

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

PRINTED: 09/04/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/22/2012
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SPENCER COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 625 TAYLORSVILLE RD TAYLORSVILLE, KY 40071	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  A Standard Health survey was initiated on 08/19/12 and concluded on 08/22/12 with deficiencies cited at the highest scope and severity of an "D". The facility has the opportunity to correct the deficiencies before remedies would be imposed. The Life Safety Code survey was conducted on 08/21/12 with deficiencies cited at the highest S/S of "E".  KY 18805 was investigated during the standard survey and found the allegation to be unsubstantiated with no regulatory violations related to the allegation.  This was a NHI survey with entrance on Sunday, 08/19/12 at 3:00 PM.	F 000	<b>Disclaimer:</b> Signature Healthcare of Spencer County does not believe and does not admit that any deficiencies existed either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS  The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's Physical Restraint policy, it was determined the facility failed to ensure one (1) of the twenty-two (22) sampled residents (Resident #8) was free from physical restraints. The facility failed to appropriately assess Resident #8 for a seat belt restraint, utilize an alternate intervention, and develop a restraint reduction plan. The Resident has been in a physical restraint since 2010.	F 221		

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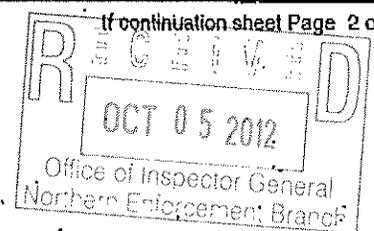
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Kathy Jones TITLE: X NHA (X6) DATE: X 9/20/12

Any agency 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 221	Continued From page 1  The findings include:  Review of the facility's policy titled Physical Restraint Reduction Program, dated 12/2010, revealed the facility supports the belief that residents should be free of any physical restraint imposed for the purposes of discipline or staff convenience. The policy revealed use of physical restraints in the facility will only be considered to treat a medical symptom/condition that endangers the physical safety of the resident or other residents and under the following conditions as a last resort measure after a trial period where alternative, less restrictive measures have been undertaken and proven to be unsuccessful. A physical restraint elimination assessment will be done quarterly and with a significant change assessment to determine the continue need of restraints, a lesser degree of restraint, or an alternative to a restraint.  Observations of Resident #8, on 8/19/12 at 5:45 PM, 8/20/12 at 8:55 AM, 9:30 AM, 10:30 AM, 11:15 AM, 12:30 PM, 1:50 PM, 2:30 PM, 3:30 PM, 4:30 PM, and 8/21/12 at 8:15 AM, 9:00 AM, 10:15 AM revealed the resident was sitting in a wheelchair with a non-alarining seat belt restraint applied around the residents waist. The resident was sitting upright, in proper body alignment, and made no attempts to bend forward in the wheelchair. The resident did not lean in the wheelchair and made no attempts to unfasten the seatbelt restraint or stand during the observations.  Review of the resident's clinical record revealed a physician's order, dated 12/01/11, to change the	F 221	Residents affected: Resident #8's restraint has been reassessed, family education completed and physician ordered clarified on 8/22/2012. Educational training will be provided to all staff by the SDC and/or the Administrator regarding resident #8 to include the need for the seatbelt and the justification of the use of the restraint along with the physician order to check and release every 2 hours during activities, meals, and toileting. Education was completed by September 20, 2012. Residents potentially affected: Residents of the facility who are restrained have the potential to be affected by the cited deficient practice. All residents with possible restraint devices were reassessed by the nursing administration team to ensure proper use of the device by September 15, 2012. No other residents were assessed as needing a restraint at this time. Systemic measures: Restraints are tracked via the white board process by the nursing administration team and the MDS scheduler. Any changes in physician orders regarding restraints and other devices will be reviewed in the clinical meeting by the nursing admin team. Documentation and assessments will be reviewed and/or completed by the nursing administration team to ensure compliance with the policy. Staff will be educated on the physical restraint policy and procedure and the reason for the restraint by the SDC and/or the Administrator on or by 9/20/2012. Nurses will be educated on the documentation related to the restraint policy and the justification of a restraint by the SDC and/or the Administrator on or by 9/20/2012. Monitoring measures: New physician's orders including devices and restraints will be reviewed in the morning clinical QA meeting. Quarterly interdisciplinary care	9/21/2012



