

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

PRINTED: 08/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185436	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/25/2015
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NAME OF PROVIDER OR SUPPLIER WELLINGTON PARC OF OWENSBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD RD OWENSBORO, KY 42303
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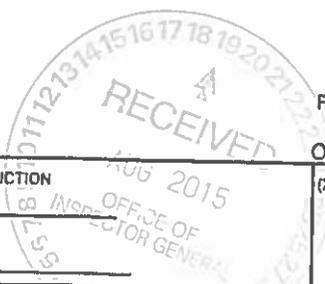
{F 000}	<p>INITIAL COMMENTS</p> <p>Based upon the implementation of the acceptable POC, the facility was deemed to be in compliance, 08/25/15 as alleged.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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 WELLINGTON PARC OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 2886 NEW HARTFORD RD OWENSBORO, KY 42303		
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F 000	INITIAL COMMENTS	F 000	<p>Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.</p> <p>F 332 MEDICATION ERRORS The facility shall ensure that it is free of medication error rates of 5% or greater. Criteria # 1: Resident # A's attending MD was notified by the DON on 7/23/15 of missed doses of medications that occurred on 7/22/15. An order was obtained to give 7/23/15 8am meds when available. Depakote (obtained from the EDK box) was administered at 9:30am; Synthroid and Namenda (obtained from the back up pharmacy were administered at 10:30 am on 7/23/15. Resident's responsible party was also notified on 7/23/15 of missed medication doses on 7/22/15 and late administration of meds on 7/23/15. Resident # A's medications are available for administration in accordance with physician orders as determined by medication cart audits performed by administrative nurses on 8/10/15, 8/17/15, 8/24/15..</p> <p>Criteria # 2: An audit of medication carts was performed by the pharmacy consultant on the afternoon of 7/23/15 to determine that all medications were available for administration in accordance with physician orders. Additional partial audits of medication carts were performed by administrative nurses on 8/10/15, 8/17/15, 8/24/15 to determine that all medications are available for administration in</p>		
F 332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and procedures, it was determined the facility failed to ensure it was free of a medication error rate of five percent (5%) or greater. Observation of a medication pass, revealed a total of thirty four (34) opportunities with three (3) errors which resulted in a medication error rate of 8.00%.</p> <p>Certified Medication Technician (CMT) was observed administering medications for Unsamped Resident A and there were three (3) medications not available for administration.</p> <p>The findings include: Review of the facility's policy and procedure titled, "Medication Administration - General guidelines", dated 12/18/12, revealed borrowing medications from one resident for another resident when a medication is not available is not permitted. Nursing staff should contact the pharmacy as soon as possible for the medication or for further instructions. If two consecutive doses of a vital</p>	F 332			

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

TITLE

Administrator

(X5) DATE

8/19/15

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 332	<p>Continued From page 1</p> <p>medication are withheld or refused, the physician should be notified.</p> <p>1. Record review revealed the facility readmitted Unsampld Resident A on 07/06/15 after a hospitalization for a Closed Fracture of the intertrochanteric section of the femur.</p> <p>Review of the July 2015 Physician Orders revealed to administer Namenda (for dementia) 10 milligrams one (1) tablet by mouth twice daily, Divalproex (Depakote) Sprinkles (for mood stabilization) 125 mg by mouth twice daily and Levothyroxine (a thyroid hormone) 0.05 mg one (1) tablet by mouth once daily.</p> <p>Observation of a medication pass performed by CMT #1, on 07/23/15 at 8:30 AM, revealed Namenda 10 milligrams (mg), Depakote Sprinkles 125 mg and Levothyroxine 0.05 mg were not administered to the Resident #1. There were empty boxes in the medication drawer for each of the medications.</p> <p>Review of the list of medications available in the Emergency Drug Kit (EDK) included Depakote Sprinkles 125 mg.</p> <p>Interview with CMT #1, on 07/23/15 at 8:30 AM, revealed the facility had not received the medications from the pharmacy. She stated she would follow up with the pharmacy after she completed the medication pass.</p> <p>Interview with the DON, on 07/24/15 at 10:15 AM, revealed the staff should call the pharmacy if they do not have a medication and the EDK box was available and should be utilized by staff as needed. She revealed that she was unaware that</p>	F 332	<p>accordance with physician orders. The partial audits consisted of a 10% sample of residents. An audit of July MAR's was completed by administrative nurses on 7/23/15 to determine if any medication errors had occurred due to omission of medication.</p> <p>Criteria #3: The facility's protocol for reviewing pharmacy fax communications regarding medication refills has been revised. The charge nurse will be responsible for reviewing all pharmacy fax communications and taking necessary action to obtain medications timely (such as phoning the pharmacy, utilizing the EDK or back up pharmacy, consulting with attending MD).</p> <p>Nurses and med techs received educational training about the revised protocol mentioned above and pharmacy policies regarding med refills, EDK and back up pharmacy on 7/23-7/28/15 as provided by the pharmacy consultant and DON/ADON. Education also included documenting the reason for medication not given on the back of the MAR.</p> <p>Criteria #4: The QA tool for the monitoring of medication pass shall be utilized monthly X 3, then quarterly as per established QA calendar under the supervision of the DON. Results of the audits will be reported to the QA Committee by the DON or ADON each month it is completed. If an accepted threshold of compliance is not achieved, the DON or ADON shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting.</p> <p>Criteria #5: Target Date</p>	8/25/15	

