

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

PRINTED: 07/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/20/2013
NAME OF PROVIDER OR SUPPLIER HILLSIDE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 PRIDE AVENUE MADISONVILLE, KY 42431	
(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)
F 000 F 253 SS=E	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted 06/18/13 through 06/20/13. A Life Safety Code Survey was conducted on 06/18/13. Deficiencies were cited with the highest scope and severity of a "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to provide effective Housekeeping and Maintenance Services to ensure a sanitary and orderly environment. The facility failed to repair wheel chair arm rests that were cracked, torn or missing for four (4) of thirteen (13) sampled (Residents #7, #9, #10 and #12) and five (5) of six (6) unsampled resident wheelchairs (Unsampled Residents A, B, C, D, and E). Additionally, the facility failed to clean a portable air conditioning unit in a resident's room that had the access cover removed from the unit exposing the condenser coils. The condenser coils were found to be covered in a dusty, dirt like substance.</p> <p>The findings include:</p>	F 000 F 253	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Hillside Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>F253</p> <p>Wheelchair arm rests were replaced on the wheelchairs for residents #7, #9, #10 and #12, A, B, C, D and E on 07/10/13 by the Maintenance Supervisor.</p> <p>Window air conditioner in room 400 was cleaned and the front cover was attached on 06/20/13 by the Maintenance Supervisor.</p>

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JUL 22 2013
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITY SERVICES

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Carol Britt* TITLE *Administrator* (X8) DATE *07/10/2013*

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.