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F 221	<p>Continued From page 2</p> <p>alarming wheelchair seatbelt restraint to a non-alarming self-release seat belt restraint. Review of physician orders, for 08/01/12 through 08/31/12, revealed continued orders for a non-alarming seatbelt restraint when in a wheelchair for posture and positioning. The physician order indicated the seat belt restraint was to serve as a reminder for the resident not to ambulate independently due to decreased safety awareness related to Alzheimer's.</p> <p>Review of the Pre-Restraining Assessment, dated 12/01/11, revealed the form did not assess all of the potential contributing behavioral factors, alternatives to restraints were not addressed, and the entire assessment was not signed by a nurse.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 08/22/12 at 12:05 PM, revealed she did not know why the resident was in a restraint. The CNA revealed she had never witnessed the resident attempting to lean over, or attempt to stand from the wheelchair. The CNA revealed she had never seen the resident attempt to unfasten the seat belt restraint.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 08/22/12 at 9:23 AM, revealed the resident did not have a problem with posture and positioning. She further stated the resident had been observed reaching for the floor in an attempt to "feed the chickens." (The resident was a farmer). The LPN stated she was not aware of the resident having a fall, and revealed the resident could not purposefully release the seat belt restraint.</p> <p>Review of the Physical Restraint Elimination</p>	F 221	<p>plans will be completed to review all aspects of the resident's care and need for the restraint. The IDT At Risk weekly committee will review all residents with restraints weekly until discontinued as well as discuss restraint reductions as needed. The Director of Nursing or the Assistant Director of Nursing will review the restraint documentation during the weekly At Risk meeting quarterly to ensure all documentation justifies the need for the restraint with proper diagnosis. Findings of the audits and rounds will be discussed in monthly QA meetings for 3 months then quarterly to ensure sustained compliance. IDT committee will discuss need for revision, correction and/or resolution during the QA process.</p> <p>Completion date: The facility will be in compliance on 9/21/2012.</p>	9/21/2012

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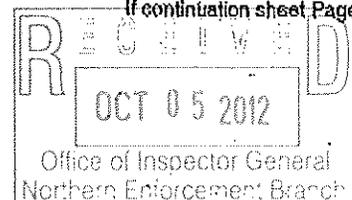
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F 221	<p>Continued From page 3</p> <p>Assessment, dated 01/13/12, revealed a score of thirty-six (36) indicating the resident was not a good candidate for a restraint reduction, but did not indicate the reasons why. Review of the reassessment, dated 05/30/12, revealed a score of twenty-nine (29) indicating the resident was a good candidate for a restraint reduction, and was assessed as having a normal sitting balance. The assessment area indicated therapy was to evaluate for a reduction of the restraint.</p> <p>Interview with the Occupational Therapist (OT), on 08/22/12 at 9:30 AM, revealed the resident had a history of falls and was referred for strengthening. The OT indicated that a seatbelt restraint can be "sort of" a positioner being that it keeps the resident in the seated position. The OT revealed the resident required supervision for verbal cues to remain seated. When OT reviewed the resident for restraint reduction, the decision to continue the seat belt restraint was made due to the risk of the resident bending forward in the wheelchair.</p> <p>Interview with the Director of Nursing (DON), on 08/22/12 at 9:50 AM, revealed the resident was not in the restraint for proper positioning or posture, but for safety to prevent falls. However, the DON revealed the resident had not fallen since April, 2011. The DON revealed the last time they tried an alternate intervention to the restraint was in July, 2010. The DON stated she was a member of the Interdisciplinary Team that reviewed all restraint assessments and had requested OT to evaluate for restraint reduction. However, the DON revealed she relied solely on the therapist assessment and the nursing department did not try any other alternate method</p>	F 221		

