

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

PRINTED: 05/16/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185378	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/03/2012
NAME OF PROVIDER OR SUPPLIER  MASONIC HOME OF SHELBYVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 711 FRANKFORT ROAD SHELBYVILLE, KY 40066	
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F 000	INITIAL COMMENTS  A standard health survey was initiated on 05/01/12 and concluded on 05/03/12 and a Life Safety Code survey was conducted on 05/01/12 with the highest scope and severity of "F". The facility had the opportunity to correct before remedies would be recommended for imposition.  This was a Nursing Home Initiative with entrance at 6:45 AM.	F 000	The preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
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.	F 441	1. Infection Control Committee met on May 3rd and reviewed the identified neighbors' infection history to assure they have not been affected by the issue identified. No residents were identified as having been affected. However, the facility has implemented corrective actions to address the issues identified as stated in items 3, 4, and 5 below.  2. Infection Control Committee met on May 3rd and reviewed infection history of any neighbor who may have the potential to be affected by the issue identified. However, the facility has implemented corrective actions to address the issues identified as stated in items 3, 4, and 5 below.	

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

TITLE

(X6) DATE

*[Signature]*

*Administrator*

6-1-12

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.

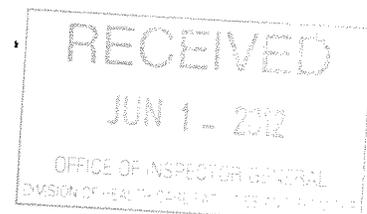
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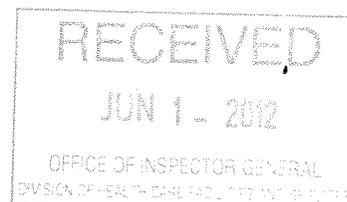
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F 441	Continued From page 1 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of facility's policies, the Centers for Disease Control (CDC) Guideline for Handwashing Techniques, and the facility's Performance Evaluation for Mini Neb Administration, it was determined the facility failed to store oxygen equipment properly to prevent the spread of infection for one (1) (Resident #3) of the twenty (20) sampled residents, and four (4) unsampled residents. Unsampled Residents A, B, D and E, who were receiving oxygen treatments. In addition, the facility failed to ensure staff changed their gloves and washed their hands when moving from dirty to clean during skin assessments for six (6) of ten (10) sampled residents, Resident #2, #3, #4, #6, #8 and #12. Additionally, the facility failed to ensure staff washed their hands prior to putting gloves on to perform catheter care for one (1) of three (3) sampled residents with a catheter, Resident #17.  The findings include:	F 441	3. The facility has initiated the following corrective measures to assure the identified deficient practice does not reoccur as follows:  • Skin/Hydration Assessment Policy was revised to include Infection Control guidelines when performing skin assessment. • Infection Control Annual QA Calendar was revised to include skin assessment under Return Demonstration of Special Procedures. • Infection Control Annual QA Calendar was revised to assure respiratory audit is conducted on all shifts. • Infection Control QA Audit (IC-1) was revised to include skin assessments. • Nursing Respiratory Therapy Compliance Audit (N-24) was revised to include proper storage of respiratory equipment (including oxygen tubing and nebulizer mouthpieces). • Infection Control Respiratory Equipment Audit (IC-11-I) was revised to include storage of respiratory equipment when NOT in use.	



