxygen as order by the physician. On June 28, 2013 Licensed Practical Nurse # 2 was re-educated and counseled on the proper administration of oxygen. <i>Identification of Other Residents with the Potential to be Affected</i> All residents utilizing oxygen have the potential to be affected by F 281. On June 28, 2013 a review of all oxygen orders was completed to assure that all residents receiving oxygen are receiving care according to physician orders. <i>Systemic Changes</i> Beginning on July 18, 2013 the Quality Assurance Nurse RNA will observe oxygen rates on all residents receiving oxygen to ensure that the rate is given as ordered by the physician. These observations will continue for thirty days and compliance is sustained.	

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F 281	Continued From page 4 three (3) liters (l) per minute (l/m) per nasal cannula. Observations on 06/26/13 at 10:45 AM, 3:00 PM and 3:45 PM and on 06/27/13 at 9:07 AM and 10:00 AM revealed Resident #1's was receiving O2 at two (2) l/m. Observation and interview with State Certified Nursing Aide (SRNA) #2, on 06/27/13 at 10:30 AM, revealed Resident #1 was receiving O2 at 2 l/m. The SRNA stated the O2 was set at 2 l/m and she would have to check the care plan to verify if it was the appropriate O2 rate. SRNA #2 stated the O2 rate was wrong after checking the care plan. Interview with Licensed Practical Nurse #2, on 06/27/13 at 10:40 AM, revealed SRNA #2 had told her Resident #1's oxygen was running at the wrong rate so she set it to the ordered three (3) l/m. Interview with the Director of Nursing (DON), on 06/28/13 2:30 PM, revealed the charge nurse should check the O2 rates when he/she completes their compliance rounds.	F 281	Monitoring All reviews of oxygen rates completed by the Quality Assurance Nurse will be submitted to the Quality Assurance and Assessment team for recommendations and follow up. Completion Date: July 22, 2013	7/22/13
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.	F 282		

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F 282	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, it was determined the facility failed to ensure care plans were followed for one (1) resident (#1), in the selected sample of nineteen (19) residents related to falls.</p> <p>Findings include:</p> <p>A review of the facility's policy entitled, "Concord Health Systems Nurse Aide Care Plan", dated 02/10/10 revealed, "It was the purpose of this form to document how each residents' daily care needs are provided by the nursing staff as outlined in the Comprehensive Care Plan in accordance with the guidance of the RAI process and in keeping with the Common Wealth of Kentucky Department of Medicaid Services".</p> <p>Record review revealed Resident #1 was admitted to the facility on 11/06/12 with diagnoses to include difficulty in walking, Abnormal Posture, personal history of fall, other convulsions, and muscle weakness. A review of the quarterly Minimum Data Set (MDS) assessment, dated 06/20/13, revealed Resident #1's cognition was assessed as cognitively intact.</p> <p>A review of the Comprehensive Care Plan for at risk for falls/injury related to impaired balance, use of psychotropic medications, and history of falls/lift, dated 06/25/13, and Certified Nurse Aide (CNA) care plan, dated 06/2013 revealed Resident #1 should have hipsters on at all times.</p> <p>Observations of Resident #1, on 6/27/13 at 2:45 PM and 06/28/13 at 9:20 AM revealed hipsters</p>	F 282	<p><u>F 282 D SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</u></p> <p><i>Residents Found to Have Been Affected</i> Hipsters were provided for Resident #1 in accordance with the care plan.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected by F 282. Systemic and Monitoring actions listed below will include all residents who have the potential to be affected.</p> <p>On July 18, 2013 a review was completed of the resident care plans and observations of the care plan provided to the resident to ensure that care was completed in accordance to the care plan.</p> <p><i>Systemic Changes</i> Beginning on June 28, 2013 - July 19, 2013 all nursing personnel including nursing assistants, medication. Technicians and licensed nurses were educated on following resident care plans to include use of hipsters and other fall prevention measures.</p>		