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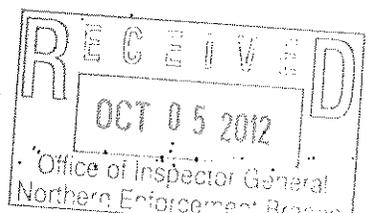
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F 221	Continued From page 4 or interventions to remove the resident from the restraint. Therefore, the resident remained in restraints, without an attempt at a reduction, since 2010.	F 221		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  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.  (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.  (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 direct contact will transmit the disease. (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.  (c) Linens	F 441  F 441	Residents affected: Resident #5 tube feeding pump and pole was cleaned 8/22/2012, and syringe placed in a bag with date. Charge nurse was educated on syringe placement after tube feeding procedure completion on 8/27/2012 by the SDC. Residents potentially affected: Residents of the facility who have a feeding tube have the potential to be affected by the cited deficient practice. All resident rooms with tube feedings ordered were audited to ensure clean tube feeding equipment 8/23/2012. Education/ training will be provided to nurses on infection control regarding tube feeding procedure, and competencies will be completed with each nurse regarding placement of equipment before and after administering a tube feeding by 9/20/2012 by SDC and/or the Director of Nursing. Systemic measures: Education/training will be provided by the SDC and/or the Administrator to nurses on infection control regarding tube feeding administration, and competencies will be completed with each nurse regarding placement of equipment before and after administering a tube feeding. Nursing and housekeeping staff will be educated by SDC and/or the Administrator regarding tube feeding pole and pump sanitation including the cleaning schedule. Education will be completed on or by	9/21/2012



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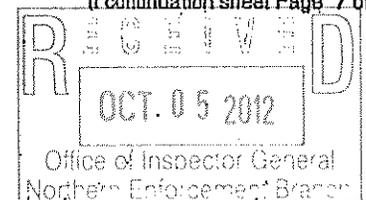
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F 441	<p>Continued From page 5</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to implement their infection control program related to care of enteral feeding pumps/pole/syringes for one (1) of two (2) sampled residents, out of total of three (3) residents with enteral feedings. Observation of Resident #5's enteral feeding pump and pole revealed tube feeding splatters on the enteral pump and bottom of the pole for all three days of the survey. In addition, the resident's feeding syringe was not stored according to the facility's policy.</p> <p>The findings include:</p> <p>1. The facility was unable to provide a policy for cleaning of a enteral feeding pump/pole.</p> <p>Observation during a medication pass, on 08/20/12 at 8:30 AM, revealed Resident #5's enteral feeding pump and pole had excessive amounts of tube feeding drippings and splatters. The splatters was dried and covered most of the legs of the feeding pole. Continued observation revealed the spillage was not cleaned and remained on the pump and feeding pole for three days until surveyor intervention on 08/22/12.</p>	F 441	<p>September 20, 2012. Housekeeping will clean poles and pumps daily during their rounds. The Housekeeping director will audit resident rooms with tube feedings 3 times a week to ensure syringes are in bags and dated and the tube feeding poles are clean.</p> <p><b>Monitoring measures:</b> The SDC and/or DON will complete observations of nurses during the tube feeding administration concentrating on infection control process and syringe placement. Random observations will occur twice a week for a month then monthly for 3 months to ensure compliance with infection control during administration of tube feeding. The QAA committee will determine need for further review depending on compliance during observations. If correction/education is needed related to compliance of audits, the IDT team will determine need for revision of plan of correction at that time. Findings of the audits and rounds will be discussed in monthly QAA meetings for at least 3 months or until sustained compliance is met.</p> <p><b>Completion date:</b> The facility will be in compliance on 9/21/2012.</p>	



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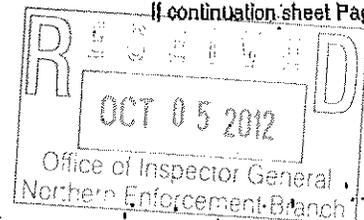
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F 441	<p>Continued From page 6</p> <p>2. Review of the facility's policy, Nasogastric/Gastrostomy Tube Feedings, dated 12-2010, revealed the feeding tube syringe is to be rinsed after each use and kept in a syringe case.</p> <p>Observation, on 08/19/12 at 5:35 PM, on 08/20/12 at 9:05 AM and 04:00 PM, and on 08/21/12, at 8:00 AM, 8:45 AM, and 12:00 PM, revealed Resident #5's enteral feeding infusion pump and pole was soiled as evidenced by a brown substance spattered over the surfaces of the pump and pole. In addition, a sixty (60) cubic centimeter (cc) syringe was stored in a container of clear liquid on Resident #5's bedside table.</p> <p>Observation, on 08/22/12, at 11:25 AM revealed Resident #5's enteral feeding infusion pump and pole remained soiled as observed on 08/19, 08/20, and 08/21/12, and a 60 cc syringe was stored in a container of light brown liquid placed on the bedside table.</p> <p>Interview, on 08/22/12 at 12:15 PM, with Licensed Practical Nurse (LPN) #2, revealed she thought Resident #5's enteral feeding infusion pump and pole looked dirty. LPN #2 stated the pump should be cleaned by the nursing staff every shift if dirty, but she was not sure who would be responsible for cleaning the pole. In addition, LPN #2 stated the syringe in the container of water on the bedside table was used for flushing the resident's gastrostomy tube (G-tube) and that a new syringe was provided each day by staff on the 11-7 shift. LPN #2 stated the syringe should be emptied, rinsed, and stored in a clean plastic bag and hung on the infusion pump. LPN #2</p>	F 441		