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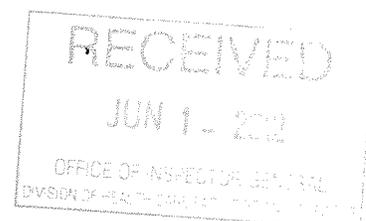
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F 441	Continued From page 2  Review of the facility's policy regarding Oxygen Therapy, Revised 04/09, revealed for the purpose of infection control, the oxygen equipment was to be labeled with the date and time, and to be stored in a zip-lock bag at bedside when not in use.  Review of the facility's Performance Evaluation Mini Neb Administration, Revised 04/09, revealed the atomizer was to be rinsed out after use and stored in a zip-lock bag at bedside.  Review of the facility's RN/LPN Orientation Checklist revealed new employees were in-serviced and checked off on the care of oxygen equipment.  Observation, on 05/01/12 starting at 7:00 AM, during the facility tour revealed Unsampld Resident E sitting in a wheelchair with an oxygen tank on the back of the wheelchair. The tank had oxygen tubing and a nasal cannula wrapped around the top of the tank, uncovered and undated. In addition, at the bedside of Unsampld Resident E was an uncovered mini-neb with droplets in the chamber. Residents #3 and Unsampld Resident A each had oxygen tubing with nasal cannula coiled up and placed on top of their oxygen concentrator in their room, uncovered and unlabeled. On the bed of Unsampld Resident B was an uncovered, undated nasal cannula and tubing. In the room of Unsampld Resident D was oxygen tubing with a	F 441	<ul style="list-style-type: none"> <li>• RN/LPN and Caregiver Orientation Checklists were revised to elaborate on Infection Control issues identified.</li> <li>• Infection Preventionist job description responsibilities were revised to reflect performance of audits on varying shifts randomly.</li> <li>• Handwashing Policy was revised to include most recent recommendations from CDC regarding hand hygiene.</li> <li>• Catheter Care Policy, Protocol, and Competency Skills checklist were revised to include additional step of washing hands and changing gloves if incontinent care is required prior to Catheter Care.</li> <li>• Specialty storage bags were placed on all wheelchairs for respiratory equipment storage when not in use.</li> <li>• In-servicing for Skin Assessment Protocol conducted on 5/3/12</li> <li>• In-servicing for Hand Hygiene during catheter care on 5/4/12</li> <li>• In-service for storage of Respiratory equipment when not in use was conducted 5/8/12 and 5/18/12.</li> <li>• Return demonstration of revised skin assessment protocol conducted 5/3/12 through 5/18/12 and ongoing.</li> <li>• Return demonstration audits of catheter care conducted 5/3/12 through 5/18/12 and ongoing.</li> <li>• Weekly audits of Respiratory Equipment Storage began 5/4/12 on varying shifts and continue ongoing.</li> </ul>	



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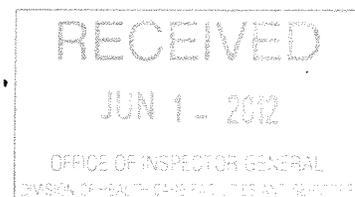
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F 441	Continued From page 3 nasal cannula lying across the air conditioning/heating unit, uncovered and undated.  Interview, on 05/02/12 at 3:30 PM, with the North Unit Coordinator revealed oxygen equipment, nasal cannulas, tubing and mini-nebs, were to be stored in the resident's room in a baggie when not in use. She stated the storage was for infection control, to prevent contamination of the equipment. If contaminated, a resident may become ill.  Interview, on 05/02/12 at 4:15 PM, with the South Unit Coordinator revealed oxygen equipment was to be stored in bags in resident's rooms when not in use. She revealed this was for infection control and to keep the equipment clean. Failure to store the equipment properly may result in an infection to the resident. She stated there had been training on the use and storage of oxygen equipment. She stated "all of us" were responsible to monitor the equipment for proper storage.  Interview, on 05/02/12 at 4:37 PM, with the Assistant Director of Nursing (ADON) revealed oxygen equipment was to be stored in a baggie in the resident's room when not in use. This was to keep it clean, she stated, for infection control purposes. It was revealed the staff had been trained on the storage of oxygen equipment and there was a risk of infection to the residents if not stored properly. She stated no one person was responsible to monitor the oxygen equipment, that everyone was responsible. Oxygen	F 441	4. The facility has implemented the following interventions to monitor the corrective action to ensure that performance is sustained as follows:  • Director of Nursing will assure the Infection Control QA Surveillance audits are conducted per the Infection Control QA calendar and education is provided with the reports brought to the QA Committees for review and recommendations monthly.  • The Quality Assurance Performance Committee will review submitted reports to ensure compliance monthly and make recommendations for revisions on an ongoing basis.  5. The Quality Assurance Performance Committee will review the documentation monthly and assess continued effectiveness of plan of correction and regulatory compliance completed by:	6/8/2012	



