

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

PRINTED: 09/15/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185120	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R 09/18/2015
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE AT HILLCREST	STREET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD OWENSBORO, KY 42303
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance 09/18/15, as alleged.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185120	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 9/18/2015
Name of Facility SIGNATURE HEALTHCARE AT HILLCREST	Street Address, City, State, Zip Code 3740 OLD HARTFORD RD OWENSBORO, KY 42303	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0441</u> Reg. # <u>483.65</u> LSC _____	Correction Completed <u>09/18/2015</u>	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <u>DH</u>	Date: <u>09/15/15</u>	Signature of Surveyor: <u>Deborah A. Hedrick Nette, CR</u>	Date: <u>09/15/15</u>
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: <u>8/21/2015</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE AT HILLCREST			STREET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD OWENSBORO, KY 42303	
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F 000	INITIAL COMMENTS	F 000	Signature Healthcare at Hillcrest does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations or compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
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 professional practice.  (c) Linens	F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility will ensure and maintain a safe and sanitary environment to prevent the development and transmission of disease and infection regarding the proper handling and disposal of resident linens after urinary catheter care and will ensure glucometers are properly disinfected after each use with an antimicrobial cleaner.  1. Glucometer used on unsampled resident "A" was removed from medicine cart of Licensed Practical Nurse #1 on 8/20/15 to clean with antimicrobial cleaner per facility policy.  2. All glucometers were removed on 8/20/15 from all medicine carts by Staff Development Coordinator and cleaned with antimicrobial cleaner per facility policy.  3. Licensed staff were re-educated by Staff Development Coordinator on cleaning glucometers with antimicrobial cleaner per facility policy by 8/30/15.  4. Nursing Administration team (Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and Unit Managers) will conduct audits	

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

TITLE

(X6) DATE

*[Signature]*

Administrator

9/10/15

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F 441	<p>Continued From page 1</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:                  Based on observation, interview, and review of the facility policy, it was determined the facility failed to provide a safe and sanitary environment to prevent the development and transmission of disease and infection related to one (1) of twenty-four (24) sampled residents (Resident #1), regarding the improper handling and disposal of linens, after urinary catheter care. In addition, the facility failed to ensure glucometers were properly disinfected after each use, with an antimicrobial wipe. Observation of blood sugar monitoring of one (1) unsampled resident (Resident A) revealed the staff were utilizing alcohol wipes to disinfect the glucometers. Unsampled Resident "A" was one (1) of eleven (11) residents who required blood glucose monitoring.</p> <p>The findings include:</p> <p>1. A review of the facility policy for "Clean Glucometer," dated 06/01/15, revealed the glucometers were to have been cleaned after each use with either an Environmental Protection Agency (EPA) registered detergent/ germicide with a tuberculoidal or Hepatitis B Virus (HBV)/ Human Immunodeficiency Virus (HIV) label claim, or a dilute bleach solution of 1:10 or 1:100 concentration.</p>	F 441	<p>daily for five days then weekly for three months to ensure that glucometers are cleaned with antimicrobial cleaner according to facility policy. Findings of audits will be reported to Director of Nursing. The Director of Nursing will report glucometer cleaning audits to the Quality Assurance team (Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Staff Development, Dietary Manager, Registered Dietician, Maintenance Director, Housekeeping Supervisor, Quality of Life Director, Social Services Director and Human Resources Director) monthly for 3 months for recommendations and follow up to ensure compliance.</p> <p>5. Corrective Action Date: 9/18/15</p>	9/18/15
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F 441	<p>Continued From page 2</p> <p>Observation of a Medication Pass, on 08/20/15 at 8:53 AM, revealed Unsampld Resident "A" had received blood sugar monitoring, utilizing a glucometer and after the testing, Licensed Practical Nurse (LPN) #1 cleaned the glucometer with an alcohol wipe.</p> <p>Interview with LPN #1, on 08/20/15 at 8:55 AM, revealed the LPN had been cleaning the glucometers with alcohol wipes for approximately fourteen (14) months, "as long as I've been working here," and was not familiar with the facility policy or the Centers for Disease Control (CDC) guidelines.</p> <p>Observation of a medication pass, on 08/20/15 at 8:40 AM, and subsequent Interview with Registered Nurse (RN) #1, revealed she generally cleans the glucometer with an alcohol wipe after the machine is used for a fingerstick blood sugar. RN #1 stated she was not familiar with the manufacturer's recommendation for cleaning the glucometer.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 08/20/15 at 11:00 AM, revealed the staff should have been utilizing the detergent wipes and they had been trained on the policy, with inservicing verification, dated 04/24/15.</p> <p>Interview with the Director of Nursing (DON), on 08/21/15 at 8:30 AM, revealed the facility should have been utilizing an antimicrobial wipe that was bleach free, as this was specific to the manufacture's recommendations that called for "a mild detergent" for cleaning, had less drying time and less harmful to the glucometer than the bleach, yet still effective to kill the viruses in the CDC Guidelines. However, due to a change in</p>	F 441		

