PRINTED: 03/11/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185250	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 02/25/2011

NAME OF PROVIDER OR SUPPLIER: OAKMONT MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE: 1100 GRANDVIEW DRIVE, P O BOX 622, FLATWOODS, KY 41139

(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 Recertification Survey was conducted 02/22-02/25/11. A Life Safety Code Survey was conducted 02/23/11. Deficient practice was identified with the highest scope and severity being a "F" level.	F 000	Oakmont Manor does not believe and does not admit that any deficiencies existed, either before, during or after the survey. Oakmont Manor reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings, or any administrative or legal proceedings. This plan of correction does not constitute any admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is it meant to establish any standard of care, contract obligation or position, and Oakmont Manor 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 or any potentially applicable peer review, quality assurance or self-critical examination privileges which Oakmont Manor does not waive, and administrative, civil or criminal claim, action or proceeding. Oakmont Manor offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care of residents.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced	F 164	RECEIVED APR - 8 2011 BY: It is and was on the day of survey the policy at Oakmont Manor to ensure the privacy and confidentiality of resident records. Resident #15 no longer resides at the facility	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shanna Carver | TITLE: Administrator | (X6) DATE: 4/7/11

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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F 164	Continued From page 1 by: Based on interview and record review it was determined the facility failed to ensure the privacy and confidentiality of clinical records for one (1) of nineteen (19) sampled residents, (Resident #15). The facility sent a billing statement to Resident #15's son, when it should have been sent to Resident #15. The findings include: The facility admitted Resident #15 on 01/08/10 with diagnoses which included Severe Osteoarthritis, Dementia, and Anxiety. He/she was not at the facility long enough for Minimum Data Set to be completed. Review of Resident #15's medical record revealed no evidence that he/she was not his/her own power of attorney (POA). A complaint received by the Office of Inspector General included a billing statement from the facility dated 03/17/10 which was addressed to Resident #15's son. Interview with Resident #15 on 02/25/11 at 11:50 AM revealed he/she managed his/her own finances and did not want his/her son to receive his/her bills. Interview with the Office Manager on 02/24/11 at 4:50 PM revealed upon Resident #15's admission, the facility had the resident's son listed as being responsible for the resident's finances. The interview revealed this was the reason the facility sent Resident #15's son a letter related to the resident's finances. However, the facility failed to provide documented evidence that Resident #15's son was the resident's POA.	F 164	The Admissions Coordinator audited all resident records on 3/14/11 to assure that proper authorization for billing records have been received. All CNAs were educated by Director of Nursing on March 11th and all RNs/LPNs on March 15th on privacy and confidentiality of resident records. The administrator educated department heads on privacy and confidentiality of resident records on 3/16/11. The Admissions office will audit new admission records monthly for six months to ensure that financial records are given to responsible party as determined by resident wishes. The abovementioned audit will be reviewed monthly for six months in the Quality Assurance Committee meeting to ensure compliance.	3/17/11

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F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure that one (1) of nineteen (19) sampled residents (Resident #1) received the Physician ordered Pulmicort 0.5 milligrams/2 milliliters nebulizer two (2) times per day. In addition, the facility failed to ensure the resident received the Physician ordered Synthroid (thyroid medication) 50 Micrograms one (1) time per day. The findings include: Review of Resident #1's medical record revealed the resident had diagnoses which included Cerebrovascular Accident, Seizure Disorder, Asthma, Chronic Obstructive Pulmonary Disease and Chronic Heart Failure. Further record review revealed Resident #1 was admitted to the facility on 10/25/10 from a hospital with Physician orders which included Synthroid 50 micrograms every morning. Review of Nurse's notes dated 10/25/10, revealed the resident arrived to the facility at 12:00 PM and the resident's medications were reviewed with Physician #4 and faxed to the pharmacy. Review of the verified orders revealed no documented evidence the Synthroid was ordered. Review of the resident's Nurses Notes dated	F 281	It is and was on the day of survey the policy of Oakmont Manor to ensure that residents receive physician ordered medications. Resident #1 had been no adverse effect and MD was notified of Synthroid on 12/8/10 and Pulmicort on 2/11/11. All charts were audited to cross reference medication administration records with physician orders. This was completed by 2/28/11 by RNs and LPNs. The Unit Coordinator and/or his/her designee will review all admission and readmission orders the day after admission to ensure that physician orders are followed. An in-service was provided to all RNs/LPNS by Director of Nursing on March 15th to educate on assuring physician orders are followed. The audits completed by the Unit Coordinator and/or his/her designee will be reviewed monthly in the Quality Assurance Committee meeting for six months to ensure compliance.	3/16/11