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F 332	Continued From page 2 there was a problem with getting medications. Interview with Physician #1, on 07/24/15 at 2:20 PM, revealed it was his expectation that medications would be available for administration to the residents as ordered.	F 332			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy it was determined the facility failed to ensure food was stored and distributed under sanitary conditions. Staff personal food from home was stored in the resident refrigerator and a kitchen aide was observed to repeatedly touch a dirty and grimy door and then handle resident trays, refrigerator handles and condiments during the noon meal. Review of the facility Census and Condition, dated 07/22/15, revealed there were forty (40) residents in the facility and all the residents received their meals from the kitchen.	F 371	F 371 SANITARY CONDITIONS The facility shall (1) procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute, and serve food under sanitary conditions: Criteria #1 and #2: The plastic container with staff food was removed from the resident refrigerator on 07/22/15. The entry door to the kitchen was cleaned by the Dietary Manager (DM) on 07/22/15. Tray line observations were completed on 8/16/15, 8/19/15, 8/21/15 by the DM and RD to verify that dietary staff are observing/practicing proper tray line hand sanitation. A kitchen sanitation audit was completed on 8/16/15 by the consultant Registered Dietician (RD) to verify that the kitchen (including, but not limited to: storage of food in refrigerators, and cleanliness of kitchen doors) meets sanitary conditions in accordance with State and Federal guidelines. Criteria #3: The dietary cleaning schedule was reviewed and revised on 8/14/15 by the DM, to include routine cleaning the kitchen door. All dietary staff members received in-service education on 8/24/15 by the DM which included, but was not limited to: revisions to the routine cleaning schedule, storage of staff food in breakroom, and tray line hand sanitation. Criteria #4: The QA tool for the monitoring of dietary sanitation (which includes, but is not		

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F 371	<p>Continued From page 3</p> <p>The findings include:</p> <p>Review of the undated facility policy titled, "Sanitation", revealed it was the policy of this facility to maintain equipment, work surfaces, wall and floors in sanitary condition through daily, ongoing procedures. The policy also revealed training was provided to appropriate personnel regarding correct procedure, cleaning agents and frequency of cleaning. All dietary services personnel will practice safe hygiene food handling techniques and will have and maintain clean hands and fingernails.</p> <p>1. Observation during the initial tour of the kitchen, on 07/22/15 at 7:40 AM, revealed a plastic container of food was being stored in the resident refrigerator that belonged to a kitchen staff. In addition, the entrance door to the kitchen was observed with a thick build up of grey, sticky grime around the door handle.</p> <p>2. Observation, on 07/22/15 at 11:45 AM, revealed one (1) of four (4) sanitizer buckets tested at 100 parts per million which was below the acceptable manufacturer's recommendation on two (2) consecutive tests. The acceptable level was to be at 200 parts per million or above according to the directions on the sanitizer label.</p> <p>3. Observation of the lunch tray line, on 07/22/15 at 11:55 AM, revealed a kitchen aide repeatedly touched a grimy door while holding the grimy door open to push loaded food tray carts out of the kitchen. The kitchen aide failed to wash her hands after touching the grimy door multiple times and continued to handle resident food trays throughout the meal service and retrieve food items from the resident refrigerator.</p>	F 371	<p>limited to, cleanliness of door, food storage, and tray line hand sanitation) shall be utilized weekly X 4, and then monthly under the supervision of the DM. Results of the audits will be reported to the QA Committee by the DM each month it is completed. If an accepted threshold of compliance is not achieved, the DM shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting.</p> <p>Criteria #5: Target Date:</p>	8/25/15	