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F 441	Continued From page 7 stated improper storage of the syringe used to flush the resident's G-tube could potentially expose Resident #6 to infection.  Interview, on 08/22/12, at 12:40 PM, with the Director of Nursing (DON) revealed a syringe used for G-tube flushes should be stored in a clean plastic bag and hung on the infusion pump's pole when not in use. The DON explained the syringe case, based on the language used in the facility's policy under care of equipment for G-tube feedings, would mean storage of the syringe in a clean plastic bag.	F 441			



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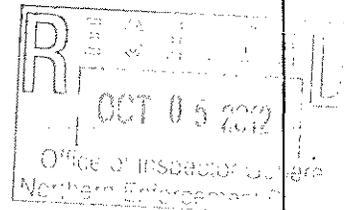
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1985, 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Nine (9) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is propane.</p> <p>A standard Life Safety Code survey was conducted on 08/21/12. Signature Healthcare of Spencer County was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility has one hundred twenty (120) certified beds with a census of one hundred nine (109) 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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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Kathy Jones</i>	TITLE <i>X NHA</i>	(X6) DATE <i>X 9/20/12</i>
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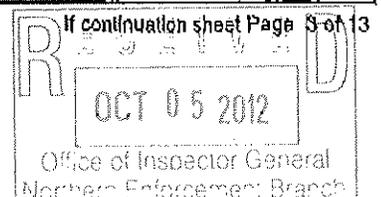
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 000	Continued From page 1 Fire)	K 000	K025	
K 025 SS=E	Deficiencies were cited with the highest deficiency identified at "E" level. NFPA 101 LIFE SAFETY CODE STANDARD 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  This STANDARD is not met as evidenced by: Based on observations 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 NFPA standards. The deficiency had the potential to affect six (6) of nine (9) smoke compartments, eighty four (84) residents, staff and visitors. The facility has one hundred twenty (120) certified beds with a census of one hundred nine (109) on the day of the survey.  The findings include:  Observations, on 08/21/12 between 8:30 AM and 9:30 AM, with the Maintenance Director revealed	K 025	Residents affected:  No residents were found to be affected by the deficient practice. Kwikfoam was removed and Fire Barrier Sealant was placed around sprinkler pipes on 100 hall and 400 hall on 8/23/2012. The penetration on 200 hall was sealed with Fire Barrier Sealant on 8/23/12. The Kwikfoam was removed around the sprinkler pipes on 200 hall and Fire Barrier Sealant was placed. The 2 pipes and 2 x 4 stud was sealed with Fire Barrier Sealant on 8/23/2012 on the 600 hall.  Residents potentially affected:  An audit of the entire building was completed on 9/14/2012 by the Regional Maintenance Consultant to ensure no penetrations existed. Those penetrations found during the life safety survey were fixed 8/23/12. Residents located in the smoke compartment areas found to be deficient could have potentially been affected but are no longer at risk of being affected.  Systemic measures:  The Maintenance Director and Assistant Maintenance Director will be educated on the regulation regarding smoke barriers and the correct material to maintain smoke-resistance on 9/14/2012 by the Regional Maintenance Consultant. The Maintenance Director and/or the Assistance Maintenance Director will conduct weekly rounds throughout the building including the attic space to detect and penetrations of the smoke barriers. The rounds will be weekly for 4 weeks. If rounds are 100% compliant, the rounds will continue monthly ongoing.	9/15/2012