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NAME OF PROVIDER OR SUPPLIER OAKMONT MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE, P O BOX 822 FLATWOODS, KY 41139	

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F 281	Continued From page 3 12/08/10, revealed Physician #6 was present and ordered Synthroid 50 micrograms every morning. Review of Resident #1's Medication Administration Records (MARs) revealed no Synthroid was given until 12/09/10. Interview with Physician #3 on 02/24/11 at 4:35 PM revealed as a result of not having taken the medication, Synthroid, for this extended period of time, the resident could have experienced fatigue or constipation. She further indicated it could have been harmful if someone had thought the resident was taking Synthroid and increased the dose, as it could cause hyperthyroidism. Interview with the Unit Coordinator on 02/25/11 at 1:50 PM revealed the Synthroid had been missed. 2. Review of Resident #1's discharge orders/instruction from his/her admission to the hospital on 02/09/11 revealed a discharge order for Pulmicort 0.5 milligrams/2 milliliters nebulizer two (2) times per day. Review of Resident #1's verified orders upon readmission from the hospital on 02/09/11 revealed Pulmicort was documented. Review of the resident's Medication Administration Record, for the month of February revealed he/she did not receive Pulmicort as ordered until 02/11/11. Interview with Physician #3, the resident's General Practitioner Physician, who had ordered the Pulmicort, on 02/24/11 at 4:35 PM revealed she felt the facility should have notified her and she could have substituted the Pulmicort with	F 281		

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F 281	Continued From page 4 something they had on hand. She further indicated she had ordered the Pulmicort because the resident was wheezing. Interview with the Pharmacist on 02/24/11 at 4:00 PM revealed once the pharmacy received verified orders all orders were filled, however if the resident returned in the evening the medications were usually filled the next morning. If it was an emergency there was an on call Pharmacist the facility could call. Interview with the Unit Coordinator on 02/25/11 at 1:50 PM revealed the reason Resident #1 had missed the Pulmicort for two (2) doses was because of the delivery times from the Pharmacy. Interview with Licensed Practical Nurse (LPN) #3 with 02/25/11 at 9:52 AM, revealed she had overlooked the Pulmicort and when she noticed it she faxed it to Pharmacy and it came with the next delivery the next day. She indicated upon a resident's readmission to the facility the Nurses were to review all medication orders with the facility Physician and then fax the verified orders to the Pharmacy.	F 281		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure residents were free of any significant medication error for one (1) of nineteen (19) sampled residents	F 333	It is and was on the day of survey the policy at Oakmont Manor to ensure that residents are free of any significant medication errors. Resident #1 had no adverse effect and the MD was notified.	

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F 333	Continued From page 5 (Resident #1). The facility failed to ensure Resident #1 received Synthroid (thyroid medication) 50 Micrograms one (1) time each day and Pulmicort 0.5 milligrams/2 milliliters nebulizer two (2) times per day as ordered by the Physician. The findings include: Review of Resident #1's medical record revealed the resident had diagnoses which included Cerebrovascular Accident, Seizure Disorder, Asthma, Chronic Obstructive Pulmonary Disease and Chronic Heart Failure. Further record review revealed Resident #1 was admitted to the facility on 10/25/10 from a hospital with Physician orders which included Synthroid 50 micrograms every morning. Review of Nurse's notes dated 10/25/10 revealed the resident arrived to the facility at 12:00 PM and the resident's medications were reviewed with Physician #4 and faxed to the pharmacy. Review of the verified orders revealed no documented evidence the Synthroid was ordered. Review of Nurses Notes dated 12/08/10, revealed Physician #5 was present and ordered Synthroid 50 micrograms every morning and was the Physician whom would be handling the resident's medical care. Review of Resident #1's Medication Administration Records (MARs) revealed the Synthroid was not administered until 12/09/10. Review of the resident's medical record revealed an order for laboratory values measuring TSH (a	F 333	All residents medication administration records and physician orders have been cross referenced for accuracy. This was completed by RNs and LPNs on 2/28/11. The Unit Coordinator and/or his/her designee will review admission and readmission records the day following admission to ensure that physician orders are followed. The abovementioned audits will be reviewed in the Quality Assurance Committee meeting monthly for six months to ensure compliance.	3/16/11