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F 441	<p>Continued From page 3</p> <p>staff and the re-ordering process, the correct product had not been re-ordered and was not in stock or available on the floors. The "blue label antimicrobial" was in stock, however, the facility policy called for a "red label antimicrobial" product. Additionally, the DON stated there had not been an outbreak or report of HBV or HIV at the facility.</p> <p>Interview with the Administrator, on 08/21/16 at 10:25 AM, revealed he would have expected the staff to have followed the facility policy in cleaning the glucometers.</p> <p>2. Review of the facility's policy and procedure, titled Standard Precautions, revised 08/2007, revealed "Standard precautions shall apply to the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. 7. Linen: Handle, transport, and process used linen soiled with blood, body fluids, secretions, excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and avoids transfer of microorganisms to other residents and environments.</p> <p>Observation of urinary catheter care, on 08/19/15 at 12:35 PM, revealed Certified Nursing Assistant (CNA) #1 performing catheter care for Resident #1. During the cleaning procedure, CNA #1 laid soiled wash cloths, which had been used to clean the catheter and the resident peri-area, on the bed side table.</p> <p>Interview with CNA #1, on 08/19/15 at 1:40 PM, revealed she was aware of the need to placed soiled linens in a plastic bag and to not place them on a bed side table due to the risk of</p>	F 441	<p>1. On 8/20/15 soiled linen in resident #1 room were immediately removed, bagged and placed in soil linen bin and bedside table was disinfected per facility policy.</p> <p>2. Observation of catheter care by Staff Development Coordinator on 8/20/15 revealed no further infection control violations.</p> <p>3. Nursing staff were educated by Staff Development Coordinator on infection control and catheter care per facility policy by 9/18/15.</p> <p>4. Nursing Administration team (Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and Unit Managers) will conduct audits daily for five days then weekly for three months to ensure proper infection control practices are observed according to facility policy. Findings of audits will be reported to Director of Nursing. The Director of Nursing will report infection control audits to the Quality Assurance team (Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Staff Development, Dietary Manager, Registered Dietician, Maintenance Director, Housekeeping Supervisor, Quality of Life Director, Social Services Director and Human Resources Director) monthly for 3 months for recommendations and follow-up to ensure compliance.</p> <p>5. Corrective Action Date: 9/18/15</p>	9/18/15

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F 441	<p>Continued From page 4 infection control.</p> <p>Interview with CNA #2, on 08/19/15 at 1:42 PM, revealed she witnessed CNA #1 place the soiled linens on the bedside table of Resident #1 and she revealed the linens should have placed in a plastic bag due to the risk of infection.</p> <p>Interview with the DON, on 08/21/15 at 8:44 AM, revealed she expected the CNA to have placed the soiled linens in a plastic bag and not on the bed side table.</p>	F 441		
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SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207, or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number 185120	Provider/Supplier Name SIGNATURE HEALTHCARE AT HILLCREST
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Type of Survey (select all that apply)