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F 371	Continued From page 4 Interview with the Dietary Manager, on 07/22/15 at 11:45 AM, revealed the sanitation solution should be at or above 200 parts per million of sanitizer solution. Additional interview at 12 30 PM revealed kitchen staff should be washing their hands if and when they touch the door. She stated no personal food items were to be stored in resident refrigerators. Interview with the Director of Nursing (DON), on 07/22/15 at 2:40 PM, revealed she would expect the kitchen staff to wash their hands after touching the door, keep sanitizer solutions at acceptable levels and not store personal food in resident refrigerators.	F 371			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	F 425 PHARMACY SERVICES The facility shall provide routine and emergency drugs and biological to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. The facility shall provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) to meet the needs of each resident. The facility shall employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Criteria # 1: Resident # A's attending MD was notified by the DON on 7/23/15 of missed doses of medications that occurred on 7/22/15. An order was obtained to give 7/23/15 8am meds when available. Depakote (obtained from the EDK box) was administered at 9:30am; Synthroid and Namenda (obtained from the back up pharmacy were administered at 10:30 am on 7/23/15. Resident's responsible party was also notified on 7/23/15 of missed		

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F 425	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and a review of the facility policy, it was determined the facility failed to provide pharmaceutical services to meet the needs of one (1) unsampled resident (Resident A) related to the failure to ensure Unsampled Resident A's medication was available for administration The findings include: Review of the facility's policy and procedures, titled Ordering and Receiving Medications From the Dispensing Pharmacy, undated, revealed medications and related products are received from the dispensing pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt. If not automatically refilled by the pharmacy, repeat medications (refills) are written on a medication order form, or ordered by peeling the reorder label from the prescription label and placing it in the appropriate area on the refill order form and ordered as follows: reorder medications three to four days in advance of need to assure an adequate supply is on hand. The refill order is faxed, called in, or otherwise transmitted to the pharmacy. Receiving medications from the pharmacy, the authorized staff receiving the medication delivery promptly reports discrepancies and omissions to the issuing pharmacy and the charge nurse/supervisor. Staff are to assure medications are incorporated into the resident's specific allocation prior to the next medication pass.	F 425	medication doses on 7/22/15 and late administration of meds on 7/23/15. Resident # A's medications are available for administration in accordance with physician orders as determined by medication cart audits performed by administrative nurses on 8/10/15, 8/17/15, 8/24/15. Criteria # 2: An audit of medication carts was performed by the pharmacy consultant on the afternoon of 7/23/15 to determine that all medications were available for administration in accordance with physician orders. Additional partial audits of medication carts were performed by administrative nurses on 8/10/15, 8/17/15, 8/24/15 to determine that all medications are available for administration in accordance with physician orders. The partial audits consisted of a 10% sample of residents. An audit of July MAR's was completed by administrative nurses on 7/23/15 to determine if any medication errors had occurred due to omission of medication. Criteria #3: The facility's protocol for reviewing pharmacy fax communications regarding medication refills has been revised. The charge nurse will be responsible for reviewing all pharmacy fax communications and taking necessary action to obtain medications timely (such as phoning the pharmacy, utilizing the EDK or back up pharmacy, consulting with attending MD). Nurses and med techs received educational training about the revised protocol mentioned above and pharmacy policies regarding med refills, EDK and back up pharmacy on (insert dates) as provided by the pharmacy consultant and DON/ADON. Education also included documenting the reason for medication not		