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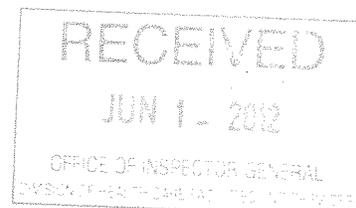
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F 441	<p>Continued From page 4 equipment and infection control were monitored within the facility as part of their Quality Assurance (QA) program, she revealed.</p> <p>Interview, on 05/03/12 at 11:50 AM, with the Director of Nursing (DON) revealed oxygen tubing with nasal cannulas and nebulizer's were to be stored covered and the staff had been trained to store oxygen equipment in that manner. She revealed no one person was responsible to monitor the oxygen equipment but numerous people in different capacities within the facility, to include the Infection Control Committee and QA Committee, were to monitor the oxygen equipment.</p> <p>Review of the facility's policy regarding Standard Infection Precautions, Revised 06/11, revealed hand hygiene was to be performed each time gloves were removed.</p> <p>Review of the Centers for Disease Control (CDC) Guideline for Handwashing Techniques, dated 10/25/02, revealed after gloves were removed, hands should be washed with a non-antimicrobial or an antimicrobial soap and water or disinfected with an alcohol-based hand rub. In addition, it stated to change gloves during patient care if moving from a contaminated body site to a clean body site.</p> <p>Review of the facility's Infection Prevention Team policy, Reviewed 01/14/11, revealed to prevent the spread of infection the staff was required to</p>	F 441			



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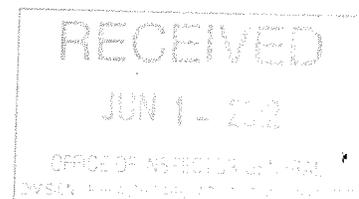
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F 441	<p>Continued From page 5</p> <p>wash their hands or use hand sanitizer after each direct resident contact for which hand washing was indicated by acceptable professional practice.</p> <p>Review of the facility's policy regarding Urinary Tract Infections, Reviewed 09/10, revealed standard infection control practices were to be utilized in managing catheters.</p> <p>Review of the facility's Basic Infection Control/Prevention of UTI (urinary tract infection) attached to the Urinary Tract Infections policy revealed to wash hands before and after all procedures.</p> <p>Review of the facility's policy regarding Skin/Hydration Assessment, revised 11/09, revealed the policy did not include any information or practice related to washing hands before the assessment, upon going from clean to non-clean during the assessment or upon the completion of the assessment. Handwashing was not included in the policy.</p> <p>1) Observation, on 05/02/12 at 11:00 AM, during the skin assessment of Resident #3 performed by Licensed Practical Nurse (LPN) #1, revealed the assessment was started with the feet of the resident. The buttock and peri area were assessed and touched with the gloved hands of LPN #1. LPN #1 moved up the body of Resident #3 with the assessment, concluding at the resident's head. The head of the resident was</p>	F 441		



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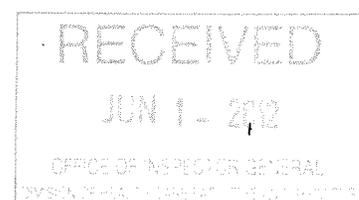
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F 441	<p>Continued From page 6</p> <p>touched with the same gloves which were worn to assess the peri and buttock area of the resident. Gloves were not changed, or hands washed, when moving from a non clean area to a clean area.</p> <p>Interview, on 05/02/12 at 3:05 PM, with LPN #1 revealed she was aware she should have changed gloves and washed her hands when she went from dirty to clean during the skin assessment of Resident #3. She revealed the reason to wash her hands was for infection control and the failure to wash may cause the resident to become ill from different infections.</p> <p>2) Observation, on 05/03/12 at 9:20 AM, during the catheter care of Resident #17 performed by Certified Nursing Assistant (CNA) #1, revealed CNA #1 had just completed assisting a nurse with a dressing change in the area of the peri-anal region and helped hold the resident on his/her side. CNA #1 then changed gloves to perform the catheter care but did not wash her hands as indicated in the policy for Basic Infection Control/Prevention of UTI.</p> <p>Interview, on 05/03/12 at 9:35 AM, with CNA #1 revealed she had been in-serviced on when to wash her hands and put on gloves. She revealed she was aware she should have washed her hands before putting on gloves to perform the catheter care on Resident #17. She stated the reason to wash her hands and change gloves before starting the catheter care was to prevent cross contamination.</p>	F 441		



