

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

PRINTED: 08/10/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/28/2011
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NAME OF PROVIDER OR SUPPLIER  GALLATIN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095
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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	<p><b>INITIAL COMMENTS</b></p> <p>A recertification survey was initiated on 07/26/11 and concluded on 07/28/11 with regulatory violations cited at the highest scope and severity of a D. A Life Safety Code survey was initiated and concluded on 07/26/11 with deficiencies cited at the highest scope and severity of an F. An abbreviated survey was initiated on 07/26/11 and concluded on 07/28/11 investigating KY #16709. The Division of Health Care substantiated the allegation without regulatory violations.</p> <p>F 441 SS=D 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if</p>	F 000  <b>F441/N144</b>  F 441	<p>A. The ADON immediately placed a sign on the door for resident # 12 to alert visitors/staff of potential exposure/spread of infectious pathogens on 07/28/2011</p> <ul style="list-style-type: none"> <li>The ADON conducted an audit to determine any other potential residents with a MDRO infection. This was completed by 07/28/2011.</li> <li>The DON added an addendum to the infection control policy to include staff/visitor notification of potential MDRO infections.</li> <li>This addendum includes placing a sign on the door for each resident diagnosed with a MDRO infection. This addendum also includes adding an infection control alert sheet. This will be completed by the staff nurse upon diagnosis of an MDRO infection and forwarded to the infection control nurse.</li> </ul>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

*X Marie W. Samsel*

*X Administrator X 8/26/11*

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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If continuation sheet Page 1 of 6  
AUG 26 2011

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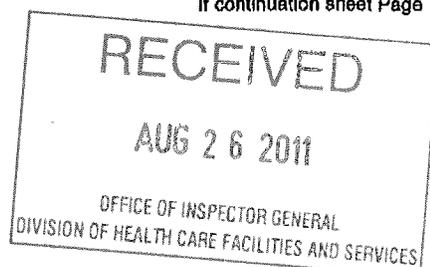
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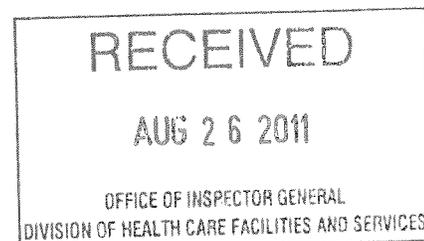
F 441	<p>Continued From page 1</p> <p>direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility "Infection Control Policy", it was determined the facility failed to have policies in place to ensure staff and visitors were aware of potential exposure/spread of infectious pathogens for Resident #12.</p> <p>In addition, the facility failed to follow its' policy regarding "Setting Up an Intravenous Infusion" for Resident #13. This affected two (2) of the nineteen (19) sampled residents.</p> <p>The findings include:</p> <p>1. Review of the facility Infection Control Policy revealed it had an active, facility wide infection control program that practices measures to identify, control and prevent infections acquired or brought into the facility from the community or other health care facilities with it's goal to improve</p>	F 441	<ul style="list-style-type: none"> <li>All nurses will be in-serviced by the ADON, Staff Development Nurse, Infection Control Nurse or Unit Coordinator on the addendum to the facility policy by 08/22/2011.</li> <li>The infection control nurse will conduct an audit to ensure compliance with the policy addendum weekly for four weeks then biweekly for four weeks and monthly thereafter.</li> <li>The audits completed by the infection control nurse will be discussed weekly during the interdisciplinary standards of care meeting. If concerns are identified then it will be addressed by the DON/ADON/Infection Control Nurse and then reviewed at the quarterly risk management meeting.</li> </ul>	
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F 441	<p>Continued From page 2</p> <p>resident care practices by reducing the potential for nosocomial (facility acquired) infections. However, review of the policy revealed no evidence of how the facility would protect families and visitors entering a resident's room with an infection.</p> <p>Review of Resident #12's clinical record revealed the facility admitted the resident on 06/20/11 with diagnosis of Post Operative Infection from a Total Left Knee Replacement. The 05/11/11 culture report from drainage from the left knee revealed an infection of Methicillin Resistant Staphylococcus Aureus (MRSA). The resident was placed in contact isolation.</p> <p>Observation of Resident #12's room, on 07/27/11 at 3:00 PM, revealed two large trash barrels labeled linens and trash located at the foot of the resident's bed, blocking the resident's sink, as well as the air conditioning unit. However, there was nothing to alert families or visitors of the potential infection when entering the room.</p> <p>Interview with Resident #12 revealed the large barrels were usually up against the sink, preventing the resident from getting to the hand washing sink. In addition, the resident stated the barrels were kept against the air conditioner most of the time.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 07/28/11 at 12:00 PM, revealed if any resident's are placed on any type of isolation, then they would obtain this information from the nurse. This</p>	F 441	<p><b>B.</b> The day shift nurse on 07/28/2011 disposed of the IV tubing and bag.</p> <ul style="list-style-type: none"> <li>The nurse involved was counseled by the Director of Nursing on 07/28/2011 related to and in-serviced on the policy for setting up an intravenous infusion.</li> <li>An audit of each resident receiving IV therapy was completed by the ADON on 07/28/2011 to ensure compliance with facility policy. There was no further deficient practice.</li> <li>An in-service was conducted by the ADON, Infection Control Nurse, Unit Coordinator and Staff Development Nurse with all nurses to review the policy for setting up an intravenous infusion by 08/22/2011.</li> <li>The Staff Development Nurse will review Intravenous therapy yearly during the nurse competency evaluations.</li> </ul>	



