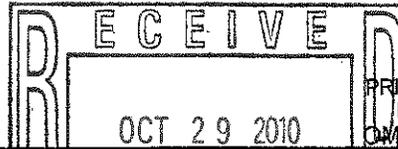


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 10/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING Division of Health Care Southern Enforcement Branch	(X3) DATE SURVEY COMPLETED 10/07/2010
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NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240
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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
F 000	INITIAL COMMENTS	F 000		
F 281 SS=D	<p>A standard health survey was conducted on Oct 5-7, 2010. Deficient practice was identified with the highest scope and severity at an 'E' level.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide services to meet professional standards of quality for two (2) of twenty-one (21) sampled residents. Resident #3 had a physician's order for a magic cup to be provided three (3) times a day between meals; however, observations on October 5-6, 2010, revealed the resident did not receive the magic cup. Resident #10 had a physician's order to apply TED (thrombo embolic deterrent) hose in the morning and to remove the TED hose at night. However, observations made on October 5-6, 2010, revealed resident #10 was not wearing the TED hose.</p> <p>1. Review of the medical record revealed resident #10 was admitted to the facility on October 6, 2007, with diagnoses of Alzheimer's Disease, Parkinson's, Psychosis, and Depressive Disorder. Review of the Quarterly Minimum Data Set (MDS) dated July 14, 2010, revealed the facility assessed resident #10 as being severely impaired in daily decision-making. Review of the Resident Assessment Protocol (RAP) dated October 14, 2009, revealed resident #10 was dependent on staff for all activities of daily living.</p>	F 281	See Attachment	11/21/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Deborah Fitzgibbon* TITLE: *Administrator* (X6) DATE: *10/29/10*

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 281	<p>Continued From page 1</p> <p>Review of the October 2010 monthly Physician's Orders revealed an order for TED (thrombo embolic deterrent) hose to be applied to resident #10's lower extremities each morning and staff was to remove the TED hose in the evening.</p> <p>Observation on October 5, 2010, at 9:25 a.m., 11:50 a.m., 2:00 p.m., and 3:00 p.m., and on October 6, 2010, at 8:45 a.m. and 9:55 a.m., revealed resident #10 was not wearing the TED hose.</p> <p>Interview on October 6, 2010, at 2:10 p.m., with Licensed Practical Nurse (LPN) #1, who was responsible for resident #10's care from 7:00 a.m. to 7:00 p.m. on October 5 and 6, revealed some of the treatments on the TAR (Treatment Administration Record) are performed by the Certified Nurse Aides (CNAs); however, LPN #1 stated it was the responsibility of the nurses to check and make sure the treatments were provided as ordered. LPN #1 stated the nurse should initial the TAR to indicate the treatment had been provided for the resident. LPN #1 stated the LPN checked resident #10 at approximately 4:00 p.m. on October 5, 2010, and the TED hose had been applied. LPN #1 stated LPN #2 was responsible for resident #10's treatments for October 6, 2010.</p> <p>Review of the TAR revealed staff had initiated the TAR on October 5 and October 6, 2010, indicating the TED hose had been applied and removed as ordered by the physician.</p> <p>Interview on October 6, 2010, at 3:10 p.m., with LPN #2 revealed LPN #2 had initiated the treatment for October 6, 2010, but had not thoroughly checked resident #10 to ensure the</p>	F 281			

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F 281	<p>Continued From page 2</p> <p>TED hose were applied by the CNA. LPN #2 stated the LPN remembered seeing something white on the resident's ankle area but had mistaken the resident's sock for the TED hose.</p> <p>Interview on October 6, 2010, at 1:40 p.m., with CNA #5 revealed CNA #5 was assigned to provide care to resident #10 on the day shift on October 6, 2010. CNA #5 stated the CNAs received a care plan sheet each day that detailed each resident's care needs. CNA #5 had the care plan in the CNA's pocket. Review of the care plan directed CNA #5 to apply TED hose to resident #10. CNA #5 stated the TED hose were in the resident's drawer, however, the CNA had just failed to apply the TED hose.</p> <p>Interview on October 6, 2010, at 2:10 p.m., with CNA #2, who was responsible for resident #10's care on October 5 and October 6, 2010, from 3:00 p.m. to 11:00 p.m., revealed the TED hose had not been applied by the day shift on October 5 or 6, 2010.</p> <p>2. Resident #3 was admitted to the facility on June 20, 2003, with diagnoses of Pneumonia, Hypertension, Osteoporosis, Confusion, Depression, and B Complex Deficiency. Resident #3, according to the MDS dated September 14, 2010, had a weight loss, left 25 percent or more of food uneaten, and was provided a mechanically altered, therapeutic diet and dietary supplements between meals. Resident #3's RAP dated September 7, 2010, revealed the resident had a weight loss due to insufficient intake amounts. The RAPs stated the weight loss was probably due to the resident's acute illness and severe dementia. According to the RAP, resident #3 had a mechanically altered and therapeutic</p>	F 281			