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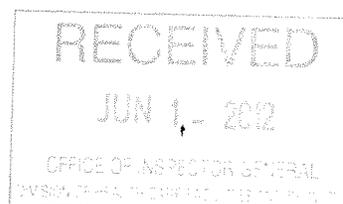
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F 441	Continued From page 7  3) Observation, on 05/01/12 at 2:30 PM, during Residnet #4's skin assessment with LPN # 3 revealed she touched the resident's privacy curtain with her dirty gloves after a skin assessment.  Interview attempted, on 05/03/12 at 3:00 PM, with LPN #3 without an answer or returned call.  4) Observation, on 05/02/12 at 9:20 AM, during Resident #8's skin assessment with the South Unit Coordinator nurse in the South Wing shower room while sitting in a shower chair revealed she failed to her wash hands and put on gloves prior to resident contact. The Unit Coordinator from the South Wing completed her skin assessment with Resident #8 and walked out of the shower room to the South Unit nursing desk and sat down in front of the computer at the desk.  Interview, on 05/03/12 at 10:10 AM, with the South Unit Coordinator nurse revealed the facility policy was to wash her hands before entering a room, before she had provided care to Residnet #8 and she should have put gloves on before performing a skin assessment. The nurse confirmed the facility had provided her with the orientation education on infection control and handwashing which she had completed a skills check off before she started working on the floor. The South Unit Coordinator nurse revealed the lack of handwashing and glove use put everybody at risk for the spread of infection and	F 441		



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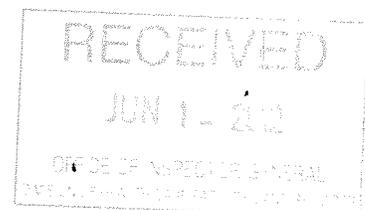
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F 441	<p>Continued From page 8</p> <p>contamination issues. She further stated as the Unit Coordinator it was her role to monitor facility staff on the South Wing for infection control issues and retrain as needed.</p> <p>5) Observation, on 05/02/12 at 9:55 AM, revealed during a skin assessment for Resident #2, the Registered Nurse (RN) did not change her gloves or wash her hands after assessing the resident's buttocks and peri area. The RN then assessed the resident's face and disconnected the resident's feeding tube.</p> <p>Interview, on 05/03/12 at 10:15 AM, with RN #1 revealed the nurse stated she should have changed her gloves and washed her hands after assessing Resident #2's buttocks and peri area. The RN stated she had been trained to conduct skin assessments and to change gloves and wash hands after assessing the resident's buttocks and peri areas, however stated she sometimes took short cuts when she got busy. She stated not washing hands or changing gloves was an infection control issue and could spread organisms from the peri area to other areas of the skin.</p> <p>6) Observation, on 05/02/12 at 9 AM, revealed during the skin assessment for Resident #6, Licensed Practical Nurse (LPN) #1 started the assessment at the feet, moved to the legs, and the abdomen. LPN #1 removed Resident #6's G-tube dressing, cleansed the site with Dial liquid gel soap, removed her gloves, applied clean gloves, and cleansed the G-tube site with a packaged container of water. LPN #1 removed her gloves, donned clean gloves, patted the site</p>	F 441			



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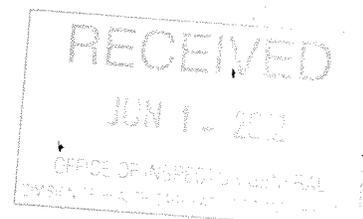
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F 441	<p>Continued From page 9</p> <p>dry with a clean 4X4 gauze, applied Remedy antifungal cream with a cotton-tipped applicator, and taped a clean 4x4 gauze over the site. LPN #1 did not remove her gloves, wash her hands, and don clean gloves, but continued the skin assessment touching Resident #6's perineal area, buttocks, and back. LPN #1 cleaned stool from Resident #6's anal area, completed the assessment touching the resident's groin and arms, and then dressed and covered Resident #6 with a blanket before removing her gloves and washing her hands.</p> <p>Observation, on 05/02/12 at 2:50 PM, revealed during a skin assessment for Resident #12, LPN #1 started the assessment at Resident #12's feet, moved to the legs, the perineal area, buttocks, arms, and ears. LPN #1 assisted Resident #6 with getting dressed before she removed her gloves and washed her hands.</p> <p>Interview, on 05/02/12 at 3:05 PM, with LPN #1 revealed she normally began skin assessments at the residents' heel/toe area and moved upward. LPN #1 stated she should have removed her gloves and washed her hands after cleaning stool from Resident #6's anal area, and that she should have donned clean gloves before she continued the skin assessment. LPN #1 stated she should have removed her gloves, sanitized her hands, and donned clean gloves after touching the perineal area and buttocks of Resident #12.</p> <p>Interview, on 05/02/12 at 3:15 PM, with the North Unit Coordinator revealed when performing a skin assessment, you were to wash your hands and change gloves after you assessed the peri area.</p>	F 441		