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F 282	Continued From page 6 were not on the resident. Interview with State Certified Nursing Assistant (SRNA) #12, on 06/28/13 at 1:30 PM, revealed Resident #1 was care planned to have hipsters on at all times due to the resident falling out of bed. Interview with Licensed Practical Nurse (LPN) #2, on 06/28/13 at 9:20 AM and 1:40 PM, revealed Resident #1 did not have hipsters on and they were supposed to be on at all times according to the care plan. LPN #2 further stated Resident #1 did not have the hipsters on the day before (06/27/13) at 2:45 PM when she was doing the skin assessment. Interview with the Director of Nursing, on 06/28/13 at 9:10 AM, revealed if the resident was care planned for hipsters on at all times then the hipsters should be on the resident at all times. The DON stated she expected staff to follow the care plans.	F 282	Care plan monitoring through direct observation will be completed each week by the Unit Managers for four weeks or until compliance is achieved. <i>Monitoring</i> The Interdisciplinary Team will monitor the care plan observation reviews at their daily meeting to ensure that care plans are being followed. Completion Date: July 22, 2013	7/22/13	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323	<u>F 323 D FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</u> <u>ES</u> <i>Residents Found to Have Been Affected</i> The Maintenance Director replaced existing emergency call light chain/cord in Rooms #302, 303, 308, 309, 407, 410, 501, 505 and 607 on 07/16/2013. <i>Identification of Other Residents with the Potential to be Affected</i> On 07/09/2013 the Maintenance Director completed a 100% audit of all emergency call light chain/cords and replaced/lengthened all		

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F 323	Continued From page 7 by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to provide an environment free of accident hazards related to emergency call light cords having adequate length to allow easy access in nine (9) of the total sixty (60) resident rooms. Findings include: A review of the facility's Resident Call Lights policy, not dated, revealed the facility should maintain an appropriate call light system for the convenience of its residents and to assist the staff in responding to needs of its residents in a timely manner, it is the policy of the facility to respond promptly to a call for assistance and to assure that the call system is in proper working order. Place call lights on the bed or close to the resident so it is within easy reach. Observations during the Initial tour, on 06/26/13 from 9:10 AM through 11:15 AM, revealed five (5) resident bathrooms in rooms #302, 303, 308, 309 and 410 had emergency call light pull chain/cord in each bathroom that were approximately the length of a ballpoint pen and one call light cord in one (1) resident's bathroom in room #407, that was less than the length of three (3) ballpoint pens with twelve (12) residents affected. Further observations, on 06/26/13 from 9:05 AM to 10:35 AM revealed a very short chain on the call light in the bathroom of rooms #501, 505, and 607 that was approximately the length of a ballpoint pen; affecting six (6) residents.	F 323	chains/cords found to be too short on 07/16/2013. <i>Systemic Changes</i> On 07/09/2013 the Maintenance Director completed a 100% audit of all emergency call light chain/cords and replaced/lengthened all chains/cords found to be too short on 07/16/2013. The Maintenance Director will complete audits each month for three months and every quarter thereafter to check for appropriate length of call light cords. These audits will be added to the Preventive Maintenance Log. <i>Monitoring</i> The Maintenance Director will review the findings in the Preventive Maintenance Log with the Administrator and CQI Team at the daily CQI meeting. Completion Date: July 17, 2013	7/17/13