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F 333	Continued From page 6 thyroid hormone) and a complete blood count (CBC) on 12/08/10 and an order was written for Synthroid 50 micrograms every morning. The results for the laboratory values was received on 12/09/10 and the results for TSH were within normal limits. Interview with Physician #3 on 02/24/11 at 4:35 PM, the resident's General Practitioner Physician who had ordered the Synthroid, revealed as a result of not having taken the medication (Synthroid) for this extended period of time the resident could have experienced fatigue or constipation. She further indicated it could have been harmful if someone had thought the resident was taking Synthroid and increased the dose it could cause hyperthyroidism. Interview with the Unit Coordinator on 02/25/11 at 1:50 PM revealed the Synthroid had been missed and she had found it during a chart audit. 2. Review of Resident #1's discharge orders/instruction from his/her admission to the hospital on 02/09/11 revealed a discharge order of Pulmicort 0.5 milligrams/2 milliliters nebulizer two (2) times per day. Review of Resident #1's verified orders upon readmission from the hospital on 02/09/11 revealed Pulmicort was documented, s being ordered. Review of the resident's MAR for the month of February revealed he/she did not receive Pulmicort as ordered until 02/11/11. Interview with Physician #3 on 02/24/11 at 4:35 PM, the resident's General Practitioner Physician	F 333		

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F 333	Continued From page 7 who had ordered the Pulmicort, revealed she felt the facility should have notified her and she could have substituted the Pulmicort with something they had on hand. She further indicated she had ordered the Pulmicort because the resident was wheezing. Interview with the Pharmacist on 02/24/11 at 4:00 PM revealed once the pharmacy received the verified orders, all orders were filled. However if the resident returned in the evening the medications were usually filled the next morning. If it was an emergency there was an on call Pharmacist the facility could call. Interview with the Unit Coordinator on 02/25/11 at 1:50 PM revealed the reason Resident #1 had missed the Pulmicort for two (2) doses was because of the delivery times from the Pharmacy. Interview with Licensed Practical Nurse (LPN) #3 with 02/25/11 at 9:52 AM, revealed she had overlooked the Pulmicort and when she noticed it she faxed it to Pharmacy and it came with the next delivery the next day. She indicated upon a resident's readmission to the facility the Nurses were to review all medication orders the resident was returning from the hospital with the facility Physician and then fax the verified orders to the Pharmacy.	F 333		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	It is and was on the day of survey the policy of Oakmont Manor to ensure food is prepared, distributed, and served under sanitary conditions. There were no adverse effects to any residents due to the practice identified in food handling or temperatures.	

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F 371	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to prepare, distribute and serve food under sanitary conditions as evidenced by improper hand sanitation during meal service and improper temperature monitoring. The findings include: Observation during the initial tour on 02/22/11 at 1:35 PM revealed the meat slicer was stored with brown particles and a greasy substance on the catching surface, around the blade, on the carriage tray and the stabilizer which assists holding the meal in place on the slicer. Interview with the Dietary Manager on 02/22/11 at 1:35 PM revealed the meat slicer should be cleaned after each use and it did not appear to have been cleaned. Observation during tray line on 02/22/11 at 5:10 PM revealed Dietary Aide #9 scratched the edge of her mouth with her thumb and continued to put silverware, spices and drinks on resident trays without washing her hands. Observation, during the evening meal, on 02/22/11 at 5:27 PM revealed Dietary Aide #9 rubbed the back of her neck and then the back of her ear and was observed to continue assembling resident trays.	F 371	On 2/22/11, the dietary aide was educated on food handling and the cook was educated on the policy of taking temperatures on tray line. On 3/11/11, all cooks and dietary aides were educated on proper food handling and the policy and procedure for tray line meal service temperatures by the dietary manager. The dietician will monitor monthly the food handling procedure and that temperatures are taken per facility policy. The abovementioned audits will be reviewed in the Quality Assurance meeting monthly for four months to ensure compliance.	3/12/11