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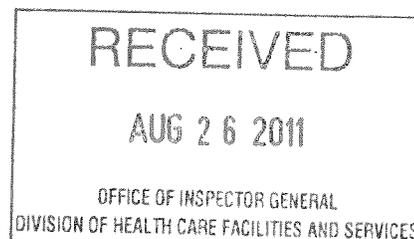
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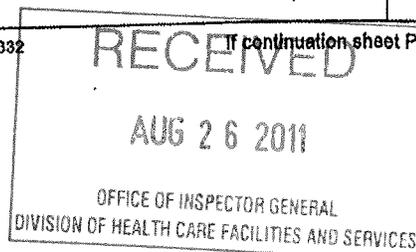
F 441	<p>Continued From page 3</p> <p>information would be placed on the nurse alde care plan sheet and placed on the inside of the resident's closet. CNA #1 stated the large barrels were usually kept by the sink and against the air conditioner.</p> <p>Interview with the Infection Control Nurse, on 07/28/11 at 11:00 AM, revealed there should be signs placed on the outside of each resident's door stating "See Nurse Before Entering", however, she had been busy this week, and had not been able to place the signs on the doors. There were two additional unsampled residents on the 400 and 600 halls in the facility requiring contact isolation; however, observation during initial tour on 07/26/11 revealed no evidence signs had been placed outside their rooms to alert families and visitors of the infection. Further interview with the Infection Control Nurse revealed she was responsible for monitoring the signs and making rounds.</p> <p>Interview with the Director of Nursing, on 07/28/11 at 10:40 AM, revealed there should be identification on the outside of each resident's room to alert visitors if there is a positive infection. The Director of Nursing stated the Center for Disease Control (CDC) information was primarily her source when implementing the infection control policy; however, there was no evidence to show policies were in place for informing visitors and family members of infectious pathogens.</p>	F 441	<ul style="list-style-type: none"> <li>The infection control nurse will conduct an audit to ensure compliance with the IV therapy policy weekly for four weeks then biweekly for four weeks and monthly thereafter. The DON/ADON/Infection Control Nurse will address any concerns immediately with staff nurse.</li> <li>The results of the IV therapy audit will be discussed in the quarterly risk management meetings.</li> </ul> <p style="text-align: right;">Completion Date: 8/22/2011</p>	
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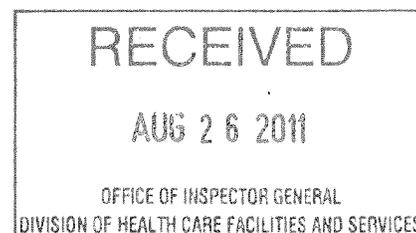
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F 441	Continued From page 4  2. Review of the facility policy on Setting Up a Primary Infusion revealed the procedure was to attach a label with date, time and the nurse's initials to the intravenous (IV) infusion tubing and bag and to change IV tubing every twenty four (24) hours for any tubing disconnected between infusions.  Interview with the Director of Nursing (DON) on 07/28/11 at 09:05 AM revealed the facility policy was to label, date and initial the IV tubing and the IV bag whenever setting up an infusion and IV tubing was to be changed every twenty four (24) hours for any tubing disconnected between infusions.  Review of Resident #9's clinical record revealed the facility readmitted the resident on 07/29/11 after discharge from the hospital for treatment of a urinary tract infection (UTI). The resident was receiving IV antibiotic treatment two (2) times a day for ten (10) days.  Observation of Resident #9's room, on 07/26/11 at 12:20 PM, revealed an empty IV antibiotic bag hanging on a pole at the bedside and IV tubing threaded through the IV pump not labeled with date, time, and nurse's initials.  Observation of Resident #9's room, on 07/26/11 at 08:00 AM, revealed an IV pole and pump with no IV bag or tubing attached. On 07/29/11 at 09:45 AM, an empty IV antibiotic bag and IV tubing threaded through the IV pump was not labled with date, time and nurse's initials.	F 441		