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F 323	Continued From page 8 Interview with Resident #19, on 06/28/13 at 2:00 PM, revealed he/she could not reach the bathroom emergency call light chain/cord if he/she fell in the bathroom floor. Interview with Licensed Practical Nurse (LPN) #1, on 6/28/13 at 2:24 PM, revealed she would expect the emergency call light chain/cord to be long enough for anyone lying on the floor to reach it and the length should be uniform throughout the facility. Interview with Registered Nurse (RAN) #2, on 6/28/13 at 2:30 PM, revealed the emergency call light chain/cord would not be easily accessible to a person lying on the floor and would expect the length to be uniform throughout the facility. Interview with the Director of Nursing (DON), on 06/28/13 at 2:45 PM, revealed she would expect anyone who fell in the bathroom floor to be able to reach the emergency call light chain/cord; however, residents would not be capable of reaching the chain/cord if it was only the length of a ballpoint pen.	F 323		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined	F 463	<u>F 463 D RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</u> <i>Residents Found to Have Been Affected</i> Coded door locks were ordered and will be installed on bathroom doors of the bathroom located on the 200 hall, 500 hall, and two bathrooms located in the front lobby by the Maintenance Director on July 23, 2013. These restrooms are designated for employees and visitors.	

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F 463	<p>Continued From page 9</p> <p>the facility failed to ensure each bathroom available for resident use was equipped to receive resident calls through a communication system.</p> <p>Findings include:</p> <p>Observation, on 06/28/13 at 11:40 AM, revealed one bathroom on the 200 hall, one bathroom on the 500 hall, and two bathrooms in the front lobby without an emergency communication system in place. All four bathrooms were unlocked and available for resident use.</p> <p>Interview with the Maintenance Director, on 06/28/13 at 1:50 PM, revealed he did not consider the four bathrooms available for resident use; however, verified they were unlocked with no emergency communication system.</p> <p>Interview with the Director of Nursing (DON), on 06/28/13 at 1:50 PM, revealed ambulatory residents would be able to use the four bathrooms, as they were unlocked.</p> <p>Interview with the Administrator, on 06/28/13 at 2:30 PM, revealed she was not aware it was a regulation to have a communication system in bathrooms available for resident use.</p>	F 463	<p><i>Identification of Other Residents with the Potential to be Affected</i></p> <p>All residents have the potential to be affected by F 463. See Systemic and Monitoring actions are listed below.</p> <p><i>Systemic Changes</i></p> <p>Coded door locks will be installed on bathroom doors of the bathrooms located on the 200 hall, 500 hall, and two bathrooms located in the front lobby by the Maintenance Director on July 23, 2013. A review was completed of all other doors that are designated for employees and visitors to ensure that these are not for resident use and for compliance with the citation in F 463. All doors not for resident use will have coded doors for security.</p> <p><i>Monitoring</i></p> <p>The Maintenance Director will monitor the door lock system on the bathroom doors of the 200 hall, 500 hall and two bathrooms located in the front lobby monthly on the Preventative Maintenance Plan.</p> <p>Any issues of concern will be reported to the Quality Assurance Committee.</p> <p>Completion Date: July 24, 2013</p>	7/24/13	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165306	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2013
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NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 426 ISLAND FORD ROAD MADISONVILLE, KY 42431
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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 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1972</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200)</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with thirty-nine (39) smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 06/28/13. Ridgewood Terrace Nursing Home was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred ten (110) beds with a census of ninety three (93) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>Preparation and execution of this plan of Correction does not constitute an admission of 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 solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge deficiencies below is not an admission that the alleged facts occurred as presented in the statements.</p> <p><u>K 018 E LIFE SAFETY CODE STANDARD</u></p> <p><i>Residents Found to Have Been Affected</i></p> <p>The wheelchair blocking the door of Room # 407 was removed; a smaller mat was placed in Room # 406 to allow door closure; walkers blocking the door were removed from doorway in room #204; and a smaller mat was placed in Room #606 to allow door closure.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature] Administrator 07/29/2013