Amended by
Carol Britt *Administrator* *07/12/13*

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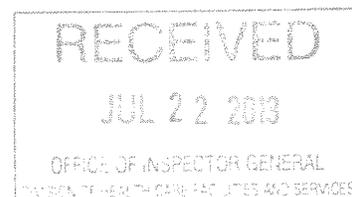
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F 253	<p>Continued From page 1</p> <p>1. Review of the facility's policy regarding HVAC (PTAC): Clean air filters, undated, revealed the steps that should be taken to clean the air filters were to remove the access cover, inspect the air filter for cleanliness and at a minimum to replace or thoroughly clean every three months, re-install filter, secure access cover and clean grill on cover.</p> <p>Observation, on 06/20/13 at 12:27 PM, revealed a portable air conditioning unit in resident room 400 to have no filter or cover, exposing the condenser coils. The condenser coils were covered with a dusty, dirt type substance.</p> <p>Review of the facility's Work History Report, for the dates of 6/30/12 through 5/31/13, revealed the air filters were cleaned and the condenser coils inspected and cleaned monthly. Further review of this report revealed this inspection was last completed on 05/07/13.</p> <p>Interview with the Maintenance Manager (MM), on 06/20/13 at 12:30 PM, revealed it was the Maintenance Department's responsibility to clean and/or repair the air conditioning units. Further interview revealed there was a monthly check list for the air conditioning units; however, the MM stated he had only been employed with the facility for approximately two weeks and was unsure when the unit was last inspected.</p> <p>Interview with the Administrator, on 06/20/13 at 2:45 PM, revealed she thought the units were cleaned as needed and did not know if inspection of the air conditioning units was on the maintenance check list. Interview further revealed a work order could have been initiated to clean</p>	F 253	<p>A facility review was completed 06/20/13 by the Maintenance Supervisor to assess for sanitary, orderly and comfortable environment including air conditioners and wheelchairs. Air conditioners were free of dust and had all the parts attached appropriately. No wheelchairs were found in need of repair. Wheelchair arm rests were ordered on 06/20/13 by Maintenance Supervisor for all wheelchairs in need of repair. No other issues were noted.</p> <p>Re-education was provided by Administrator and Director of Nursing to staff and Maintenance Supervisor on 07/09/13 to maintain effective housekeeping and maintenance services necessary to a sanitary, orderly and comfortable interior including environmental repair needs such as covers not on air conditioners or dust on air conditioners and tears in wheelchair arm rests.</p>	
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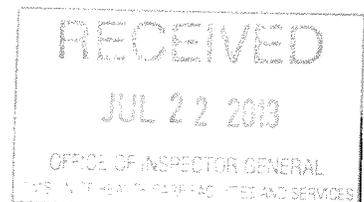
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F 253	Continued From page 2 the unit. 2. The facility did not provide evidence of a policy regarding the maintenance and upkeep of wheelchairs. Observation during the environmental tour, on 06/20/13 at 10:05 AM, revealed Residents #7, #9, #10 and #12 and Unsampled Resident A, B, C, D, and E had wheelchairs that had cracked, torn or missing arm rests. Interview with the Physical Therapy Manager (PTM), on 06/20/13 at 10:45 AM, revealed she had verbal communications with the Maintenance Manager approximately three months ago to order ten (10) sets of wheelchair arm rests. The PTM further stated she was not sure if the order was placed and the Maintenance Manager, that she told, was not longer employed at the facility. Further interview revealed the PTM would generally try to tape the arm rests that were torn or cracked to protect the residents from skin tears. Interview with the Assistant Director of Nursing (ADON), on 06/20/13 at 10:54 AM, revealed it was everyone's responsibility to monitor the working condition of the resident's wheelchairs, but it was Maintenance's responsibility to order and replace the arm rests. Further interview revealed she did feel the torn, cracked or missing arm rests could be a safety issue for the residents. Interview with the Administrator, on 06/20/13 at	F 253	Administrator and/or Maintenance Supervisor will conduct facility rounds once a week for one month then quarterly to assess for sanitary, orderly and comfortable environment. The Administrator will report findings to the Performance Improvement Committee monthly for three months then quarterly for review and further recommendations. Completion date	07/10/13
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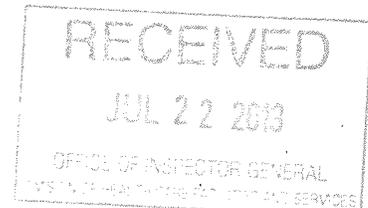
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F 253	Continued From page 3 2:45 PM, revealed she had not identified any previous issues with the residents wheel chairs, and stated she did not want the wheelchairs to have cracks or tears because she did not want the residents to have skin tears. The Administrator further stated Maintenance was responsible for the repair of the wheelchairs. Further interview revealed the Maintenance Manager was a new employee and she had not provided oversight to his orientation to the facility.	F 253		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to complete a comprehensive assessment within fourteen (14) days after the facility determined, or should have determined, that there had been a significant change in the resident's physical	F 274	F274 Resident #2 Significant Change MDS was completed and transmitted on 06/28/13 by MDS Coordinator. Current residents' charts were reviewed by Director of Nursing and Assistant Director of Nursing on 06/21/13 to determine if significant change of condition had occurred. None were noted. MDS Coordinator was re-educated by RAI Specialist on 07/10/13 on significant change guidelines per the RAI manual. Competency after re-education was determined by the the MDS Coordinator verbalizing to the Administrator on 07/10/13 her understanding of the RAI Manual in relation to Significant Changes.	