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F 441	Continued From page 5 Interview with Licensed Practical Nurse (LPN) #1, on 07/27/11 at 03:45 PM, revealed good nursing practice was to always label, date, and initial IV bag and tubing when setting up an infusion.  Interview with LPN #2, on 07/28/11 at 09:15 AM, revealed she was aware of the facility policy concerning setting up a primary infusion and was aware that she failed to label, date, and initial the IV tubing and the IV bag for Resident #9 on two (2) different occasions.	F 441		



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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: 1989</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V Unprotected</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator installed in 1989. Fuel source is Natural Gas with a Letter of Reliability.</p> <p>A standard Life Safety Code survey was conducted on 07/26/11. Gallatin Health Care was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred twenty (120) beds and the census was ninety two (92) 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</p>	K 000		
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OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

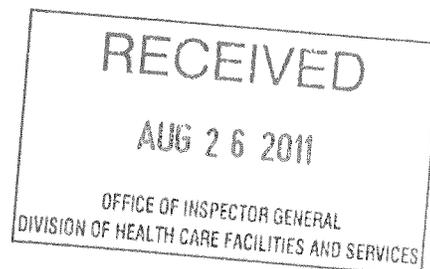
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X. Stain W. Donald</i>	TITLE <i>X. Administrator X</i>	(X6) DATE <i>8/26/11</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Fire)	K 000		
K 018 SS=E	Deficiencies were cited with the highest deficiency identified at F level. CFR: 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ 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  Roller latches are prohibited by CMS regulations in all health care facilities.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, according to NFPA standards. The deficiency had the potential to affect three (3) of six (6) smoke compartments,	K 018  K 018	Resident room 110 and 602 were affected and were filed by Maintenance staff to ensure proper closure by 8/12/2011. Resident rooms 506 and 503 were fixed by Maintenance staff on 7/27/2011 by rearranging furniture to ensure doors were not blocked from closing properly.  The Maintenance assistant ensured proper closure of all doors while on rounds with the Life Safety Code officer on 7/26/2011. The QA nurse and Administrator conducted an audit on 8/23/2011 of all doors to ensure proper closure and Maintenance fixed any identified issues by 8/24/2011.	



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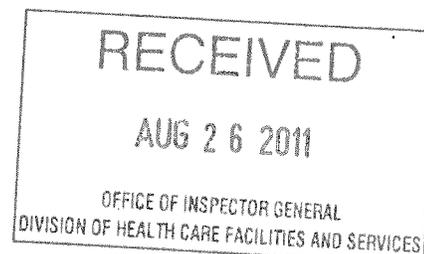
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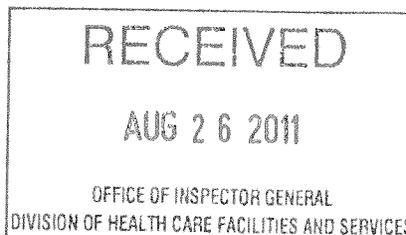
K 018	<p>Continued From page 2 residents, visitors, and staff. The facility is licensed for one hundred twenty (120) beds with a census of ninety two (92) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/26/11 between 9:30 AM and 5:00 PM, with the Maintenance Staff revealed the corridor door to resident room 110, and 602 would not latch. The corridor doors to resident rooms 503, and 506 were blocked from closing by the resident beds.</p> <p>Interview, on 07/26/11 between 9:30 AM and 5:00 PM, with the Maintenance Staff confirmed all the observations.</p> <p>Reference: NFPA 101 (2000 edition) 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.</p>	K 018	<p>The systemic changes made were that the Administrator/Charge Nurse were to in-service all staff members on these types of hazards and to report to Maintenance via work order or repair log. The in-service will be completed by 8/26/2011.</p> <p>The QA nurse/Administrator will conduct bi-weekly rounds of corridor doors for two months and quarterly thereafter to ensure proper closure. The QA nurse/Administrator will also audit the maintenance repair book to ensure proper communication and timely repairs are done on a bi-weekly basis for two months and quarterly thereafter to ensure compliance. The results will be reviewed in the quarterly risk management meetings.</p> <p>Completion date: 8/26/2011</p>	
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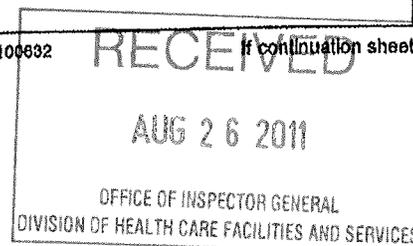
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K 018	Continued From page 3 Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout 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 19.3.5.2. 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: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.  19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.	K 018		