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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NAME OF PROVIDER OR SUPPLIER RIDGEWOOD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 425 ISLAND FORD ROAD MADISONVILLE, KY 42431	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000	The Maintenance Director replaced the corridor door latch to Room # 601 on July 17, 2013 so that the door properly latches.	
K 018 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ Inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors of resident rooms were in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, ninety-four (94) residents, staff, and visitors. The facility is certified for one-hundred ten (110) beds with a census of</p>	K 018	<p>The Maintenance Director removed a rubber strip from the corridor door to Room # 306 on July 17, 2013 so that the door properly latches.</p> <p>The Maintenance Director will repair the corridor door to Room # 401 on July 25, 2013 so that the door will properly latch.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i> All residents, visitors and staff have the potential to be affected by K 018.</p> <p>On June 28, 2013 the Maintenance Director completed a 100% audit of all corridor doors to resident rooms to ensure no objects prevented doors from closing.</p> <p>On July 18, 2013 the Maintenance Director completed a 100% audit of all corridor doors for proper latching.</p> <p><i>Systemic Changes</i> The Maintenance Director will complete audits each month for three months and every quarter thereafter to check for clearance of corridor to</p>	

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K 018	<p>Continued From page 2</p> <p>ninety three (93) on the day of the survey. The facility failed to ensure four (4) resident doors could be closed with a single motion, and three (3) doors would properly latch.</p> <p>The findings include:</p> <p>Observations, on 06/26/13 between 11:00 AM and 4:00 PM with the Maintenance Supervisor and the Staff Development Coordinator, revealed the corridor doors to the resident rooms were blocked from closing. The rooms affected by this were rooms #407- wheelchair blocking door, 406-padded mat blocking door, 204- walkers blocking door, and 606- padded mat blocking the door.</p> <p>Interviews, on 06/26/13 between 11:00 AM and 4:00 PM with the Maintenance Supervisor and the Staff Development Coordinator, revealed they were unaware the items were blocking the door. Further Interview reviewed the padded mats were down when the residents were in bed but the staff was to pick them up if the resident was not in bed.</p> <p>Observations, on 06/26/13 between 11:00 AM and 4:00 PM with the Maintenance Supervisor and the Staff Development Coordinator, revealed the corridor doors to rooms #401, 601, and 306 would not latch properly.</p> <p>Interview, on 06/26/13 between 11:00 AM and 4:00 PM with the Maintenance Supervisor and the Staff Development Coordinator, revealed they were unaware the doors were not latching to the rooms.</p> <p>Reference: NFPA 101 (2000 edition)</p>	K 018	<p>resident rooms and for proper latching of corridor doors to rooms. These audits will be added to the Preventive Maintenance Log.</p> <p><i>Monitoring</i> The Maintenance Director will review the findings in the Preventive Maintenance Log with the Administrator and CQI Team at the daily CQI meeting.</p> <p>Completion Date: July 26, 2013</p>	7/26/13

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K 018	Continued From page 3 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.6.3.3*	K 018			

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K 018	Continued From page 4 Hold-open devices that release when the door is pushed or pulled shall be permitted. A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018	<u>K 029 D LIFE SAFETY CODE STANDARD</u> <i>Residents Found to Have Been Affected</i> The Maintenance Director replaced the door closer in the dry storage area of the kitchen on July 2, 2013. The Maintenance Director will install a door closer and latching device for the brief room on July 19, 2013.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, forty (40) residents, staff, and visitors. The facility is certified for one-hundred ten (110) beds with a	K 029	<i>Identification of Other Residents with the Potential to be Affected</i> Forty residents, staff and visitors are affected by K 029. On July 2, 2013 the Maintenance Director completed a 100% audit of all doors to ensure that doors on hazardous rooms are equipped with door closers. On July 18, 2013, the Maintenance Director completed a 100% audit of all doors to hazardous rooms to ensure that doors properly latched. <i>Systemic Changes</i> The Maintenance Director will complete audits each month for three months and every quarter thereafter to check for door closers and proper latching of doors to hazardous rooms.	