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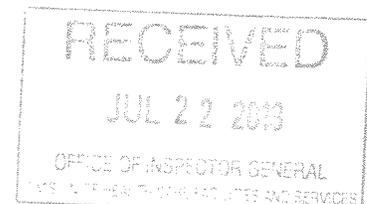
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F 274	Continued From page 4 condition for one (1) out of the total of thirteen (13) sampled and six (6) unsampled residents. Resident #2 sustained a fall resulting in a hip fracture that required hospitalization. Upon readmission the nursing facility identified the resident had a new onset of pain, decline in Activities of Daily Living (ADLs), and development of a new pressure ulcer. There was no documented evidence the facility had completed a Significant Change in Status assessment. The findings include: The facility utilized the Center for Medicare and Medicaid Services (CMS) Long Term Care Facility Resident Assessment Instrument User's Manual as guidelines for completion of required assessments. The facility used the Minimum Data Set (MDS) 3.0 as mandated by CMS. Review of the user manual, version 3.0 (September 2010) Chapter 2, page 20-21, revealed a significant change was a decline or improvement in a resident's status that would not normally resolve itself without intervention by staff, impacted more than one area of the resident's health status, and required interdisciplinary review and/or revision of the care plan. The assessment reference date (ARD) must be within fourteen (14) days after the determination the criteria for a Significant Change in Status assessment had been met. Review of the clinical record for Resident #2 revealed the facility admitted the resident on 03/06/13 with the following diagnoses: Alzheimer's Disease; Seizures; Diabetes; and Hypertension. Review of the admission MDS assessment, (ARD date of 03/13/13) revealed the resident required minimum assistance with bed	F 274	MDS Coordinator, the Director of Nursing or the Assistant Director of Nursing will review five charts weekly for four weeks, then two charts weekly for three months and one chart per month for two months to determine significant change of condition guidelines for MDS completion were met. Based on audit outcomes, the Performance Improvement Committee will increase or decrease audits and implement further re-education and/or system evaluations as needed. Completion date	07/11/13
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F 274 Continued From page 5
mobility, transfers, and ambulation. The facility assessed the resident to have no pain, falls, or pressure ulcers. The facility assessed the resident with a severe cognition impairment utilizing the Brief Interview Mental Status (BIMS) score of a three (3). A Quarterly assessment, dated 05/06/13, was completed with no changes identified in the resident's functional ability with no pain, falls, or pressure ulcers noted.

F 274

Continued review of the clinical record revealed the resident sustained a fall on 05/17/13 that resulted in a right hip fracture. The resident was in the hospital from May 17-23, 2013. Review of the re-admission nursing assessment, dated 05/23/13, revealed the resident had a pressure ulcer to the right heel and coccyx. In addition, the resident had a surgical wound to the right hip. The facility documented the resident was experiencing pain with pain medication provided routinely. Review of the June 2013 Resident Functional Performance Record (nurse aides complete this form) revealed the resident was now dependent on staff for grooming, dressing, and bathing. The facility completed a re-admission PPS (prospective payment system) assessment where the facility assessed the resident to be totally dependent on staff for bed mobility, transfers, and bathing. The resident required extensive assistance with dressing, grooming, and eating. The resident was no longer able to ambulate. Pain was identified to be frequent and moderate in scope. The facility assessed the pain to have limited the resident's day-to-day activities. Further review of the MDS assessment, revealed the facility failed to document the resident's fall with injury and new onset of a pressure ulcers.