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F 425	<p>Continued From page 6</p> <p>Record review revealed the facility readmitted Unsampld Resident A on 07/06/15 after a hospitalization for a Closed Fracture of the intertrochanteric section of the femur.</p> <p>Review of the July 2015 Physician Orders revealed to administer Namenda (for dementia) 10 milligrams one (1) tablet by mouth twice daily, Divalproex (Depakote) Sprinkles (for mood stabilization) 125 mg by mouth twice daily and Levothyroxine (a thyroid hormone) 0.05 mg one (1) tablet by mouth once daily, however, observation during a medication pass on, 07/23/15 at 8:30 AM, revealed there was no Namenda, Levothyroxine, and Depakote in the drawer for Unsampld Resident A, there were empty boxes. Further review of the July 2015 MAR, revealed the resident had been out of the Depakote, Levothyroxine and Namenda since 07/22/15 at 8:00 AM which meant the resident had missed a total of three (3) doses of each medication in two (2) days.</p> <p>Review of the list of medications available in the Emergency Drug Kit (EDK) included Depakote Sprinkles 125 mg.</p> <p>Review of Refill Request Sheets revealed staff had faxed reorder sheets to the pharmacy on 07/16/15 requesting Depakote 125 mg for Unsampld Resident A; and on 07/20/15 and 07/22/15, staff had requested Depakote Sprinkles 125 mg, Levothyroxine 50 mcg and Namenda 10 mg.</p> <p>Interview with CMT #1, on 07/23/15 at 8:30 AM, revealed the facility had not received the medications from the pharmacy. She stated she would follow up with the pharmacy after she</p>	F 425	<p>given on the back of the MAR.</p> <p>Criteria #4: The QA tool for the monitoring of medication pass shall be utilized monthly X 3, then quarterly as per established QA calendar under the supervision of the DON. Results of the audits will be reported to the QA Committee by the DON or ADON each month it is completed. If an accepted threshold of compliance is not achieved, the DON or ADON shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting.</p> <p>Criteria #5: Target Date</p>	8/25/15	

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F 425	<p>Continued From page 7 completed the medication pass.</p> <p>Interview with CMT #2, on 07/24/15 at 1:34 PM, revealed she had circled medications for Unsampld Resident A the night of 07/22/15 as they were not available and the pharmacy had been faxed. She stated she did not even think to look for them in the EDK box. The process for reordering medications was to pull the sticker when the resident was down to a three (3) day supply and fax it to the pharmacy for refill.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/23/15 at 2:56 PM, revealed when a resident reenters the facility, a telephone order is written to continue previous orders and the order is faxed to the pharmacy. She stated she was working the day Unsampld Resident A returned to the facility and faxed the orders to the pharmacy. She stated she was off work by the time the pharmacy delivered medication that night. She further stated the physician wasn't necessarily notified each time a resident misses a medication.</p> <p>Interview with the Pharmacy Consultant, on 07/23/15 at 1:19 PM, revealed the pharmacy did receive a copy of the discharge summary from the hospital prior to the resident's return to the facility. He stated after receiving that document, the pharmacy filled a one (1) day supply of Unsampld Resident A's medications pending a fax from the facility with the admission orders. He revealed the pharmacy did not receive a copy of the physician's orders until either 07/22/15 or 07/23/15 and the orders were dated 07/08/15 by the physician. He stated when a resident's medication supply is getting low, down to a three (3) day supply, the staff should pull a sticker off of the medication box and fax it to the pharmacy.</p>	F 425			

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F 425	Continued From page 8 He said the facility staff should have made a follow up phone call to the pharmacy to ensure the fax was received. He also stated the Depakote should have been retrieved from the EDK box. Interview with the Director of Nursing (DON), on 07/24/15 at 10:15 AM, revealed the physician orders should be faxed by staff to the pharmacy. She stated the staff should have called the pharmacy if they did not have the medication and the EDK box was available and should have been utilized by staff as needed. She revealed that she was unaware that there was a problem with getting medications.	F 425			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185436	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 08/25/2015
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NAME OF PROVIDER OR SUPPLIER WELLINGTON PARC OF OWENSBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD RD OWENSBORO, KY 42303
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{K 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility is deemed to be in compliance on 08/25/15, as alleged.</p>	{K 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185436	(Y2) Multiple Construction A. Building 01 - MAIN BUILDING 01 B. Wing	(Y3) Date of Revisit 8/25/2015
Name of Facility WELLINGTON PARC OF OWENSBORO		Street Address, City, State, Zip Code 2885 NEW HARTFORD RD OWENSBORO, KY 42303

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # <u>NFPA 101</u> LSC <u>K0025</u>	Correction Completed 08/25/2015	ID Prefix _____ Reg. # <u>NFPA 101</u> LSC <u>K0029</u>	Correction Completed 08/25/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: <i>Deborah C. Huelster NCF, DR</i>	Date: <i>08/24/15</i>
State Agency	<i>OH</i>	<i>08/24/15</i>		
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO				