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K 018	Continued From page 4 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		
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, per NFPA Standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred and twenty (120) beds with a census of ninety two (92) on the day of the survey.	K 029  K 029	No residents were affected by the deficient practice as a result of fire drills being conducted and residents accounted for during drills. The facility has not had an actual fire to reveal problems with smoke barrier doors.  The systemic change made was that all previously approved hold-open devices with on step motion for release were removed on 7/27/2011 by maintenance. An approved device was installed by maintenance on the kitchen doors by 8/03/2011. The storage room had a hold open device installed by maintenance on 8/15/2011 and dining room doors were installed by 8/26/2011.	



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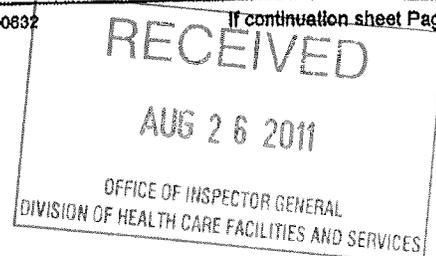
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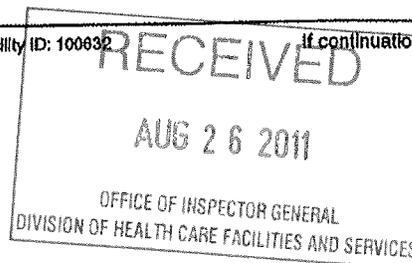
K 029	<p>Continued From page 5</p> <p>The findings include:</p> <p>Observation, on 07/26/11 at 10:20 AM, with the Maintenance Staff revealed the door to the Dining Room, and the Kitchen were held open with a door stop.</p> <p>Interview, on 07/26/11 at 1:20 PM, with the Maintenance Staff revealed he was unaware that the doors could not have door stops.</p> <p>Observation, on 07/26/11 at 10:30 AM, with the Maintenance Staff revealed the door to the Dry Storage Room, located in the Kitchen did not have a self closing device installed on the door.</p> <p>Interview, on 07/26/11 at 10:30 AM, with the Maintenance Staff confirmed the observation.</p> <p>This is the fourth repeat deficiency the facility has received for unapproved door stops. Previous surveys include, 7/28/10, 2/04/08, 12/07/05.</p> <p>Interview, on 07/26/11 at 5:10 PM, with the Administrator revealed that she thought the previous deficiencies were only pertaining to a mechanical room door.</p> <p>Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a</p>	K 029	<p>The QA nurse/Administrator/Maintenance will audit hold open devices biweekly for two months and quarterly thereafter to ensure the mechanism becomes self-closing upon release and any failure to do so will be reported for repair. Results will be discussed during risk management meetings.</p> <p>Completion date: 8/26/2011</p>	
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K 029	Continued From page 6 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 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), 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.  Reference: NFPA 101 (2000 Edition).  19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to	K 029		



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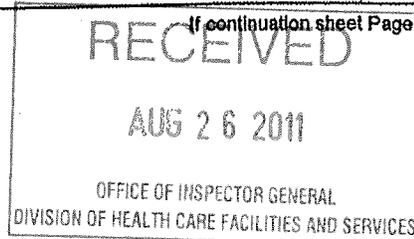
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K 029	<p>Continued From page 7</p> <p>be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility.</p> <p>7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met:</p> <p>(1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.</p> <p>19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.</p>	K 029		
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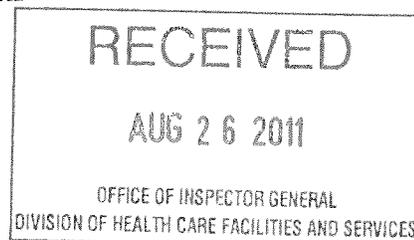
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K 029	Continued From page 8	K 029		
K 038 SS=E	<p>A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access and exit doors were maintained to be clearly recognizable as a means of egress, per NFPA standards. The deficiency had the potential to affect three (3) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred twenty (120) beds with a census of ninety two (92) on the day of the survey.</p> <p>The findings include:</p>	K 038	<p>No residents were affected by the reported deficient practice as a result of doors being marked as exits on the facility diagram posted in the hallways. Also, exit signs are mounted for residents and staff to identify exit locations in the event of an evacuation.</p> <p>The maintenance staff removed all blinds from doors by 8/24/2011 to ensure compliance. The Administrator conducted an in-service for all staff to communicate problem identified during survey with the blinds.</p>	