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K 029	<p>Continued From page 5</p> <p>census of ninety three (93) on the day of the survey. The facility failed to ensure two (2) hazardous rooms were properly separated.</p> <p>The findings include:</p> <p>Observations, on 06/26/13 at 11:25 AM with the Maintenance Supervisor and the Staff Development Coordinator, revealed the closing device on the door for the dry storage area in the kitchen had been removed. Further observation revealed the Brief room did not have a latching device to keep the door closed.</p> <p>Interview, on 06/26/13 at 11:25 AM with the Maintenance Supervisor and the Staff Development Coordinator, revealed they were unaware the door closer had been removed and that just a door closer for the brief room was not a proper way to separate the hazardous room.</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 with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p>	K 029	<p><i>Monitoring</i></p> <p>The Maintenance Director will review the findings in the Preventive Maintenance Log with the Administrator and CQI Team at the daily CQI meeting.</p> <p>Completion Date: July 22, 2013</p>	7/22/13

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K 029	Continued From page 6 (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), 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		
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on interview and policy review, it was determined the facility failed to implement a proper Fire Safety Plan and Procedure Policy in the event of an emergency in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for one-hundred ten (110) beds with a census of ninety three (93) on the day	K 048	<u>K 048 F LIFE SAFETY CODE STANDARD</u> <i>Residents Found to Have Been Affected</i> All residents, staff and visitors have the potential to be affected by K 048. <i>Identification of Other Residents with the Potential to be Affected</i> All residents, staff and visitors have the potential to be affected by K 048. Systemic and Monitoring actions listed below will include all residents who have the potential to be affected. <i>Systemic Changes</i> On July 18, 2013 the Consulting Administrator revised the Fire Safety Plan and Procedure Policy to include evacuation of residents from smoke compartments. Employees will be in-serviced on the revised Fire Safety Plan and Procedure Policy by the Maintenance Director on July 26, 2013. <i>Monitoring</i> The Maintenance Director will monitor adherence to the revised Fire Safety Plan and Procedure Policy to ensure evacuation of residents, staff and visitors from smoke compartments during fire drills.	

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K 048	<p>Continued From page 7 of the survey. The facility failed to ensure the evacuation of a smoke compartment was addressed in the fire safety plan.</p> <p>The findings include:</p> <p>Fire Safety Plan review, on 06/26/13 at 11:17 AM with the Maintenance Supervisor and the Staff Development Coordinator, revealed the facility's Fire Safety Plan and Procedure Policy did not address the evacuation of a smoke compartment in the facility.</p> <p>Interview, on 06/26/13 at 11:17 AM with the Maintenance Supervisor and the Staff Development Coordinator, revealed they were unaware the policy did not address the evacuation of a smoke compartment and they do practice this procedure during their fire drills.</p> <p>Actual NFPA Standard: 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every healthcare occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator's position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include</p>	K 048	<p>Reports of the evacuation drills will be maintained by the Maintenance Director in the Fire Drill Log and reviewed with the Administrator and CQI Team at the monthly CQI meeting.</p> <p>Completion Date: July 27, 2013</p>	7/27/13

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K 048	Continued From page 8 the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. 19.7.2 Procedure in Case of Fire. 19.7.2.1* For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy's fire safety plan. 19.7.2.2 A written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area	K 048		

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K 048	Continued From page 9 (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire 19.7.2.3 All health care occupancy personnel shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions: (1) When the individual who discovers a fire must immediately go to the aid of an endangered person (2) During a malfunction of the building fire alarm system Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and	K 048	<u>K 056 E LIFE SAFETY CODE STANDARD</u> <i>Residents Found to Have Been Affected</i> All residents, staff and visitors have the potential to be affected by K 056. <i>Identification of Other Residents with the Potential to be Affected</i> All residents, staff and visitors have the potential to be affected by K 056. See Systemic and Monitoring actions below. <i>Systemic Changes</i> On July 24, 2013 bids will be received from Tri-State Fire Protection, Inc and Armor Fire Protection LLC for installation of sprinkler protection in the skylight areas of the two nurses' stations and the front lobby area. Bids will be reviewed by the Maintenance Director and awarded on July 25, 2013.	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by:	K 056	<i>Monitoring</i> Armor Fire Protection LLC provides on-site quarterly inspections of the sprinkler system. Reports are submitted to the Maintenance Director. The Maintenance Director will review the findings in the Preventive Maintenance Log with the	