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K 025	<p>Continued From page 2</p> <p>the smoke partitions, extending above the ceiling had multiple penetrations of pipes and wires. The penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. The penetrations and unrated material were noted in the following locations:</p> <ol style="list-style-type: none"> <li>1) The area around the sprinkler pipe was not sealed to resist the passage of smoke in the 100 Hall above the cross corridor doors.</li> <li>2) An unsealed penetration and the use of flammable kwik foam to seal around pipes located in the 200 Hall above the cross corridor doors next to room #209.</li> <li>3) The use of flammable kwik foam to seal around two (2) sprinkler pipes in the Fire Wall located in the 400 Hall above the cross corridor doors next to room #401.</li> <li>4) Two (2) pipes used as a sleeve through the smoke partition were not sealed inside the pipes; also a 2x4 stud was projecting into the wall and was not sealed with a rated material. These penetrations were located in the 600 Hall above the cross corridor doors next to room #601.</li> </ol> <p>Interview, on 08/21/12 between 8:30 AM and 9:30 AM, with the Maintenance Director revealed he was not aware of the penetrations, and was not aware of who had installed the unrated Qwik Foam.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar</p>	K 025	<p>Monitoring measures:</p> <p>The Administrator and/or Regional Maintenance Consultant will conduct monthly rounds throughout the building to include an audit of smoke barriers. Findings of the monthly rounds will be presented to the QAA committee monthly by the Maintenance director. The QAA committee will determine the need for further review based on results of monthly audits for 6 months.</p> <p>Completion date:</p> <p>The facility will be in compliance on September 15, 2012.</p>	



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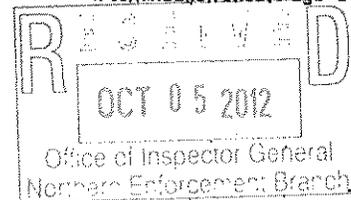
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K 025	Continued From page 3 building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining 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 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7	K 027	K027 Residents affected:  No residents were found to be affected by the deficient practice.  Residents potentially affected:  The hall 600 doors were corrected and close properly on 8/22/2012. The smoke compartments affected by this deficient practice could have potentially affected residents located in these areas but are no longer at risk of being affected.	9/15/2012	

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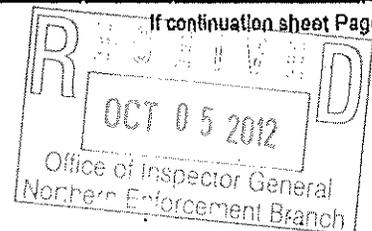
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K 027	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect two (2) of nine (9) smoke compartments, twenty four (24) residents, staff and visitors. The facility has one-hundred twenty (120) certified beds with a census of one hundred nine (109) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 08/21/12 at 3:22 PM, with the Maintenance Director revealed the cross-corridor doors located in the 600 Hall would not close completely when tested, leaving a gap of approximately one inch or greater between the pair of doors and would not resist the passage of smoke.</p> <p>Interview, on 08/21/12 at 3:22 PM, with the Maintenance Director revealed he was unaware the doors would not close all the way leaving a gap between the doors in the closed position.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <p>Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7</p>	K 027	<p>Systemic measures:</p> <p>The Regional Maintenance Consultant will educate the facility Maintenance Director and Assistant Maintenance Director regarding the appropriate closure of cross-corridor doors on 9/14/2012. The Maintenance Director and/or Assistant Maintenance Director will audit cross-corridor doors in the building weekly to ensure the gap does not exceed 1/8 inch gap. The audit will be weekly for a month. If the audits are 100% compliant, the audits will be monthly ongoing.</p> <p>Monitoring measures:</p> <p>The Administrator and/or the Regional Maintenance Consultant will conduct monthly rounds to include cross-corridor doors close properly with minimal gap. Findings of the monthly rounds will be discussed during QAA committee monthly for 3 months. If sustained compliance is not met through the monthly preventative maintenance audits, QAA committee will continue review until compliance for 3 months thereafter.</p> <p>Completion date:</p> <p>The facility will be in compliance on September 15, 2012.</p>	