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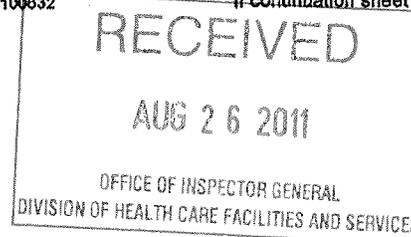
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K 038	<p>Continued From page 9</p> <p>Observation, on 07/26/11 at 9:34 AM, with the Maintenance Staff revealed mini-blinds mounted on the 100 Exit Door, 300 Exit Door, and the B Side Exit Door.</p> <p>Interview, on 07/26/11 at 9:34 AM, with the Maintenance Staff revealed they were unaware that mini-blinds were prohibited to be mounted on exit doors.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>7.5.2.2 Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit.</p>	K 038	<p>The QA nurse/Administrator will conduct a monthly audit for two months ensure compliance and quarterly thereafter to ensure that nothing is blocking or obscuring any exits.</p> <p>Completion date: 8/24/2011</p>	
K 060 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and fire drill review it was determined the facility failed to ensure fire drills were conducted at unexpected times under</p>	K 050  K 050	<p>No residents were affected by the deficient practice as evidence of staff conducting unexpected fire drills monthly and all residents were accounted for and safe during the drills.</p>	



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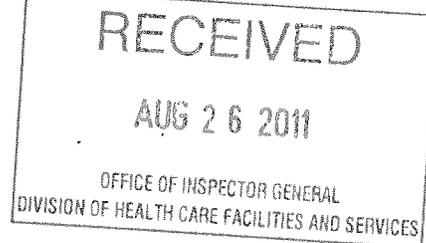
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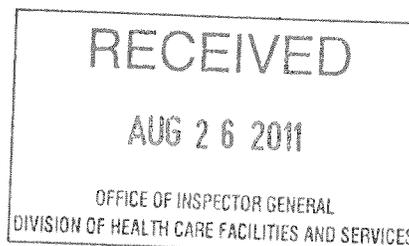
K 050	Continued From page 10 varied conditions. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred twenty (120) beds with a census of ninety two (92) residents on the day of the survey.  The findings include:  Fire Drill review, on 07/26/11 at 4:00 PM, with the Maintenance Staff revealed the fire drills were not being conducted at unexpected times under varied conditions.  Interview, on 07/26/11 at 4:00 PM, with the Maintenance Staff revealed he was unaware the fire drills were not being conducted as required.  Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050	Administrator conducted an audit of drills that did indicate variation of <i>times and conditions</i> , but IDR was lost. The Administrator in serviced all departments by 8/25/2011 on the reported non-compliance and informed that Maintenance will be conducting unannounced drills at even more varied times and conditions to ensure compliance. The Administrator educated the maintenance department on the changes.  The QA nurse/Administrator will conduct audits of the fire drill log to ensure varied times and conditions were met on a quarterly basis.  Completion date: 8/25/2011	
K 056 SS=D	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	K 056	No evidence of residents sustaining an injury identified from not have a 5' by 5' covered porch area connected to the sprinkler system.	



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K 056	Continued From page 11 building fire alarm system. 19.3.5  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, according to NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred twenty (120) beds with a census of ninety two (92) on the day of the survey.  The findings include:  Observation, on 07/26/11 at 1:40 PM, with the Maintenance Staff revealed a recessed, 5' by 5' covered porch, located in the courtyard, that was used to store plywood. The porch roof was made of combustible materials, and was not sprinkler protected.  Interview, on 07/26/11 at 1:40 PM, with the Maintenance Staff confirmed the observation.  Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056	Brown Sprinkler installed a sprinkler head in the 5' by 5' overhang to ensure compliance. The Administrator for compliance with LSC standards checked all other areas and no deficient practice were identified.  Maintenance will monitor the need for sprinkler heads if the build has space added on to ensure compliance.  Completion date: 8/15/2011	
K 070 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 070		