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F 281	<p>Continued From page 3</p> <p>diet, snacks were offered, and diet and supplements were provided as ordered.</p> <p>Review of resident #3's medical record revealed a dietary recommendation dated September 10, 2010, for a magic cup three times a day between meals to be provided to the resident. A physician's order dated September 15, 2010, revealed an order for a magic cup to be provided three times a day between meals to the resident.</p> <p>Observations made of resident #3 on October 5, 2010, from 8:30 a.m. until 4:15 p.m., and again on October 6, 2010, from 9:05 a.m. until 4:30 p.m., revealed no magic cup was provided to the resident when the snack tray was passed to residents.</p> <p>Interview on October 6, 2010, at 10:05 a.m., with CNAs #3 and #4, revealed resident #3 received a health shake most of the time in the afternoon.</p> <p>Interview on October 6, 2010, at 11:00 a.m., with the LPN #3 revealed the LPN was unaware if resident #3 received a magic cup, and was unaware of any weight loss resident #3 had experienced.</p> <p>Interview on October 6, 2010, at 12:55 p.m., with the Dietary Manager (DM) revealed the Dietary Department was unaware of an order for resident #3 to receive a magic cup three times a day. The DM stated that the nurse on the floor received the order from the physician and was required to fill out a diet order form. The diet order form was then placed in the dietary box, which was located at each nursing station, and a dietary staff member made rounds throughout the day and collected the diet order forms from the floors.</p>	F 281			

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F 281	Continued From page 4 The dietary orders were then placed into the computer so that dietary staff would know to send a snack for residents who required a snack at snack time. The DM was unable to provide a record of resident #3's dietary order form for a magic cup three times a day between meals. Review of resident #3's resident detail report provided by the Dietary Department which showed resident #3's daily food requirements revealed resident #3 did not receive a magic cup three times a day. Interview on October 6, 2010, at 4:45 p.m., with the Assistant Director of Nursing (ADON) revealed the ADON was unaware resident #3 did not receive the magic cup three times a day as per physician's order.	F 281			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents received the necessary care and services related to incontinence care for two (2) of twenty-one (21) sampled residents. Observation on October 5, 2010, revealed staff failed to provide resident #4 and #10 with proper incontinence care. The findings include:	F 312	See Attachment	11/21/10	

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F 312	<p>Continued From page 5</p> <p>1. Review of the medical record revealed resident #10 was admitted to the facility on October 6, 2007, with diagnoses of Alzheimer's Disease, Parkinson's, Psychosis, and Depressive Disorder. Review of the Quarterly Minimum Data Set (MDS) dated July 14, 2010, revealed the facility assessed resident #10 as being severely impaired in daily decision-making. Review of the Resident Assessment Protocol (RAP) dated October 14, 2009, revealed resident #10 was dependent on staff for all activities of daily living and utilized briefs due to urinary incontinence.</p> <p>Review of the comprehensive care plan with a review date of July 20, 2010, revealed resident #10 was incontinent of bowel and bladder and was not a candidate for bowel/bladder retraining or scheduled toileting. Review of the intervention for incontinence revealed staff was to check the resident for incontinence every two hours and perform peri-care and change clothes as needed.</p> <p>Observation on October 5, 2010, at 4:10 p.m., revealed CNA #1 and CNA #2 entered resident #10's room to provide incontinence care. Resident #10's pants were wet from urine leaking from the resident's brief. CNA #1 and CNA #2 removed the resident's wet pants and wet brief and then applied a dry brief and clean pants. The CNAs failed to cleanse the resident's skin after the incontinence episode. No redness or irritation of the skin was present.</p> <p>2. Review of the medical record revealed resident #4 was admitted to the facility on July 29, 2010, with diagnoses of Dementia with behaviors, Decubitus Ulcer and Dysphagia. Review of the admission MDS dated August 11, 2010, revealed</p>	F 312			