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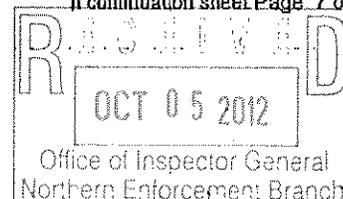
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K 027	Continued From page 5 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.	K 027		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of nine (9) smoke compartments, twenty four (24) residents, staff and visitors. The facility has one hundred twenty (120) certified beds with a census of one hundred nine (109) on the day of the survey.  The findings include:  Observation, on 08/21/12 between 9:45 AM and	K 029	K029  Residents affected:  No residents were found to be affected by the deficient practice. A self-closing device was installed on the Janitor's closet in the kitchen, the Environmental Services Director's office, the Janitor's closet located on Unit 2, and the oxygen room door on 8/22/2012.  Residents potentially affected:  All areas that were deficient during survey were corrected with installation of door closers by 8/23/2012. Residents in these areas could have potentially been affected but are no longer at risk of being affected.  Systemic measures:  The Regional Maintenance Consultant will educate the Maintenance Director and the Assistant Maintenance Director on the NFPA 101 19.3.2 Protection of Hazards on 9/14/2012. The Maintenance Director will audit all doors weekly to ensure the requirement is met in this regulation. The audit will be done weekly for 4 weeks then included on the monthly rounds audit ongoing to ensure continued compliance.	9/15/2012



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K 029	<p>Continued From page 6</p> <p>3:38 PM, with the Maintenance Director revealed the following hazardous areas did not have a self-closing device to keep the door closed.</p> <ol style="list-style-type: none"> <li>1) Janitor's closet in the Kitchen.</li> <li>2) Environmental Services Directors Office.</li> <li>3) Janitor's closet located in Unit 2.</li> <li>4) Oxygen storage room was not self-closing and the door was not rated.</li> </ol> <p>Interview, on 08/21/12 between 9:45 AM and 3:38 PM, with the Maintenance Director revealed he was not aware the doors were required to be self-closing.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> <li>(1) Boiler and fuel-fired heater rooms</li> <li>(2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>)</li> <li>(3) Paint shops</li> <li>(4) Repair shops</li> </ol>	K 029	<p>Monitoring measures:</p> <p>The administrator and/or Regional Maintenance Consultant will conduct monthly rounds to include doors and door closers to ensure compliance. Findings of the monthly rounds will be reviewed in the monthly QAA meeting for 6 months. The QAA committee will determine the need for further review based on compliance.</p> <p>Completion Date:</p> <p>The facility will be in compliance on September 15, 2012.</p>	



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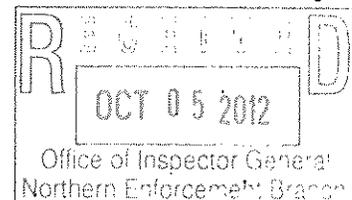
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K 029	Continued From page 7 (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority 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. NFPA 101 LIFE SAFETY CODE STANDARD	K 029		
K 068 SS=D	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure combustion air and ventilation for boilers, incinerators, and heater rooms were installed in accordance with NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, twenty (20) residents, staff, and visitors. The facility has one hundred twenty (120) certified beds and had a census of one hundred nine (109) on the day of the survey.  The findings include:	K 068	K068  Residents affected:  No residents were found to be affected by the deficient practice.  Residents potentially affected:  The Unit 1 Mechanical Room was vented properly on August 23, 2012. Residents were found to be potentially affected by this deficient practice but are no longer at risk of being affected.  Systemic measures:  The Regional Maintenance Director educated the Maintenance Director and the Assistant Maintenance Director on NFPA 101 Life Safety Code 19.5.2.2 which includes proper ventilation for heater rooms. Education will be completed on 9/14/2012. The Maintenance Director will conduct weekly rounds of all heater rooms for 1 month and monthly thereafter to ensure compliance with ventilation.	9/15/2012



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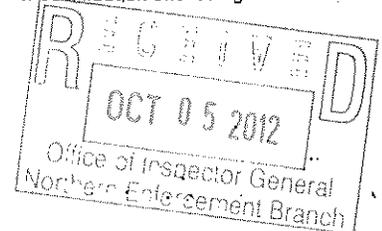
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K 130	Continued From page 9  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the hazardous areas in accordance with NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, twenty two (22) residents, staff and visitors. The facility had one hundred twenty (120) certified beds with a census of one hundred nine (109) on the day of the survey.  The findings include:  Observation, on 08/21/12 at 2:24 PM, with the Maintenance Director revealed a heavy build-up of lint, in the top of the dryer, in the Laundry Room.  Interview, on 08/21/12 at 2:24 PM, with the Maintenance Director revealed he was not aware the lint build up was so excessive.  NFPA 101 (2000 Edition) 4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be	K 130	K130  Residents affected:  No residents were affected by the deficient practice.  Residents potentially affected:  The lint was removed on top of the dryer on 8/23/2012. Residents were potentially affected by the deficient practice but are no longer at risk of being affected.  Systemic measures:  The Regional Maintenance Consultant will educate the Maintenance Director, Assistant Maintenance Director and Environmental Services Director on removal of lint on top of the dryer on 9/14/2012. The Environmental Services Director will check the dryer 3 times a week to ensure no lint buildup. The Environmental Services Director will report lint buildup to the maintenance dept as it is found. Maintenance will clean the area monthly and add to the preventative maintenance checklist.  Monitoring measures:  The Administrator and/or the Regional Maintenance Consultant will conduct monthly rounds for 6 months to include the affected area to ensure compliance. Findings of these rounds will be reviewed in the monthly QAA committee for 6 months. The QAA committee will determine the need for further review based on results of the rounds and compliance.  Completion date:  The facility will be in compliance on September 15, 2012.	