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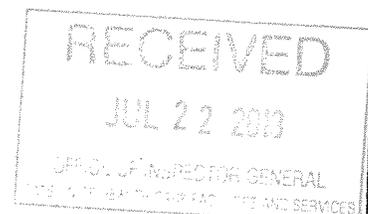
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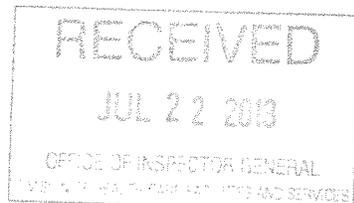
F 274	<p>Continued From page 6</p> <p>Interview with the MDS Coordinator, on 06/20/13 at 10:02 AM, revealed she had just been informed of the resident's pressure ulcer by the Assistant Director of Nursing (ADON) on 06/10/13. She stated she was out of the office on June 11, 12, and 13th. Therefore, she did not set a ARD date for the Significant Change in Status assessment. She stated she thought the resident would improve with some of the ADLs, but that had not happened. She was aware of the new onset of pain related to the hip fracture, but did not consider those changes to be enough to require a Significant Change in Status assessment. She stated she did not document the fall with injury because the question asked about the number of falls since admission and she thought they were talking about the readmission date. She stated if she had known of the pressure ulcer, she would have completed a Significant Change in Status assessment. When asked if the facility's computer software alerted her of changes from assessment to assessment, she said, "Yes." Review of the computer program with the MDS Coordinator, on 06/20/13 during the interview, revealed the software did send a message to consider a Significant Change in Status assessment based on changes identified since the last MDS assessment. The MDS Coordinator said she should have completed a Significant Change in Status assessment based on the resident's decline in ADLs, pain, fall with injury, and new onset of a pressure ulcer that required treatment.</p> <p>Interview with the ADON, on 06/20/13 at 2:20 PM, revealed she was responsible for section M (pressure ulcers) on all MDS assessments. She</p>	F 274		
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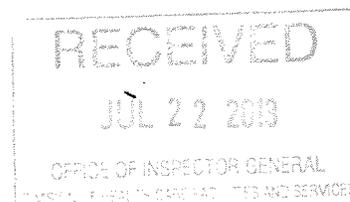
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F 274	Continued From page 7 stated she had not captured the resident's pressure ulcer on the Readmission assessment, dated 05/30/13, and had to make a modification to the assessment to correct that information. She stated the resident's pressure ulcer and other changes were discussed during the stand-up morning meetings. She stated the MDS Coordinator would determine if a Significant Change assessment was needed and would set the ARD date. She had been informed today the ARD date would be today's date, June 20, 2013.	F 274			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as possible. The facility failed to ensure the water temperatures in the resident care areas did not exceed regulatory requirements. During environmental tour, the water temperatures in the resident care areas were in excess of one-hundred and ten (110) degrees Fahrenheit.	F 323	F323 The Maintenance Supervisor and a Master Plumber, contracted by the facility adjusted the water heater temperature and mixing valve settings as to not exceed 110 degrees Fahrenheit in resident care areas on 06/20/13. The facility water temperatures in the resident care areas were audited by the Maintenance Supervisor on 06/20/13 to ensure temperatures did not exceed regulatory requirements of 110 degrees Fahrenheit. No issues were noted. The Maintenance Supervisor was re-educated on 06/20/13 by the Administrator to ensure the water temperatures in resident care areas did not exceed regulatory requirements of 110 degrees Fahrenheit.		



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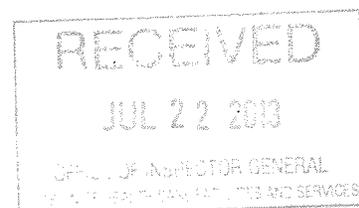
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F 323	<p>Continued From page 8</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Water Temps, undated, revealed the facility should ensure the resident room water temperatures were between one-hundred and five (105) degrees and one-hundred and twenty (120) degrees Fahrenheit (F) or as specified by state requirements.</p> <p>Review of the state requirement 902 KAR 20:046 Section 15, Mechanical Requirements, Subsection four (4)[h] revealed plumbing fixtures which required hot water and were intended for resident use should be supplied with water which was controlled to provide a maximum water temperature of one-hundred ten (110) degrees Fahrenheit (F) at the fixture.</p> <p>Review of the facility's temperature logs revealed the water temperatures to be above one-hundred and ten (110) degrees Fahrenheit (F) in the resident care areas for fifty-five (55) of the fifty-five (55) days available for review with temperatures documented to be as high as one-hundred and thirteen (113) degrees (F).</p> <p>Observations of water temperatures in resident care areas during the environmental tour on 06/18/13, at various times throughout the day, revealed at the sink in shower room #1 (100 hall) the temperature was 113.8 degrees (F), in shower room #2 (100 hall) at the sink the water temperature was 112.6 degrees (F) and the shower was 113.2 degrees (F), resident room 417 at the sink was 113.4 degrees (F), resident room 411 at the sink was 116.2 degrees (F) and the 400 hall shower room at the sink 118.7 degrees</p>	F 323	<p>The Administrator and/or the Maintenance Supervisor will monitor water temperatures in resident care areas five times a week for one month, two times per week for one month, and then monthly for four months. Based on audit outcomes, the Performance Improvement Committee will increase or decrease audits and implement further re-education and/or system evaluations as needed.</p> <p>Completion date</p>	07/10/13