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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
K 056	Continued From page 10 Based on observation 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 three (3) of four (4) smoke compartments, seventy (70) residents, staff, and visitors. The facility is certified for one-hundred ten (110) beds with a census of ninety three (93) on the day of the survey. The facility failed to ensure three (3) skylight areas were properly sprinkler protected. The findings include: Observation, on 06/26/13 at 4:05 PM with the Maintenance Supervisor and the Staff Development Coordinator, revealed the two (2) nurses' stations and the front lobby area did not have proper sprinkler protection at the peaks of the skylight areas. Interview, on 06/26/13 at 4:05 PM with the Maintenance Supervisor and the Staff Development Coordinator, revealed they were unaware the areas at the skylights were not properly sprinkler protected. Reference: S&C 09-04 Adoption of New Fire Safety Requirements for Long Term Care Facilities, Mandatory Sprinkler Installation Requirement http://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter09-04.pdf	K 056	Administrator and CQI Team at the daily CQI meeting. Completion Date: July 26, 2013	7/26/13
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	K 066	<u>K 066 D LIFE SAFETY CODE STANDARD</u> <i>Residents Found to Have Been Affected</i> All residents, staff and visitors have the potential to be affected by K 066. <i>Identification of Other Residents with the Potential to be Affected</i> All residents, staff and visitors have the potential to be affected by K 066. See Systemic and Monitoring actions are listed below.	

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K 086	<p>Continued From page 11</p> <p>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.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays at an entrance, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff, and visitors. The facility is certified for one-hundred ten (110) beds with a census of ninety three (93) on the day of the survey. The facility failed to ensure cigarette butts were not being discarded onto the ground.</p> <p>The findings include:</p> <p>Observation, on 06/26/13 at 3:58 PM with the</p>	K 086	<p>Systemic Changes</p> <p>Beginning on June 27, 2013, the Maintenance Director moved the employee break area to a location on the pavement where cigarette receptacles are located. The cigarette butts were removed from area of grounds where they had been improperly discarded. The area was taped off and a sign posted to restrict smoking to the designated area only.</p> <p>As of July 31, 2013 the facility will no longer allow employee smoking on the campus. NO SMOKING signs will be posted in visible areas of entryways.</p> <p>On July 18, 2013 letters notifying employees were mailed regarding the change to a non-smoking campus.</p> <p>Monitoring</p> <p>The Administrator and Department Directors will monitor the campus to ensure enforcement of the employee No Smoking Policy.</p> <p>Any issues of concern will be reported to the Quality Assurance Committee during the daily CQI meetings.</p> <p>Completion Date: July 19, 2013</p>	7/19/13

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K 066	<p>Continued From page 12</p> <p>Maintenance Supervisor and the Staff Development Coordinator, revealed the employee smoking area had over one-hundred fifty cigarette butts on the ground.</p> <p>Interview, on 06/26/13 at 3:58 PM with the Maintenance Supervisor and the Staff Development Coordinator, revealed they were not aware cigarette butts could not be on the ground since the area was across the parking lot from the facility.</p> <p>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. 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.</p>	K 066		