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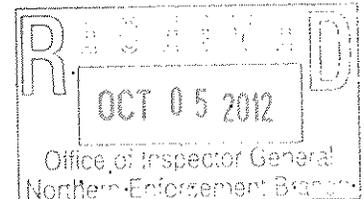
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K 130	Continued From page 10	K 130		
K 147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of nine (9) smoke compartments, twenty (20) residents, staff, and visitors. The facility has one hundred twenty (120) certified beds with a census of one hundred nine (109) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 08/21/12 between 9:46 AM and 10:08 AM, with the Maintenance Director revealed:</p> <ol style="list-style-type: none"> <li>1) An extension cord plugged into a power strip located in the Human Resources Office.</li> <li>2) A chest type deep freeze, a juice dispenser, and an air compressor were plugged into a power strip located in the Kitchen.</li> <li>3) A blender in the Kitchen had electrical tape on the cord.</li> <li>4) A light fixture located in the Kitchens water heater closet was hanging from the wires and the</li> </ol>	K 147	<p>K147</p> <p>Residents affected:</p> <p>No residents were found to be affected by the deficient practice. The extension cord in the Human Resources office was removed on 8/26/2012. The power strip in the kitchen was removed on 8/23/2012. The cord on the blender was repaired and electrical tape was removed on 8/23/2012. The light fixture in the water heater closet in the kitchen was secured and junction box was added on 8/26/2012.</p> <p>Residents potentially affected:</p> <p>All areas that were found to be deficient have been corrected. Residents were found to be potentially affected but are not longer at risk of being affected.</p> <p>Systemic measures:</p> <p>The Regional Maintenance Consultant will educate the Maintenance Director, Assistant Maintenance Director, Director of Dietary Services and Environmental Services Director on the use of extension cords, bad repair of electrical cords, and repair of light fixture and lack of a junction box on September 14, 2012. All staff will be educated on these areas by the SDC and/or the Administrator by September 20, 2012. The Maintenance Director and/or the Assistant Maintenance Director will conduct weekly rounds for 1 month then monthly thereafter in all departments throughout the facility to ensure compliance to the electrical code.</p>	9/21/2012



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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AT AN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185327	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  08/21/2012.
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SPENCER COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 626 TAYLORSVILLE RD TAYLORSVILLE, KY 40071	
(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 147	Continued From page 11 wire connection for the light fixture did not have a junction box, leaving the wire connections exposed.  Interview, on 08/21/12, between 9:46 AM and 10:08 AM, with the Maintenance Director revealed he thought he had removed all power strips that were being misused. Further interview revealed he was not aware of the cord on the blender; also how the light in the water heater closet was in such bad repair.  NFPA 70 400-8 ( Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces  Reference: NFPA 99 (1999 edition).  3-3.2.1.2 D  Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid	K 147	Monitoring measures:  The Administrator and/or the Regional Maintenance Consultant will conduct monthly rounds to include compliance with the electrical code for 6 months. Findings of these rounds will be reviewed by the monthly QAA committee. The QAA committee will determine the need for further review based on the results of rounds and compliance.  Completion date:  The facility will be in compliance on September 21, 2012.	



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

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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SPENCER COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 625 TAYLORSVILLE RD TAYLORSVILLE, KY 40071	
(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 147	Continued From page 12 the need for extension cords or multiple outlet adapters.  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.  Reference: NFPA 70 (1999 edition)  370.28(c) Covers.  All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147		