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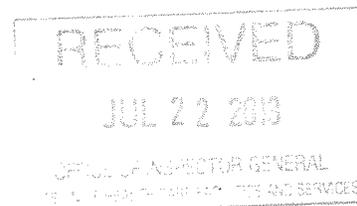
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F 323	<p>Continued From page 9 (F) and the shower was 117 degrees (F).</p> <p>Environmental rounds with the Maintenance Manager, on 06/19/13 at 7:35 AM, revealed water temperatures to be above 110 degrees (F). The temperatures were obtained in room 411 at the sink with a temperature 113.9 degrees (F), 400 shower room at the sink was 117.1 degrees (F), the shower was 116.6 degrees (F), in shower room #1 at the sink the tempeature read at 111.6 degrees (F), and shower room #2 at the sink was 111.2 degrees (F).</p> <p>Interview with the Maintenance Manager, on 06/18/13 at 7:35 AM, revealed he had a check sheet/temperature log that he completed and he thought the temperatures should have been between 105 degrees (F) and 116 degrees (F).</p> <p>Interview with a Master Plumber contracted by the facility, on 06/20/12 at 10:50 AM, revealed he adjusted the mixing valve and lowered the water temperature settings. Further interview revealed the water temperature of the 400 hall shower room after adjusting the mixing valve was 105 degrees (F).</p> <p>Interview with the Administrator, on 06/20/13 at 2:45 PM, revealed she was not aware the water temperatures were too high. Further interview revealed the Maintenance Manager was a new employee and did not know the water temperature maximum for resident care areas was 110) degrees (F). The Administrator further stated a Master Plumber was hired to assist the Maintenance Manager with learning the equipment. Further interview revealed she had not provided any oversight regarding the</p>	F 323		



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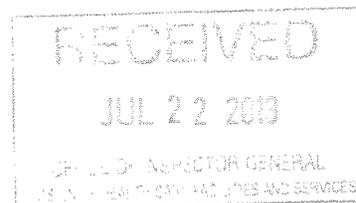
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/20/2013
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F 323 F 441 SS=D	Continued From page 10 orientation of the new Maintenance Manager. 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 Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 323 F 441	Unsamped Resident F was assessed by on 06/20/13 by the Director of Nursing found not to have any negative outcome related to the observed medication pass. Licensed Nurse #2 was immediately put into training for review of medication administration techniques with a Licensed Nurse on June 22 and 23. The Staff Development Coordinator performed a competency review of medication administration techniques on June 24 which Licensed Nurse #2 passed before returning to the floor independently. All residents benefit from proper infection control practices. No residents were affected by practice. 100% competency review was completed with all Licensed Nursing staff by the Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator on 07/09/13.	



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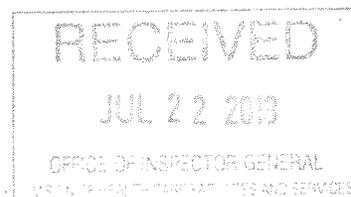
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F 441	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to maintain an effective Infection Control Program when staff failed to ensure medications were not contaminated by contacting dirty surfaces for one (1) unsampled resident of thirteen (13) sampled and six (6) unsampled residents (Unsampled Resident F). LPN #2 was observed to have dropped an open capsule into the medication cabinet, picked up the medication with bare hands, and gave the medication to Unsampled Resident F. The findings include: A review of the facility's policy regarding Medication Administration Technique (undated) revealed the staff would correctly handle medications. Observation of the medication administration pass, on 06/19/13 at 8:45 AM, revealed a Potassium Extended Release capsule was removed from the package and dropped into an open medication drawer. LPN #2 then used his/her bare hands to pick up the medication, place the medication into a medication cup, and administered the medication to Resident F. Interview with LPN #2, on 06/19/13 at 9:35 AM, revealed the Potassium Capsule should have been discarded when the medication went into the medication cart. LPN #2 said bare hands	F 441	Two med pass audits per month for six months will be completed by the Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator. Director of Nursing will report results to Performance Committee for six months for review and further commendations. Based on audit outcomes, the Performance Improvement Committee will increase or decrease audits and implement further re-education and/or system evaluations as needed. Date of Completion	07/10/13