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K 066	Continued From page 13 (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			
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no highly flammable furniture was used in the facility, in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, forty (40) residents, staff, and visitors. The facility is certified for one-hundred ten (110) beds with a census of ninety three (93) on the day of the survey. The facility failed to ensure resident upholstered chairs from home were being properly protected by a smoke detector. The findings include: Observation, on 06/26/13 between 11:00 AM and 4:00 PM with the Maintenance Supervisor and the Staff Development Coordinator, revealed resident chairs that were brought from home with no smoke detector installed in rooms #409, 408, 401, 501, 508, 506, 504, 609, 610, 605, 102, 104,	K 073	<u>K 073 F LIFE SAFETY CODE STANDARD</u> <i>Residents Found to Have Been Affected</i> Battery operated smoke detectors were installed in resident rooms with upholstered chairs brought from home in rooms #409, 408, 401, 501, 508, 506, 609, 610, 605, 102, 104, 103, 110, and 310 on July 18, 2013. <i>Identification of Other Residents with the Potential to be Affected</i> Forty residents, staff and visitors are potentially affected by K 073. See Systemic and Monitoring Actions listed below. <i>Systemic Changes</i> On July 18 - 19, 2013, the Maintenance Director equipped all resident rooms with battery operated smoke detectors.		

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K 073	Continued From page 14 103, 110, and 310. Interview, on 06/26/13 between 11:00 AM and 4:00 PM with the Maintenance Supervisor and the Staff Development Coordinator, revealed they were unaware that if a resident brings a chair from home then the room must have a smoke detector installed. Reference: NFPA 101 (2000 Edition) 19.7.5.2 Newly introduced upholstered furniture within health care occupancies shall meet the criteria specified when tested in accordance with the methods cited in 10.3.2(2) and 10.3.3. Exception: Upholstered furniture belonging to the patient in sleeping rooms of nursing homes, provided that a smoke detector is installed in such rooms. Battery-powered single-station smoke detectors shall be permitted.	K 073	Monitoring The Maintenance Director will monitor the function of the smoke detectors monthly per the Preventive Maintenance Plan. Any issues of concern will be reported to the Quality Assurance Committee. <i>Completion Date:</i> July 19, 2013	7/19/13
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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical	K 147	<u>K 147 D LIFE SAFETY CODE STANDARD</u> <i>Residents Found to Have Been Affected</i> Power cords were removed from Room #406 and Room # 504 on June 26, 2013 by the Maintenance Director. <i>Identification of Other Residents with the Potential to be Affected</i> Fifty-Six (56) residents, staff and visitors have a potential to be affected by K 147. On June 26, 2013, the Maintenance Director completed a 100 % audit of all rooms to ensure proper usage of power strips. <i>Systemic Changes</i> On June 26, 2013, the Maintenance Director completed a 100 % audit of	

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K 147	<p>Continued From page 15</p> <p>wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, fifty-six (56) residents, staff, and visitors. The facility is certified for one-hundred ten (110) beds with a census of ninety three (93) on the day of the survey. The facility failed to ensure power strips were being used properly.</p> <p>The findings include:</p> <p>Observations, on 06/26/13 between 11:00 AM and 4:00 PM with the Maintenance Supervisor and the Staff Development Coordinator, revealed a bed, an Oxygen concentrator, and a mini nebulizer were plugged into a power strip located in room #406. Further observation revealed a mini nebulizer plugged into a power strip located in room #504.</p> <p>Interview, on 06/26/13 between 11:00 AM and 4:00 PM with the Maintenance Supervisor and the Staff Development Coordinator, revealed he was unaware of the items being improperly plugged into power strips. He stated he does rounds often to check power strips to verify they are being used properly.</p> <p>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.</p> <p>Reference: NFPA 70 (1999 Edition).</p>	K 147	<p>all rooms to ensure proper usage of power strips.</p> <p>The Maintenance Director will complete audits each month for three months and every quarter thereafter to check for proper usage of power strips. These audits will be added to the Preventive Maintenance Log.</p> <p><i>Monitoring</i> The Maintenance Director will review the findings in the Preventive Maintenance Log with the Administrator and CQI Team at the daily CQI meeting.</p> <p><i>Completion Date:</i> July 29, 2013</p>	7/29/13	

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K 147	Continued From page 16 400-8. Uses Not Permitted Unless specifically permitted in Section 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 Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code.	K 147			