I	D			
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- A Complaint Investigation
- B Dumping Investigation
- C Federal Monitoring
- D Follow-up Visit
- M Other
- E Initial Certification
- F Inspection of Care
- G Validation
- H Life Safety Code
- I Recertification
- J Sanctions/Hearing
- K State License
- L CHOW

Extent of Survey (select all that apply)

A	F			
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- A Routine/Standard Survey (all providers/suppliers)
- B Extended Survey (HHA or Long Term Care Facility)
- C Partial Extended Survey (HHA)
- D Other Survey
- F offsite/Paper

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 18332			0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....	0.25	Total RO Supervisory Review Hours....	0.00
Total SA Clerical/Data Entry Hours....	0.75	Total RO Clerical/Data Entry Hours.....	0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No



**DIVISION OF HEALTH CARE  
PACKET PROCESS LIST**

FACILITY: Signature Healthcare, H. Ward CITY: \_\_\_\_\_

LEVEL OF CARE: SNF/NE Provider/Licensed Number \_\_\_\_\_ SURVEY DATE(S): 08/18/15

SURVEY TYPE: INITIAL RELIC. RECERT. REVISIT OTHER ISO

COMPLAINT # \_\_\_\_\_ PRIORITY: 1 2 3 4

\*LIST TIME/DATE IF OFF-HOURS SURVEY: \_\_\_\_\_ (M E W H)

TEAM: Glen Martin SECRETARY: Laura

*See Out  
09/04/15*

ACTION	INITIALS	DATE	Date in ACO
Packet completed: Deficiency(ies)? YES NO	<u>GM/DA</u>	<u>08/18/15</u>	
RPM Review	<u>OH</u>	<u>09/01/15</u>	
Packet to Secretary	<u>OH</u>	<u>09/01/15</u>	
SoD to Facility	<u>AP/ST</u>	<u>09/02/15</u>	<u>09/02/15</u>
PoC Received/Copy to Coordinator/Admin Sign Off	<u>AP/ST</u>	<u>09/01/15</u>	<u>09/01/15</u>
POC Acceptable: YES NO			
Provider notified by <u>AP/ST</u> on <u>09/01/15</u>	<u>OH</u>	<u>09/01/15</u>	
POC Returned to Facility			
2 <sup>nd</sup> POC Received/Copy to Coordinator/Admin Sign Off			
2 <sup>nd</sup> POC Acceptable: YES NO			
Provider notified by _____ on _____			
Revisit Required: YES <u>NO</u>	<u>OH</u>	<u>09/01/15</u>	
Revisit Completed: Deficiency (ies) YES NO			
Revisit SoD to Facility			
PoC Received/Copy to Coordinator/Admin Sign Off			
PoC Acceptable: YES NO			
Provider notified by _____ on _____			
2 <sup>nd</sup> Revisit Required: YES NO			
2 <sup>nd</sup> Revisit Completed: Deficiency(ies) YES NO			

Packet Completed  
 Highest Scope/Severity D Opportunity to Correct or No Opportunity to Correct (OTC or NOTC) OTC  
 SQC 13 15 25 (X area of SWC) (Complete from CMS-673 if SQC identified)  
 RPM/CO notified of SQC \_\_\_\_\_ Doctors/Board Letters Mailed \_\_\_\_\_

If Citation Issued: TYPE A OR TYPE B Date issued: \_\_\_\_\_

POC Due 09/12/15 Latest POC Date 09/18/15 Date to be Corrected: 10/05/15  
 1<sup>st</sup> Revisit Due \_\_\_\_\_ 2<sup>nd</sup> Revisit Due \_\_\_\_\_

IDR Requested \_\_\_\_\_ IDR Scheduled/Notice \_\_\_\_\_ IDR Held \_\_\_\_\_  
 Changes to SoD? YES NO IDR SoD/Notice \_\_\_\_\_ IDR PoC Due \_\_\_\_\_  
 IDR PoC Received \_\_\_\_\_ PoC Acceptable? YES NO