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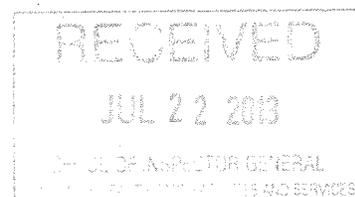
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F 441	Continued From page 12 should not have been used to pick up the medication, and Resident F should not have been given the Potassium that had been dropped in the medication cart.	F 441		
F 460 SS=D	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure full visual privacy for residents where provided. The facility failed to ensure one (1) resident room was equipped with privacy curtains to ensure privacy for the two residents in the room. In addition, the facility failed to ensure one (1) of two (2) shower rooms on the 200 hall; had a shower curtain to provide privacy. The findings include:	F 460	F460 A privacy curtain in room 402 and a shower curtain and a door locking mechanism were installed in the shower room on 100 hall by Maintenance Supervisor on 06/20/13. A review of all resident rooms and shower rooms was conducted 6/20/13 by Maintenance Supervisor to ensure complete privacy for each patient. No other issues were noted. Maintenance Supervisor was re-educated by Administrator on 06/20/13 on the requirements to ensure complete privacy for all residents.	



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F 460	<p>Continued From page 13</p> <p>Review of the facility's policy regarding Patient Rights (undated) revealed the resident had the right to full visual privacy.</p> <p>Observations of Resident Room 402, on 06/18/13 at 10:00 AM, 06/19/13 at 3:00 PM, and on 06/20/13 at 9:30 AM, revealed no privacy curtains were provided for the residents who resided in that room. Further observation revealed there were no curtain tracks on the ceiling for a curtain to be hung for bed #2. The residents who resided in Room 402 were cognitively impaired and were unable to be interviewed.</p> <p>Interview with CNA #3, on 06/20/13 at 9:40 AM; CNA #4 at 9:45 AM, and CNA #5 at 9:50 AM, revealed they would provide privacy to residents by knocking on the residents' doors, pulling the privacy curtains, and by closing the residents' door. CNA #3, CNA #4, and CNA #5 were not aware the privacy curtains from Room 402, bed 1 and bed 2 had been removed.</p> <p>Interview with the Housekeeping Supervisor, on 06/20/13 at 9:55 AM, revealed the privacy curtains had been pulled down by the resident in bed 2 and the curtains were removed to be laundered. The Housekeeping Supervisor stated the curtain track had come down and the screws had been stripped from the ceiling. She then notified the Maintenance Director of the problem. The Housekeeping Supervisor stated the curtain should have been replaced immediately and was just missed.</p> <p>Interview with the Maintenance Director, on 06/20/13 at 10:00 AM, revealed he was aware of the curtain track being down in Room 402, bed 2.</p>	F 460	<p>The Maintenance Supervisor and/or Administrator will audit privacy curtains and 100 hall shower room door for locking capabilities five time per week for one month, two times per week for one month, then monthly for four months. The Administrator will report to the Performance Committee monthly for six months for review and further recommendations. Based on audit outcomes, the PI Committee will increase or decrease audits and implement further re-education and/or system evaluations as needed.</p> <p>Completion date:</p>	07/10/13



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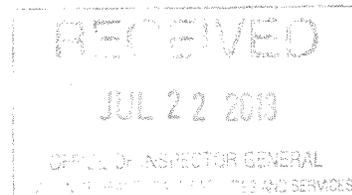
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F 460	Continued From page 14 However, he had been busy with putting up new beds and mattresses that he was unable to put the curtain track back up in Room 402, bed 2. The Maintenance Director stated when repairs were needed he made the decision what to repair first, with resident care areas being a top priority. Observation during the initial tour of the facility, on 06/18/13 at 8:10 AM, revealed no privacy curtain in the shower area or toileting area in shower Room #1 on the 100 Hall. Further observation revealed the door had no locking capabilities for privacy. Interview with the Maintenance Director, on 06/20/13 at 8:45 AM, revealed there had not been a curtain in that shower room since he had been employed at the facility for approximately two (2) weeks. Further interview revealed he did feel that it would be a privacy issue for the residents. Interview with the Administrator, on 06/20/13 at 2:45 PM, revealed she was not aware there was not a privacy curtain in that shower room. She further stated not having a curtain in the shower room would be a privacy issue for the residents.	F 460		
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of	F 469	F469 Three new air curtain were ordered and installed above the entrance door, the door off the main dining room and the 400 hall door to the resident deck area on 07/10/13 by the Maintenance Supervisor. The pest company completed an onsite visit on 07/02/13 and will continue monthly visits and as indicated. Approved fly traps were placed in the facility as needed on 07/09/13.	