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F 312	Continued From page 6 the facility assessed resident #4 as being moderately impaired in daily decision-making and resident #4 was frequently incontinent of urine. Review of the RAP dated July 30, 2010, revealed resident #4 was frequently incontinent of bladder and required the use of briefs. Additionally, resident #4 required the use of a diuretic. Observation on October 5, 2010, at 2:30 p.m., revealed CNA #1 and CNA #2 were to provide incontinence care for resident #4. Observation revealed CNA #1 and CNA #2 removed a wet brief from resident #4 and then applied the dry brief. The CNAs failed to cleanse resident #4's skin before a clean brief was applied. Interview on October 6, 2010, at 3:30 p.m., with CNA #1, who was responsible for providing care to resident #4 and resident #10, revealed CNA #1 was knowledgeable of the requirement to cleanse the resident's skin during the provision of incontinence care. CNA #1 stated the CNA was nervous and should have used moistened wipes to cleanse the residents. Review of the facility policy (not dated) regarding Incontinence Care revealed staff was directed to cleanse residents after each incontinence episode with incontinence care wipes or soap and water.	F 312			
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.	F 323	See Attachment	11/21/10	

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F 323	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as is possible. The facility failed to ensure cleaning products were not accessible to residents.</p> <p>The findings include:</p> <p>Observation on October 6, 2010, at 11:30 a.m., during the environmental tour of the facility revealed a gallon container of Total Plus Disinfectant sitting on the floor in the second floor women's shower room unattended. A clear plastic bag was observed to cover the container. Further observation revealed the disinfectant container did not have a lid and the container was three-fourths full of solution. A lid was observed floating in the solution of disinfectant.</p> <p>Further observation revealed a gallon container of Total Plus Disinfectant sitting on the floor in the men's shower room on the second floor unattended. The disinfectant did not have a lid.</p> <p>Interview on October 6, 2010, at 5:15 p.m., with the Director of Nursing (DON) revealed chemicals should not be accessible to residents. The DON stated the disinfectant could be dangerous to a resident if ingested. The DON stated the housekeeping staff should have stored the disinfectant in a locked area. The DON provided a list dated September 27, 2010, of 16 residents</p>	F 323			

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F 323	<p>Continued From page 8</p> <p>in the facility that had been assessed as exhibiting wandering/elopement behavior.</p> <p>Interview on October 7, 2010, at 9:20 a.m., with the Housekeeping Supervisor (HS) revealed the Maintenance Department staff was responsible for changing the disinfectant to the whirlpools. The HS stated the facility had recently had new whirlpools installed. The HS stated the housekeeping staff was aware of the requirement to store all the cleaning supplies in a locked/secured area.</p> <p>Interview on October 7, 2010, at 1:40 p.m., with the second floor housekeeper (housekeeper #1) revealed the housekeeper was aware the container of disinfectant was in the men's and women's shower rooms unsecured. The housekeeper stated the disinfectant had been sitting on the floor in the women's shower room for approximately one week; however, the container of disinfectant in the men's shower room had been there much longer.</p> <p>Interview on October 7, 2010, at 1:45 p.m., with housekeeper #2 revealed the housekeeper was aware of the disinfectant sitting on the floor in the women's bathroom. Housekeeper #2 stated the housekeeper attempted to put a lid on the container; however, the lid did not fit and fell into the solution. Housekeeper #2 stated the Housekeeping Department was not responsible for the whirlpool disinfectant chemicals.</p> <p>Interview on October 7, 2010, at 2:00 p.m., with the Maintenance Supervisor (MS) revealed a new whirlpool was installed in the men's shower room on August 23, 2010, and the women's new whirlpool was installed on September 20, 2010.</p>	F 323			

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F 323	Continued From page 9 The MS stated the Total Plus Disinfectant was used in the old whirlpools and should have been discarded when the old whirlpools were removed. Review of the Material Safety Data Sheet (MSDS) for Total Plus Disinfectant revealed the disinfectant could be harmful if swallowed or if a spray mist is inhaled. The MSDS also revealed prolonged exposure could cause eye and skin irritation. Review of the facility policy (not dated) that addressed Environmental Supplies revealed environmental supplies (liquids and solids) are to be stored in locked areas.	F 323			
F 465 SS-E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment. Scraped and chipped drywall was observed in two (2) resident rooms, two (2) commodes ran continuously, exposed screws were protruding from the commode base, floor tiles were cracked, and tissue paper bars were missing. The findings include: During the environmental tour of the facility on October 6, 2010, at 11:15 a.m., the following	F 465	See Attachment	11/21/10	