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F 371	Continued From page 9 Observation, during the evening meal, on 02/22/11 at 5:32 PM revealed Dietary Aide #9 touched her face and did not wash her hands prior to continuing to assemble resident trays. Observation, during the evening meal, on 02/22/11 at 5:34 PM revealed Dietary Aide #9 scratched the side of her nose and did not wash her hands prior to continuing to assemble resident trays. Continued observation on 02/22/11 at 5:42 PM revealed Dietary Aide #9 rubbed her face and nose with her hand and did not wash her hands prior to continuing to assemble resident trays. Observation, during the evening meal, on 02/22/11 at 5:45 PM revealed Dietary Aide #9 touched the corner of her mouth and did not wash her hands prior to continuing to assemble resident trays. Interview, with Dietary Aide #9, on 02/22/11 at 6:12 PM revealed she should have washed her hands after touching her face before continuing to assemble resident trays. Observation, during the evening meal, on 02/22/11 at 4:40 PM revealed the tomato soup temperature was not taken before four (4) bowls of tomato soup were sent out on resident trays. Observation during the evening meal on 02/22/11 at 5:25 PM revealed the Dietary Manager heated up a bowl of chicken noodle soup in the microwave and did not check the temperature before sending it out to a resident.	F 371		

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F 371	Continued From page 10 Interview with Dietary Aide #10 revealed temperatures should be taken before food is sent out to residents. Review of facility's policy titled, "Tray Line Meal Service Temperatures," not dated, revealed food temperatures would be taken prior to the start of each meal at the service line and recorded.	F 371		
F 441 SS=E	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	F 441	It is and was on the day of survey the policy of Oakmont Manor to ensure a sanitary environment. Resident #7 and #10 had no adverse effect from the identified practice. On 2/24/11, a staff member observed the family member dip a cup in ice bin and the staff member removed the ice bin and sanitized it and refilled with ice. All CNAs were educated on March 11th regarding proper catheter care and all RNs/LPNs were educated on March 15th by the Director of Nursing regarding proper catheter care. "Ask staff for assistance" signs were placed on ice carts to prevent family members from handling ice. No other residents were identified to have signs or symptoms of infection related to identified practice as Unit	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185250		C 02/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKMONT MANOR	1100 GRANDVIEW DRIVE, P O BOX 822 FLATWOODS, KY 41139

(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 441	Continued From page 11 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for two (2) of nineteen (19) sampled residents (Residents #7 and 10). The facility failed to ensure staff removed contaminated gloves after providing catheter care and before touching residents and items in the room. The findings include: 1. Record review for Resident #7 revealed he/she was admitted to the facility on 05/20/10 with diagnoses which included Debility/Generalized Weakness, Dementia, Status Post Cerebral Vascular Accident, Hypertension and Benign Prostatic Hypertrophy. Observation of catheter care on 02/24/11 at 11:15 AM by State Registered Nurse Assistant (SRNA) #4 revealed he gathered supplies, pulled the curtain and closed the door. Further observation revealed he gloved and used soap and water to provide catheter care. After drying the resident, SRNA #4 pulled up the resident's covers, touched	F 441	Coordinator monitors daily shift reports. The Unit Coordinator or designee will audit catheter care two times monthly for four months to ensure proper catheter care by observing nurse aides provide catheter care to residents. The abovementioned audits will be reviewed by the Quality Assurance committee meeting monthly for four months to ensure compliance.	3/16/11

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	Continued From page 12 the resident and the toiletries without discarding contaminated gloves and washing his hands. Interview with SRNA #4, at this time, revealed he knew he should have washed his hands before gloving for catheter care. Further interview revealed he was aware he should have removed the contaminated gloves and washed his hands before touching anything or touching the resident. 2. Record review revealed Resident #10 was admitted on 02/09/11, with diagnoses which included Acute Cerebral Vascular Accident, Benign Prostatic Hypertrophy and Urinary Retention. Observation of catheter care on 02/24/11 at 3:55 PM, by SRNA #3 revealed she pulled the curtain, gathered supplies, explained to the resident about the procedure and gloved. Further observation revealed SRNA #3 used one (1) wipe down the catheter tubing about four (4) inches, folded the wipe over for another wipe down the tubing, threw that wipe away, used a clean wipe for two (2) more passes down the catheter tubing. SRNA #3 then pulled the brief up, moved the resident's Gastrostomy tube and bandaged right arm before removing the contaminated gloves and washing her hands and pulling covers back around the resident. Interview with SRNA #3, at this time, revealed she knew she should have removed the gloves and washed her hands before touching the resident's Gastrostomy tube and bandaged right arm. Observation of the dining room on 02/24/11 at 4:35 PM, revealed a resident's family member took a six (6) ounce cup and dipped it through the	F 441		