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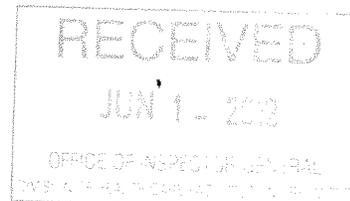
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185378	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  05/03/2012
NAME OF PROVIDER OR SUPPLIER  MASONIC HOME OF SHELBYVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 711 FRANKFORT ROAD SHELBYVILLE, KY 40066		
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F 441	<p>Continued From page 10</p> <p>She stated the purpose to wash your hands and change your gloves was to prevent contamination, germs and illness. In addition, the policies for Hand Hygiene and Skin Assessment were located on the computer for staff to access. Continued interview, on 05/02/12, at 3:20 PM, with the North Unit Coordinator revealed training on how to conduct skin assessments occurred during the facility's orientation of newly hired nurses. The Unit Coordinator stated she did not conduct random checks of the nurses' clean technique methods.</p> <p>Interview, on 05/02/12 at 4:30 PM, with the ADON revealed after assessing the peri area on a resident during a skin assessment, you were to wash your hands and change gloves, then finish your assessment. She revealed the reason for washing hands and changing gloves was to prevent cross contamination. Infection was always a risk if you failed to wash hands and change gloves, she revealed.</p> <p>Interview, on 05/02/12 at 4:50 PM, with the Education Director revealed all new hires were trained on infection control and the importance of wearing gloves and washing hands. She stated numerous in-services were held throughout the year, to include when to wash hands, and when to wear gloves. A new hire was partnered with a trainer and their orientation documentation was turned into the educator. This included a skin assessment check-off. No specific means to monitor skin assessments after orientation were revealed.</p>	F 441			



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F 441	Continued From page 11 Interview, on 05/03/02 at 11:50 AM, with the Director of Nursing (DON) revealed she did not monitor the process of conducting skin assessments of residents. She stated staff were trained to wash hands and change gloves after assessing a resident's soiled area of the body to a clean area, and after assessing the resident's peri area, based upon nursing standards of practice.	F 441			



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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1902, 1930, 1951</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two (2) story, Type II (222)</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet and dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 05/01/12. Masonic Home of Shelbyville was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred seventeen (117) beds with a census of one hundred (100) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>The preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.</p> <p>1. No resident was identified as being affected by the issues identified. However, the facility has implemented corrective actions to address the deficient practice as stated under items 3 and 4.</p> <p>2. No other residents were identified as being affected by the issues identified. However the facility has implemented corrective actions to address the issues identified as stated under items 3 and 4.</p> <p>3. The facility has initiated the following corrective measures to assure that the deficient practice does not reoccur as follows:</p> <ul style="list-style-type: none"> <li>Identified duct was sealed with proper fire stop sealant containing fire resistance and flame spread required rating. Completed 5/2/12</li> <li>Smoke barriers penetrations sealant was replaced and resealed with proper fire stop sealant containing fire resistance and flame spread rating. Completed by 5/25/12.</li> </ul>	

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

*[Signature]*

TITLE

*Administrator* 6-1-12

(X8) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

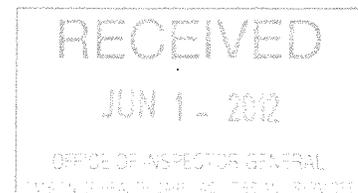
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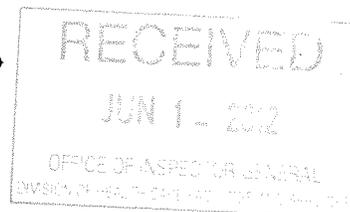
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K 000	Continued From page 1	K 000	<ul style="list-style-type: none"> <li>Maintenance completed an audit of smoke barriers to identify penetrations that required fire stop replacement. Completed 5/11/12</li> <li>Facility "Outside Contractor" Policy revised to include proper fire stop be applied to smoke barrier penetrations. Completed 5/7/12</li> </ul> <p>4. The facility has implemented the following interventions to monitor the corrective actions to ensure that performance is sustained as follows:</p> <ul style="list-style-type: none"> <li>Revised Maintenance QA of Life Safety Codes During Constructions (MNT-19) to include proper fire-stopping methods 5/7/12</li> <li>Provided Maintenance department education regarding revisions to QA tool, Policy, and NFPA regulations regarding smoke barrier penetration protection. 5/7/2012</li> <li>QA Committee met and approved plans of correction and policy revision 5/21/2012</li> </ul> <p>5. The facility will monitor the corrective actions to ensure that compliance is maintained by:</p> <ul style="list-style-type: none"> <li>The QA committee will review required audits and supportive documentation to ensure the effectiveness of the compliance plan monthly and make revisions as necessary on an ongoing basis completed by</li> </ul>	6/8/2012
K 025 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on 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 three (3) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred seventeen (117) beds with a census of one hundred (100) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/01/12 at 11:00 AM, with the Maintenance Director revealed the smoke partitions extending above the ceiling located</p>	K 025		