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F 465	<p>Continued From page 10 items were in need of repair:</p> <ol style="list-style-type: none"> 1. The drywall was observed to be scraped/chipped in resident rooms 203 and 247. 2. A night light covering was loose in the bathroom of resident room 243 and a screw was protruding from the night light in the bathroom of resident room 220. 3. Mineral deposits were observed on the hot/cold knobs on the sink in resident rooms 109 and 243. 4. The commode was running continuously in resident rooms 205 and 246. 5. The tissue paper bar was missing in the bathroom of resident rooms 143 and 246. 6. A rust stain was observed on the wall and floor in the bathroom of resident room 238 and a rust stain was on the wall in the bathroom of resident room 146. 7. Beige masking tape was observed to be covering the reset button on one of the two emergency call bells in the resident bathroom of room 248. 8. The floor tile was cracked across the room from the entry door to the window in resident room 236 and a portion of a floor tile was missing in resident room 205. 9. Screws were observed to be protruding upward from the commode base in resident rooms 111, 120, 139, 143, and 146. 10. The rolling overbed table in resident room 141 was observed to have rough edges. <p>Interview on October 7, 2010, at 2:00 p.m., with the Maintenance Supervisor (MS) revealed staff was required to fill out a work order for any items in need of repair. The MS stated the MS made rounds of all resident rooms once a month to detect items in need of repair but had failed to</p>	F 465		

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240		
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F 465 F 468 SS=D	Continued From page 11 Identify the items listed. 483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to equip corridors with firmly secured handrails. On October 6, 2010, the handrails between resident rooms 136 and 137 were observed to be loose and not firmly attached to the wall. The findings include: Observations during the environmental tour on October 6, 2010, at 1:00 p.m., revealed the handrails between rooms 136 and 137 were loose and not firmly attached to the wall. An interview with the Maintenance Supervisor (MS) conducted on October 7, 2010, at 2:00 p.m., revealed the handrails were checked monthly, and the MS was not aware the handrails were loose.	F 465 F 468	See Attachment	11/21/10	

It is the policy of this facility that the services provided or arranged by the facility meet professional standards of quality. This is evidenced by the following:

Resident #10

1. A chart and care plan review was completed for resident #10 related to treatment orders. An incident report was completed related to failure to apply TED hose during the survey. The family was notified and the physician was notified. The physician discontinued the order for the TED hose.
2. The treatment mars of all residents will be reviewed. An internal investigation will be completed by the DON _____, ADON _____, Assistant Administrator _____ and _____ to determine if other treatments are being completed timely as ordered.
3. All nursing staff will be inserviced concerning administration and documentation of treatments. Nurse aides will be inserviced specifically concerning thorough utilization of their care plan sheet. Licensed staff will be inserviced specifically concerning their responsibility to insure that treatments are being administered even if they are not administering them and to confirm prior to documenting. The inservice will be given by _____ DON and _____ ADON.
4. Six (5) TARS per nursing unit (12 total) will be audited monthly for 6 months to determine and ensure compliance. Assurance that the audits are completed will be the responsibility of Robyn Akers. She will designate various licensed staff to complete the audits at the time the audits are due. This will serve as a training tool for nurses.

The results of the audits will be reported quarterly through CQI by _____

5. Completion date is 11/21/10

Resident #3

1. All dietary orders for resident #3 were reviewed. A dietary change order was completed and sent to dietary notifying dietary of the magic cup order.
2. Dietary orders for all residents will be reviewed and the dietary department will be notified of any additional changes. This will be completed by the Food Service Director,
3. In addition to filling out the change order sheet for dietary, nursing will be required to contact dietary by phone as well during dietary hours and notify them of diet changes. Dietary will pick up change orders at 6am, 10am, 2pm and 8pm. The snack list was revised to ensure that nursing staff will be able to identify the individual snacks along with the snack being labeled.

~~Staff will now be required to document whether the snack was accepted or not and the list will be returned to dietary for monitoring.~~

Food Service Director and Kitchen Manager will monitor intake of snacks and will notify nursing of any intake results that may need further investigation. Random audits of one daily snack pass per nursing unit will be completed monthly for 6 months to ensure compliance Laurie Morgan/Amanda Sparks. Residents will be monitored weekly for weight changes. Continued weight loss for these residents will be reported to nursing, physician, families and the dietitian.

Nursing and dietary staff will be inserviced on the changes related to snack lists and reporting diet changes to dietary.