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F 441	Continued From page 13 ice bin. Interview with Assistant Director of Nursing, at this time, revealed the facility needed to educate family members on infection control.	F 441		

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	185250	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on February 23, 2011. 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 an "F".	K 000	Oakmont Manor does not believe and does not admit that any deficiencies existed, either before, during or after the survey. Oakmont Manor reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings, or any administrative or legal proceedings. This plan of correction does not constitute any admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is it meant to establish any standard of care, contract obligation or position, and Oakmont Manor 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 or any potentially applicable peer review, quality assurance or self-critical examination privileges which Oakmont Manor does not waive, and administrative, civil or criminal claim, action or proceeding. Oakmont Manor offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care of residents.	
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 ensure hazardous areas were protected, according to NFPA standards. The deficiency has the potential to affect one (1) smoke compartment and (39) residents. The findings include: Observation on 2/23/2011 at 11:45 AM, revealed chemicals stored in the Environmental Services office without a self-closing device on the door.	K 029	RECEIVED It is and was on the day of survey the policy of Oakmont Manor to ensure that hazardous areas are protected. The chemicals were removed from the Environmental Services area on 2/23/11 by maintenance and stored in a closet with a self-closing device on door.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shanna Carver
TITLE: Administrator
(X6) DATE: 3/21/11

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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K 029	Continued From page 1 Interview with the Maintenace Director at 11:45 AM, indicated that the chemicals would be moved or a self-closing device would be placed on the door.	K 029	An audit of the facility was completed by maintenance on 3/17/11 to ensure that chemicals were properly stored.	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	An audit will be completed monthly for four months by the maintenance department to ensure that all chemicals are properly stored and any deviations will be reported to the Administrator immediately. The results of this audit will be reviewed by the Quality Assurance Committee monthly for four months to determine compliance.	3/18/11
	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 could affect all (98) residents, staff and visitors. The facility is licensed for (103) beds and the census on the day of the survey was (98) residents. The findings include: Observation on 2/23/2011 at 12:00 PM with the Maintenance Director, revealed the three overhangs at the exits to D, E, and G corridors were not sprinkled. All three overhangs exceeded		It is and was on the day of survey the policy of Oakmont Manor to ensure the building has a complete sprinkler system. Sprinkler heads will be placed on overhangs at exits D, E, and G corridors. Sentry Fire is contracted to complete. The building was inspected by maintenance director on 2/23/11 to ensure that all overhangs at exit corridors over four feet in width have sprinklers.	

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K 056	Continued From page 2 the 4 ft. width as required by NFPA 13. (All three overhangs measured 5ft. x 7ft.) Interview with the Maintenance Director on 2/23/2011 at 12:00 PM, indicated that he was not aware that the overhangs needed to be sprinkled. 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	Maintenance will inspect the sprinklers on the overhangs at exit corridors monthly for four months to ensure compliance. The results of the above mentioned audits will be reviewed by the Quality Assurance Committee monthly for four months to ensure compliance	3/14/11
K 072 88=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that corridors were maintained free from obstructions to the full instant use in the case of fire or other emergencies. Exits must be maintained to ensure their use in an emergency. The deficiency has the potential to affect all (98) residents, staff, and visitors. The findings include: Observation on 2/23/2011 at 11:20 AM with the Maintenance Director, revealed clean linen carts,	K 072	It is and was on the day survey the policy of Oakmont Manor to ensure corridors are free from obstructions in case of fire or other emergencies. RNs, LPNs, and CNAs were educated on 2/23/11 by Director of Nursing and Administrator regarding carts not being stored in hallways for greater than 30 minutes. An in-service was held for CNAs on March 11th and RNs and LPNs March 15th by the Director of Nursing to educate staff on not blocking the egress of the hallways for more than thirty minutes.	