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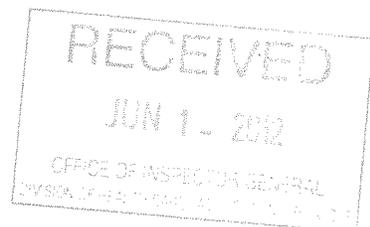
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K 025	<p>Continued From page 2</p> <p>between the basement activities room and basement storage were noted to have penetrations by pipes and wires. Further observation revealed penetrations around duct work located above the ceiling by the Shell Cove Exit. The spaces around the penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke.</p> <p>Interview, on 05/01/12 at 11:00 AM, with the Maintenance Director revealed they were not aware of the penetrations.</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 building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(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</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(c) Where designs take transmission of vibration</p>	K 025			



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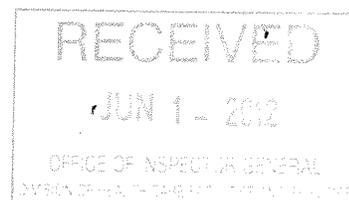
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K 025	Continued From page 3 into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on Fire Drill record review and interview, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred seventeen (117) beds and the census was one hundred (100) on the day of the survey.  The findings include:  Fire Drill record review, on 05/01/12 at 10:10 AM, with the Maintenance Director revealed the fire drills were not being conducted quarterly and at unexpected times under varied conditions. The	K 050	1. No resident was identified as being affected by the issues identified. However, the facility has implemented corrective actions to address the deficient practice as stated under items 3 and 4. 2. No other residents were identified as being affected by the issues identified. However the facility has implemented corrective actions to address the issues identified as stated under items 3 and 4. 3. The facility has initiated the following corrective measures to assure that the deficient practice does not reoccur as follows: • Revised "Testing of the Fire Alarm" policy to include NFPA regulation 19.7.1.2 regarding fire drills. 5/7/2012 • Fire Drill MNT-5 Reviewed for compliance with NFPA regulations, no revisions necessary. Quality Assurance Committee will review Audit Monthly to ensure deficient practice does not reoccur. 4. The facility has implemented the following interventions to monitor the corrective actions to ensure that performance is sustained as follows: • Provided education to Maintenance department regarding NFPA regulation 19.7.1.2 and updates to "testing of the fire alarm" policy. 5/7/2012	



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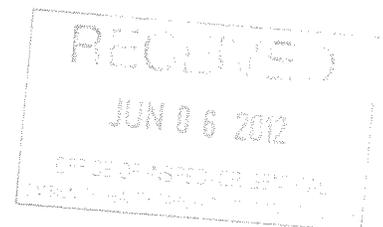
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K 050	Continued From page 4 third shift fire drills were routinely being conducted at 10:05 PM.  Interview, on 05/01/12 at 10:10 AM, with the Maintenance Director revealed he was unaware the fire drills were not being conducted as required on third shift.  Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050	• QA Committee met and approved plans of correction and policy revision. 5/21/2012  5. The facility will monitor the corrective actions to ensure that compliance is maintained by: • The QA committee will review required audits and supportive documentation to ensure the effective of the compliance plan monthly and make revisions as necessary on an ongoing basis completed by	6/8/2012
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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  This STANDARD is not met as evidenced by: Based on observation, interview, and sprinkler testing record review, it was determined the facility failed to maintain the sprinkler system according to NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred seventeen (117) beds with a census of one hundred (100) on the day of the survey.  The findings Include:	K 062	1. No resident was identified as being affected by the issues identified. However, the facility has implemented corrective actions to address the deficient practice as stated under items 3 and 4. 2. No other residents were identified as being affected by the issues identified. However the facility has implemented corrective actions to address the issues identified as stated under items 3 and 4. 3. The facility has initiated the following corrective measures to assure that the deficient practice does not reoccur as follows: a. Sprinkler head dusted. Completed 5/2/12 • Maintenance audit MNT 28 and Environmental audit ES 10 revised to include sprinkler head cleaning in shower and resident rooms. 5/7/2012	