4. All diet orders will be reviewed monthly for accuracy by Laurie Morgan. This will be reported quarterly through CQI by [redacted] Weight review for these residents will continue to be completed weekly.
5. Completion Date is 11/21/10

F312

483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

It is the policy of this facility that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene. This is evidenced by the following:

1. All nursing staff providing care for resident #10 and #4 will be inserviced on proper incontinence care for these residents.
2. Other incontinent residents will be identified through a care plan review. [redacted] and will audit each resident's plan of care.
3. All nursing staff will be inserviced on proper incontinence care using the DVD incontinence training video. Each staff member will complete a post test after viewing the video. This incontinence video will be included as part of the orientation process for all nursing staff. Incontinence care will be randomly audited monthly by [redacted] and/or designee. Prevalence of UTI will be monitored for increase as well as any increase in skin alterations potentially related to improper incontinence care. [redacted] will monitor.
4. The results will be reported quarterly through CQI by [redacted]

11/21/10

483.25 (h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

It is the policy of this facility 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 is evidenced by the following:

1. The disinfectant observed by the surveyor was removed from the whirlpool rooms.
2. All shower rooms were examined and no other disinfectant was found to be out of a locked cabinet. The newly installed whirlpool tubs have locked cabinets to store disinfectant utilized in the cleaning of the whirlpool tubs. Disinfectant not being utilized is stored in a locked supply room.
3. All staff will be inserviced on proper storage of chemicals as well as their individual responsibility to remove chemicals found to be improperly stored. The inservices will be completed by Assistant Administrator and/or designee.
4. A tracking sheet is kept by maintenance to record the date the disinfectant container is changed. An additional column will be added to indicate proper disposal of the old disinfectant container.

Housekeeping personnel will observe the shower rooms daily for improperly stored chemicals and record. This will be done for a three (3) month period.

Results will be monitored and reported quarterly through CQI by the Maintenance Supervisor.

5. 11/21/10

F465

483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT

It is the policy of this facility to provide safe, functional, sanitary, and comfortable environment for residents, staff and the public. This is evidenced by the following:

1. The drywall in rooms 203 and 247 will be repaired. The night lights were repaired in 243 and 220. A different mineral deposit remover has been ordered to clean the faucet knobs. Housekeeping will begin cleaning faucets. The commodes in 205 and 246 have been repaired. Tissue paper bar in 143 and 246 have been replaced. Rust stains were removed from rooms 238 and 146. The masking tape was removed from the reset button on the resident bathroom call light. The light is functional. The floor tile has been repaired in 236 and 205. The commode bolts were shortened and caps applied to 111, 120, 139, 143, and 146. The overbed table in resident room #141 has been repaired (rough edges removed).
2. A review of all resident rooms will be completed to include all the items listed above. The maintenance department will complete the audit.

-
3. ~~All staff will be inserviced on reporting items needing repair to maintenance using the work orders. A different cleaner has been ordered to clean chemical deposits from faucets.~~
 4. Six (6) rooms per month will be audited for items needing repair or extra cleaning. Any item needing repair or cleaning will be reported to the appropriate department. Results will be reported quarterly through CQI by _____ Housekeeping Supervisor.
 5. 11/21/10

F468

483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS

It is the policy of this facility that corridors are equipped with firmly secured handrails on each side. This is evidenced by the following:

1. The hand rail between the resident rooms 136 and 137 were secured.
2. All handrails will be checked to ensure that they are secure. All staff will be inserviced on resident safety related to hand rails.
3. Housekeeping will check handrails daily while cleaning and record. If the rails are not secure they will notify maintenance. Maintenance will increase their rail checks to bi-weekly. All staff will be inserviced on safety regarding hand rails. _____ Maintenance Supervisor.
4. Random audits will be done weekly by the housekeeping supervisor and reported quarterly through CQI.
5. 11/21/10

K062

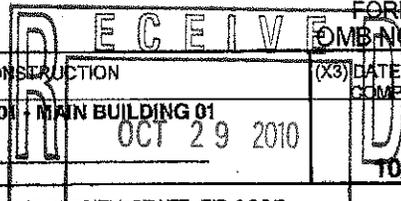
NFPA 101 LIFE SAFETY CODE STANDARD

It is the policy of this facility that required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. This is evidenced by the following:

1. The six (6) sprinkler heads in the laundry room were cleaned.
2. Maintenance staff will inspect all sprinkler heads in the facility.
3. All staff will be inserviced on the importance of cleaning and maintaining sprinkler heads. The will inspect all sprinkler heads monthly and clean if necessary. Laundry will inspect