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K 072	Continued From page 3 soiled linen carts and lifts were observed to be stored over 30 minutes in the A, C, D, E and F corridors. This observation was also confirmed with the Mantenance Director. Interview with the Administrator on 2/23/2011 at 4:00 PM, revealed they would in-service the staff on the importance of keeping the corridors clear. Reference: NFPA 101 (2000 Edition) Means of Egrees Reliabilty 7.1.10.1 Means of egrees shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	An audit will be completed weekly for four months by the Director of Nursing or designee to ensure that all items are not stored for more than 30 minutes in the hallways. The abovementioned audit will be reviewed in the Quality Assurance meeting monthly for four months to ensure compliance.	3/16/11
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustable decorations were used in the facility, according to NFPA standards. The deficiency could effect all (98) residents, staff and visitors. The facility is licensed for (103) beds and the census on the day of the survey was (98) residents. The findings include: Observation on 2/23/2011 at 11:30 AM with the Maintenance Director, revealed resident rooms with hanging decorations on the doors that were not flame retardant.	K 073	It is and was on the day of survey the policy of Oakmont Manor to ensure that no combustible decorations are used in the facility. There were no adverse effects to any resident. The maintenance department sprayed fire retardant spray on hanging door decorations. This was completed by 3/16/11. Maintenance will inspect monthly for six months to ensure that all hanging decorations have been treated with fire retardant spray and marked as such.	

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K 073	Continued From page 4 Interview with the Maintenance Director on 2/23/2011 at 11:30 AM, revealed they did not have a written policy for treating the decorations with a flame-retardant material. Reference: NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073	The abovementioned audit will be reviewed for six months by the Quality Assurance Committee to determine compliance.	3/17/11
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen cylinders were stored according to NFPA standards. The findings include: Observation on 2/23/2011 at 12:30 PM with the Maintenance Director, revealed combustible supplies stored within 5 ft. of the oxygen cylinders in the oxygen storage room on the G corridor.	K 076	It is and was on the day of survey the policy of Oakmont Manor to ensure that oxygen is stored properly. Boxes were moved five feet away from oxygen cylinders in storage room on G corridor on 2/23/11 by the maintenance director. Maintenance audited all other storage areas of oxygen cylinders on 2/23/11 to ensure that no combustible materials were within five feet of oxygen cylinders. Maintenance will audit one time monthly for six months all areas of oxygen cylinder storage to ensure that no combustible material is stored within five feet.	

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K 076	Continued From page 5 Interview with the Maintenance Director on 2/23/2011 at 12:30 PM, indicated that he was unaware that the cylinders could not be stored within 6 ft. of the combustible supplies. Reference: NFPA 99 (1999 Edition) 8-3.1.11.2	K 076	The above mentioned audit will be reviewed in the Quality Assurance Committee meeting monthly for six months to ensure compliance.	2/24/11
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical equipment was maintained according to NFPA standards. The facility has the capacity for (103) beds with a census of (98) on the day of the survey. The findings include: Observation on 2/23/2011 at 11:30 AM with the Maintenance Director, revealed the furnace room and the electrical room had storage located within (36) inches of the electrical panels. Also the fire alarm panel in the nurses station on the North Lodge Unit was blocked. Interview with the Maintenance Director on 2/23/2011 at 11:30 AM, indicated that he was unaware of the panels being blocked.	K 147	It is and was on the day survey the policy of Oakmont Manor to ensure that electrical equipment is maintained according to NFPA standards. On 2/23/11, the maintenance department moved items 36 inches from the electrical panels in the furnace room. Maintenance director also ensured that there was no obstruction in front of the alarm panel on 2/23/11 at Lodge unit. Staff members were educated on 3/16/11 by Administrator that all items must be 36 inches from electrical panels and alarm panels must not be blocked. An audit will be completed one time weekly for six months by maintenance director or his/her designee to ensure that items are not within 36 inches of electrical panel and that alarm panel is not blocked at nurses stations. The abovementioned audits will be reviewed by the Quality Assurance committee monthly for six months to ensure compliance.	3/17/11