PACKET TO C.O. 09/30/15 PACKET TO R.O. \_\_\_\_\_

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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <u>DA</u>	Date: <u>09/18/15</u>	Signature of Surveyor: <u>Deborah A. Henderson</u>	Date: <u>09/18/15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 8/18/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <b>YES</b> <b>NO</b>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/02/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  08/18/2015
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE AT HILLCREST			STREET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD OWENSBORO, KY 42303	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1984</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III unprotected</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments</p> <p>FIRE ALARM: Complete automatic fire alarm system with eleven (11) heat detectors and one hundred and thirty-seven (137) 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 Recertification Life Safety Code Survey was conducted on 08/18/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred and fifty-six (156) beds with a census of one-hundred and nineteen (119) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000		

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

TITLE

(X8) DATE

*[Signature]*

Administrator

9/10/15

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

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K 000	Continued From page 1 Fire)	K 000	Signature Healthcare at Hillcrest does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers it response, credible allegations or compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.  K027 NFPA 101 Life Safety Code Standard SS=D  The facility will ensure and maintain fire/smoke barrier doors to where they will resist passage of smoke in accordance with National Fire Protection Association (NFPA) standards.  1. Maintenance Director repaired set of cross corridor fire/smoke barrier doors located in "recovery" unit on 8/25/15 to allow doors to close all the way and not leave an excessive gab between the two doors.  2. Maintenance Director began inspecting all facility fire/barrier doors on 8/20/15 to ensure no other issues were found with doors not closing or excessive gaps.  3. Administrator in-serviced Maintenance Director and Assistant Maintenance Director on 8/24/15 fire/barrier doors and how they should close all the way with minimal gaps (1/8") between doors. The Maintenance Director or Assistant Director will monitor all facility fire/barrier doors weekly for four weeks then monthly for three months to ensure compliance. Any negative findings will be reported to Administrator immediately for correction.	
K 027 SS=D	Deficiencies were cited with the highest deficiency identified at "D" level.  NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure door located in a smoke barrier door, would resist the passage of smoke in accordance with National Fire Protection Association (NFPA) standards. This deficiency had the potential to affect two (2) of seven (7) smoke compartments, approximately forty two (42) residents, staff and visitors. The facility has the capacity for one-hundred and fifty-six (156) beds with a census of one-hundred and nineteen (119) on the day of the survey.  The findings include:  During the Life Safety Code tour, on 08/18/15 at 1:50 PM with the Director of Maintenance (DOM),	K 027		

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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE AT HILLCREST	STREET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD OWENSBORO, KY 42303
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K 027	<p>Continued From page 2</p> <p>a set of cross corridor fire/smoke barrier doors located at the Recovery Unit was observed not to close all the way and would leave an excessive gap through the middle of the two (2) doors. These doors must close all the way to help prevent fire/smoke from spreading to other parts of the building in case of a fire situation.</p> <p>Interview with the DOM, on 08/18/15 at 1:50 PM, revealed he was not aware the doors were rubbing and would not close all the way.</p> <p>The Census of one-hundred and nineteen (119) was verified by the Administrator on 08/18/15. The findings were acknowledged by the Administrator and verified by the DOM at the exit interview on 08/18/15.</p> <p>Reference: NFPA 101 2000 edition</p> <p>Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel. Positive latching hardware shall not be required per NFPA 101, 19.3.7.6*.</p> <p>8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <p>A.8.3.4.1 The clearance for proper operation of smoke doors is defined as 1/8 in. (0.3 cm). For additional information on the installation of smoke-control door assemblies, see NFPA 105, Recommended</p>	K 027	<p>4. The Maintenance Director will report inspection findings to Quality Assurance team (Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and Unit Managers) monthly for three months for review and recommendations to ensure compliance.</p> <p>5. Corrective Action Date: 9/18/15</p>	9/18/15
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K 027	Continued From page 3 Practice for the Installation of Smoke-Control Door Assemblies.	K 027			