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

PRINTED: 10/20/2010
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING <input checked="" type="checkbox"/> MAIN BUILDING 01 B. WING <input type="checkbox"/>	(X3) DATE SURVEY COMPLETED 10/06/2010
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240	
(X4) ID PREFIX TAG K 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG K 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062 SS=E	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and concluded on October 6, 2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure sprinkler heads were maintained according to NFPA standards. This deficient practice could affect all staff located in the laundry room if the sprinkler system failed to activate due to dirty sprinkler heads.</p> <p>The findings include:</p> <p>Observation on October 6, 2010, at 11:10 AM, revealed that six sprinkler heads located in the laundry room were dirty with a buildup of lint and dust. The observation was confirmed with the Maintenance Director.</p> <p>Interview on October 6, 2010, at 11:10 AM, with the Maintenance Director revealed that he cleans the sprinkler heads approximately every two months.</p> <p>Reference: NFPA 25 (1998 Edition).</p>	K 062	See Attachment	11/21/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Nelma F...* TITLE: *Administrative* (X6) DATE: 10/29/10

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 MOUNTAIN MANOR OF PAINTSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240
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K 062	Continued From page 1	K 062		
K 155 SS=F	<p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection.</p> <p>Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a fire watch was performed when parts of the fire alarm were not working. This deficient practice could affect all staff and residents if a fire was to go unnoticed due to the fire alarm not working.</p> <p>The findings include:</p>	K 155	See Attachment	11/21/10

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240		
(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 155	Continued From page 2 Record review on October 6, 2010, at 2:45 PM, revealed that during a fire alarm inspection on May 11, 2010, the company that does the fire alarm inspection found that four smoke detectors were turned off. This was confirmed with the Maintenance Director. Interview on October 6, 2010, at 2:45 PM, with the Maintenance Director revealed that the facility could not produce any documentation of a fire watch at the time the four smoke detectors were turned off.	K 155			

- ~~3. All staff will be inserviced on reporting items needing repair to maintenance using the work orders. A different cleaner has been ordered to clean chemical deposits from faucets.~~
4. Six (6) rooms per month will be audited for items needing repair or extra cleaning. Any item needing repair or cleaning will be reported to the appropriate department. Results will be reported quarterly through CQI by Kitty Harmon, Housekeeping Supervisor.
5. 11/21/10

F468

483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS

It is the policy of this facility that corridors are equipped with firmly secured handrails on each side. This is evidenced by the following:

1. The hand rail between the resident rooms 136 and 137 were secured.
2. All handrails will be checked to ensure that they are secure. All staff will be inserviced on resident safety related to hand rails.
3. Housekeeping will check handrails daily while cleaning and record. If the rails are not secure they will notify maintenance. Maintenance will increase their rail checks to bi-weekly. All staff will be inserviced on safety regarding hand rails. William Endicott, Maintenance Supervisor.
4. Random audits will be done weekly by the housekeeping supervisor and reported quarterly through CQI.
5. 11/21/10

K062

NFPA 101 LIFE SAFETY CODE STANDARD

It is the policy of this facility that required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. This is evidenced by the following:

1. The six (6) sprinkler heads in the laundry room were cleaned.
2. Maintenance staff will inspect all sprinkler heads in the facility.
3. All staff will be inserviced on the importance of cleaning and maintaining sprinkler heads. The will inspect all sprinkler heads monthly and clean if necessary. Laundry will inspect

sprinkler heads daily and record. Laundry personnel should notify maintenance if sprinkler heads are dirty.

4. Three (3) sprinkler heads in each unit or department will be audited monthly for 6 months by the Housekeeping Supervisor. The results will be reported quarterly through CQI.
5. 11/21/10

K 155

NFPA 101 LIFE SAFETY CODE STANDARD

It is the policy of this facility that if a fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm has been returned to service.

1. The smoke heads were placed back in service.
2. The fire alarm company was notified and it was confirmed that all smoke detectors were operational.
3. All staff and department managers will be inserviced on fire watch procedures. Smoke detector operation is monitored by Simplex Grinnell. Appropriate fire procedures will be followed if a smoke detector is down for more than 4 hours in a 24 hour period. Maintenance will be responsible to initiate a fire watch. Robyn Akers will inservice staff.
4. Smoke detector problems will be monitored quarterly by Maintenance (Supervisor) and reported quarterly through CQI.
5. 11/21/10