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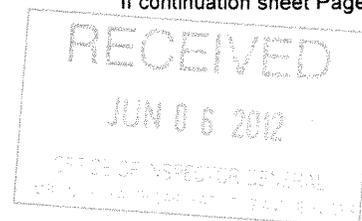
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K 062	<p>Continued From page 5</p> <p>Observation, on 05/01/12 between 11:00 AM and 4:00 PM, with the Maintenance Director revealed sprinkler heads located in the shower room across from room 330, and 333 to be covered in lint.</p> <p>Interview, on 05/01/12 between 11:00 AM and 4:00 PM, with the Maintenance Director revealed he was not aware of the lint build up on the sprinkler heads.</p> <p>Observation, and record review, on 05/01/12 between 11:00 AM and 4:00 PM, with the Maintenance Director revealed the facility had STAR ME1 sprinkler heads located in the Sunset Lounge Hall, Coral Bay Hall, and the Malibu Shores Hall that were part of a recall. The facility failed to produce evidence that the sprinkler heads had been checked to confirm if the Star sprinkler heads in the facility were part of the recall.</p> <p>Interview, on 05/01/12 between 1:00 PM and 4:00 PM, with the Maintenance Director revealed he was aware of the recall and did not know if the heads had been checked.</p> <p>Record review, on 05/01/12 at 11:21 AM, with the Maintenance Director revealed the facility had not calibrated or replaced the gauges on the sprinkler riser within the last five years.</p> <p>Interview, on 05/01/12 at 11:21 AM, with the Maintenance Director revealed he was not aware the gauges on the sprinkler system were required to be calibrated or replaced every five years.</p>	K 062	<ul style="list-style-type: none"> <li>• Maintenance and Environmental staff in-serviced on revised audits completed 5/11/12</li> <li>b. Recalled sprinkler heads replaced by 6/16/2012</li> <li>• Maintenance Director completed 100% audit of system to identify affected sprinkler heads 5/3/12</li> <li>• Sprinkler service contractor, Brown Sprinkler Corporation, notified of audit results on 5/3/12</li> <li>• All effected sprinkler heads to be replaced by Brown Sprinkler Corp. by 6/16/2012</li> <li>• Revised Maintenance Annual CQI calendar to include sprinkler riser gauge replacement/calibration date. Calendar will be reviewed QA monthly to ensure 5 year requirement time frames.</li> </ul> <p>4. The facility has implemented the following interventions to monitor the corrective actions to ensure that performance is sustained as follows:</p> <ul style="list-style-type: none"> <li>a. Maintenance Director educated on routine inspection, testing, and maintenance of sprinkler systems as directed by NFPA regulations referenced in Table 2-1 of NFPA 25 5/11/2012</li> <li>b. QA Committee met and approved plans of correction and policy revision 5/21/2012</li> </ul>	



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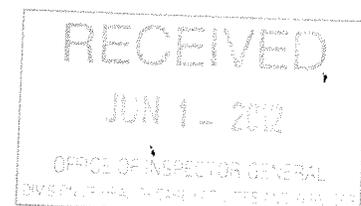
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K 062	Continued From page 6  Reference: NFPA 13 (1999 Edition)  5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.  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. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for	K 062	5. The facility will monitor the corrective actions to ensure that compliance is maintained by: a. The QA committee will review required audits and supportive documentation to ensure the effective of the compliance plan monthly and make revisions as necessary on an ongoing basis completed by:  Extension Waiver We are submitting a waiver request for an extension regarding Life Safety deficiency K062. Our sprinkler contractor, Brown Sprinkler Company, has already been contacted and has initiated manufacturing the replacement sprinkler heads. Because each sprinkler head has to be measured separately and individually manufactured the initial timeline for the date of the allegation of compliance cannot be completed by 6/16/2012. Therefore we are requesting a waiver to extend the date of the allegation of compliance to 8/17/2012.  Attachment 1 is Brown Sprinkler Company's estimated complete date with the Masonic Home of Shelbyville regarding the installation of the new sprinkler heads.  During the installation of the new sprinkler heads, Don Carey, Maintenance Director for the Masonic Home of Shelbyville will be responsible for managing the installation and the safety of the building during the installation process.	6/16/2012