Followup to Survey Completed on: 7/22/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		

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NAME OF PROVIDER OR SUPPLIER WELLINGTON PARC OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD RD OWENSBORO, KY 42303	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1990.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1990 with 85 smoke detectors and 5 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1990.</p> <p>GENERATOR: Type II generator installed in 1990. Fuel source is Diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 07/22/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for forty-four (44) beds with a census of forty (40) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000	<p>Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.</p>	



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

[Handwritten Signature]

TITLE

Administrator

(X6) DATE

8/19/15

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	K 000			
K 025 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "D" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for forty-four (44) beds and at the time of the survey, the census was forty (40).</p> <p>The findings include:</p> <p>Observation, on 07/22/15 at 11:46 AM, with the Maintenance Director revealed two (2) penetrations around sprinkler piping located above the ceiling in the Hall 10 smoke barrier.</p>	K 025	<p>K025 NFPA 101 Life Safety Code Standard</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Criteria #1: The two (2) penetrations around the sprinkler piping located above the ceiling in the hall 10 smoke barrier have been repaired per NFPA guidelines</p> <p>Criteria #2: All other smoke barriers have been inspected and noted to be sealed in accordance to NFPA standard.</p> <p>Criteria #3: The Maintenance Director received in-service education on 7/27/15 from the administrator on the need to inspect the smoke walls on a quarterly basis and/or when any service vendor has had access to the attic space to assure any unsealed penetrations are corrected.</p> <p>Criteria #4: The CQI indicator, ES-3 which includes monitoring of Smoke Barriers shall be completed by the Maintenance Director monthly x 2 months and then quarterly per the CQI schedule under the supervision of the Administrator.</p> <p>Criteria #5:</p>	8/25/15	

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NAME OF PROVIDER OR SUPPLIER WELLINGTON PARC OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 2885 NEW HARTFORD RD OWENSBORO, KY 42303		
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K 025	<p>Continued From page 2</p> <p>Interview, on 07/22/15 at 11:47 AM, with the Maintenance Director revealed the facilities sprinkler contractor had just replaced some piping in that location two (2) days prior to the survey; however, he was not aware of the unsealed penetration around the pipes.</p> <p>The census of forty (40) was verified by the Administrator on 07/22/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 07/22/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition).19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.</p> <p>Reference: NFPA 101 (2000 Edition) 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as</p>	K 025			

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K 025	Continued From page 3 follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025			
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	K 029	K029 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 Criteria #1: When not in use the two(2) linen carts stored on hall 20 and the two(2) linen carts store in the hall outside the DON office have been relocated and are stored within an area containing a self-closure on the door. Criteria #2 Compliance checks have been complete to ensure there were no other hazardous carts stored		

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K 029	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for forty-four (44) beds and at the time of the survey, the census was forty (40).</p> <p>The findings include:</p> <p>1. Observation, on 07/22/15 at 1:45 PM, with the Maintenance Director revealed two (2) clean linen carts were being stored in the Side Hall open to the egress path of Hall 20.</p> <p>Interview, on 07/22/15 at 1:46 PM, with the Maintenance Director revealed he was not aware of the requirements for protection from hazards.</p> <p>2. Observation, on 07/22/15 at 2:35 PM, with the Maintenance Director revealed two (2) clean linen carts were being stored in the hall by the Director of Nursing Office.</p> <p>Interview, on 07/22/15 at 2:36 PM, with the Maintenance Director revealed he was not aware of the requirements for protection from hazards.</p> <p>The census of forty-four (44) was verified by the Administrator on 07/22/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 07/22/15.</p>	K 029	<p>outside NFPA guidelines.</p> <p>Criteria #3 The maintenance director received in-service training on hazardous storage on 7/27/15 from the administrator. All nursing, laundry and housekeeping staff received in-service training regarding the appropriate storage of the linen carts on 8/20/15 by the Staff Development Coordinator.</p> <p>Criteria #4 The CQI indicator, ES-8 which includes monitoring of linen cart storage shall be completed by the Maintenance Director monthly x 2 months and then quarterly per the CQI schedule under the supervision of the Administrator</p> <p>Criteria #5</p>	8/25/15

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K 029	Continued From page 5 Actual NFPA Standard: Reference: NFPA 101 (2000 Edition) 19.3.2 Protection from Hazards. Reference: NFPA 101 (2000 Edition) 9.3.2.1 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: (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			

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