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K 070	<p>Continued From page 12</p> <p>Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were according to NFPA standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred twenty (120) beds with a census of ninety two (92) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/26/11 at 11:00 AM, with the Maintenance Staff revealed a portable space heater located in the Office Managers Office.</p> <p>Observation, on 07/26/11 at 1:35 PM, with the Maintenance Staff revealed another portable heater located in the Computer Room.</p> <p>Interview, on 07/26/11 at 11:00 AM and 1:35 PM, with the Maintenance Staff revealed they were aware of the portable heaters located in the nonresident rooms, but did not know the heaters could not exceed 212 degrees.</p> <p>Reference: NFPA 101 (2000 edition)</p>	K 070	<p>No residents were affected by deficient practice as a result of an audit conducted by the QA nurse to ensure no portable heaters were found in rooms.</p> <p>Portable space heaters were removed from the Office Managers Office on 7/26/2011 and the heating/cooling unit was removed from the Computer Room on 8/18/2011. The Administrator educated those individual people on the non-compliance on 7/26/2011 and 8/18/2011.</p> <p>The QA nurse/Administrator will conduct a monthly audit for two months to ensure compliance and quarterly thereafter.</p> <p>Completion date: 8/18/2011</p>	
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K 070	Continued From page 13 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). NFPA 101 LIFE SAFETY CODE STANDARD	K 070		
K 147 SS=F	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 wiring was maintained according to NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred twenty (120) beds with a census of ninety two (92) on the day of the survey.  The findings include:  Observation, on 07/26/11 between 9:30 AM and 5:00 PM, with the Maintenance Staff revealed:  1) Electrical panels located in resident corridors were found to be unlocked. 2) Hair dryers, and curling irons plugged into a power strip located in the Beauty Shop.	K 147 K 147	The only resident room identified during LSC rounds with the Maintenance assist was room 210 on 7/26/2011 having a medical device plugged in to an expansion plug. It was corrected on 7/26/2011. The facility has not reported injuries as a result of electrical panels not being locked.  The Maintenance department is placing locks on the electrical panels and it was completed by 8/24/2011. The Maintenance department added additional wall plugs in the Office Managers Office, Beauty Shop, Laundry Room and Social Service Office by 8/11/2011. The storage in front of the electrical panel in the	

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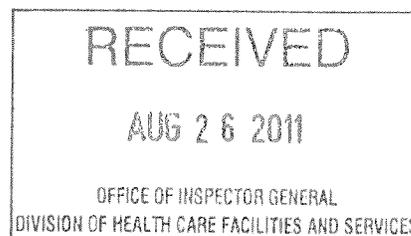
PRINTED: 08/10/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/26/2011
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NAME OF PROVIDER OR SUPPLIER  GALLATIN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095
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K 147	Continued From page 14 3) Storage in front of electrical panels located in the Laundry Room and the Mechanical Room, next to the Kitchen. 4) An extension cord plugged into a power strip running a refrigerator located in the Medical Records Office. 5) An extension cord in use in the Admissions Office. 6) A microwave oven plugged into a power strip located in the Office Managers Office. 7) A washing machine plugged into an extension cord located in the Laundry Room. 8) A refrigerator and a microwave plugged into a power strip located in the Social Services Office. 9) An oxygen concentrator plugged into a multi plug adaptor located in Room 210.  Interview, on 07/26/11 between 9:30 AM and 5:00 PM, with the Maintenance Staff revealed they were aware of the extension cords and power strips but were unaware that they were being misused. The Maintenance Supervisor also revealed, they were aware, items could not be stored in front of electrical panels, and medical equipment could not be plugged into multi plug adaptors, but did not know who placed the items in front of electrical panels, or who plugged the oxygen concentrator into the multi plug adaptor.  Reference: NFPA 99 (1999 edition)	K 147	Laundry Room and Mechanical Room was removed on 7/26/2011 and in servicing was completed by the Administrator for all departments by 8/25/2011 to ensure future compliance. The oxygen concentrator was plugged into a wall plug on 7/26/2011 after identified in a multi plug adaptor in room 210. The two extension cords found in the Medical Records Office and Admissions Office were removed on 7/26/2011.  The QA nurse/Administrator will be conducting monthly audits for three months and quarterly thereafter to ensure compliance with the electrical equipment and report findings to the risk management meetings.  Completion date: 8/25/2011.	
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K 147	Continued From page 15 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.  Reference: NFPA 70 (1999 edition)  110-26. Spaces  About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K 147		
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