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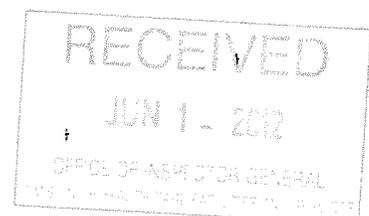
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185378	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  05/01/2012
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K 062	<p>Continued From page 7</p> <p>determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p>	K 062		



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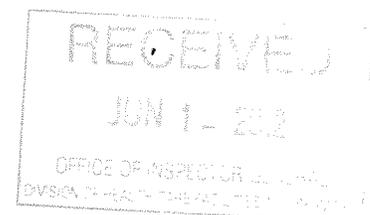
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K 062	Continued From page 8 Reference: NFPA 25 (1998 Edition).  2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.  Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1	K 062		



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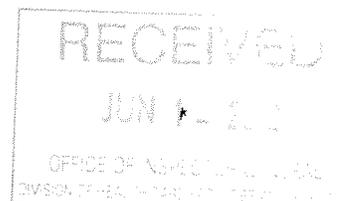
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K 062	Continued From page 9 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10  9-4.2.1 9-4.2.1 Inspection. Valves shall be inspected internally every 5 years to verify that all components operate properly, move freely, and are in good condition.	K 062		
K 147 SS=D	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 wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, residents, staff, and visitors. The facility is	K 147	1. No resident was identified as being affected by the issues identified. However, the facility has implemented corrective actions to address the deficient practice as stated under items 3 and 4. 2. No other residents were identified as being affected by the issues identified. However the facility has implemented corrective actions to address the issues identified as stated under items 3 and 4.	



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K 147	Continued From page 10 licensed for one hundred seventeen (117) beds with a census of one hundred (100) on the day of the survey.  The findings include:  Observations, on 05/01/12 between 10:00 AM and 3:00 PM, with the Maintenance Director revealed:  1) An extension cord was plugged into a power strip located in the Director of Nursing Office. 2) A microwave, refrigerator, and a coffee pot were plugged into a power strip located in the Maintenance Directors Office. 3) A microwave and refrigerator were plugged into a power strip located in the MDS Office. 4) The Hydrocollator was not plugged into a ground fault protected outlet, located in the Therapy Office. 5) A cabinet was installed in front of an electrical panel located in the South Shores Nurses Station Nourishment Room.  Interview, on 05/01/12 between 10:00 AM and 3:00 PM, with the Maintenance Director revealed they were not aware of the storage in front of electrical panels, or the misuse of power strips, and extension cords.  Reference: NFPA 99 (1999 edition)  3-3.2.1.2 D	K 147	3. The facility has initiated the following corrective measures to assure that the deficient practice does not reoccur as follows: a. Duplex plug for hydrocollator equipment was replaced with a ground fault interruption (GFI) plug completed 5/2/12. b. Extension cord / power strips in use in offices with refrigerators and microwave removed from use by maintenance completed 5/2/12 • Maintenance conducted 100% audit of all rooms to assure that no extension cords or power strips were in use with high draw equipment completed 5/2/12 • Facility safety policy for "Electrical Power" revised to include restriction of power strips for high draw equipment completed 5/7/12 • Department managers in-serviced on use restrictions for extension cords and power strips/GFI plugs for equipment with water involvement. Completed on 5/7/12. • Maintenance staff in-serviced on revised safety policy- Completed 5/7/12 • Base cabinet in clean utility room removed to assure that a three (3) foot clearance was maintained for the identified electrical panel completed 5/11/12.	



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K 147	Continued From page 11  Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.  110-26. Spaces  About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K 147	4. The facility has implemented the following interventions to monitor the corrective actions to ensure that performance is sustained as follows: a. Electrical Outlets and Equipment (MNT - 13) revised to include proper usage of power strips and extension cords. i. Staff educated on safety policy update and maintenance educated on audit updated 5/7/2012 ii. QA calendar reviewed to ensure monthly audit of MNT-18 5/7/2012. b. QA Committee met and approved plans of correction and policy revision 5/21/2012 5. The facility will monitor the corrective actions to ensure that compliance is maintained by: a. The QA committee will review required audits and supportive documentation to ensure the effective of the compliance plan monthly and make revisions as necessary on an ongoing basis completed by	6/8/2012	