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F 469	Continued From page 15 the facility's policy, it was determined the facility failed to have an effective pest control program to ensure the facility was free of pests. The facility's pest control program did not include the elimination of flying insects and although the program did provide for the elimination of bugs and spiders, these were found walking across the floors of the facility. The findings include: A review of the facility's agreement regarding Pest Management Program, effective 02/24/02, revealed pests that would be controlled were roaches, house spiders, little black ants, silverfish, mice and rats. Pests not covered under the agreement were listed as follows: Termites, fleas, flying insects, carpenter and pharaoh ants, brown recluse and black widow spiders. Review of the last several treatments dated for 06/03/13 and 06/14/13 revealed baits were monitored inside and outside the facility and ants were sprayed for in a resident room. Observation during initial tour, on 06/18/13 at 7:56 AM, revealed a quarter size spider on the floor in resident room 204. Further observation at 8:15 AM, revealed small dark colored bugs crawling in and around the shower drain in the 400 hall shower room. Observation, on 06/18/13 at 10:00 AM, of resident room 402 revealed flying insects. Observation of the dining room, on 06/18/13 at 4:55 PM, revealed three (3) flying insects in the	F 469	The facility was audited for fly control by the Administrator and Maintenance Supervisor on 06/21/13. No other issues were noted. The Maintenance Supervisor was re-educated on 06/18/13 by the Administrator and the staff was re-educated on 07/09/13 by the Maintenance Supervisor and the Staff Development Coordinator that the facility will have an effective pest control program to ensure the facility is free of pests. The Administrator and/or Maintenance Supervisor will audit the facility for flies, five times per week for one month, then two times per week for three weeks, then monthly for three months. The Administrator will report findings to the Performance Improvement Committee monthly for three months for review and further recommendations. Completion date	07/11/13	

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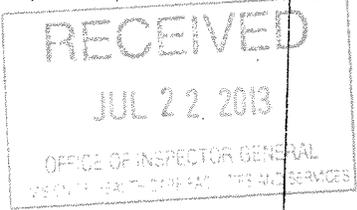
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F 469	<p>Continued From page 16</p> <p>dining area. Observation, on 06/19/13 at 8:15 AM, of the dining room revealed flying insects.</p> <p>Observation, on 06/19/13 at 9:30 AM, of resident room 102 revealed flying insects.</p> <p>Continued observations of the dining room, on 06/20/13 at 8:15 AM, revealed flying insects landing on the resident's food and drinks.</p> <p>Observation of the 300 hall, on 06/20/13 at 10:50 AM, revealed an unidentified bug crawling on the floor in the hall.</p> <p>Observation in room 400, on 06/20/13 at 12:30 PM, revealed three (3) unidentified dead bugs in the window sill.</p> <p>Observation of Wing 1 medication room, on 06/20/13 at 1:00 PM, revealed a spider crawling on the cabinets.</p> <p>Interview with the Administrator, on 06/20/13 at 2:30 PM, revealed the pest control company had not sprayed for flying insects. The Administrator did contact the pest company on 06/18/13 for a light to place by the entrance after a flying insect issue was identified; however, the pest company brought an electric light system that was based on a 220 watt system and the facility had to have a 110 watt system. The administrator stated there had been no issues with spiders and flies prior to 06/18/13. The administrator stated if a pest was seen the pest control company should be called and the pest control company would come and spray.</p>	F 469	



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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: 1969</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (222)</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke and heat detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 06/18/13. Hillside Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for seventy one (71) beds with a census of fifty two (52) 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>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Hillside Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carol Britt TITLE: Administrator (X6) DATE: 07/10/2013

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.

Amended by Carol Britt Administrator 07/18/2013

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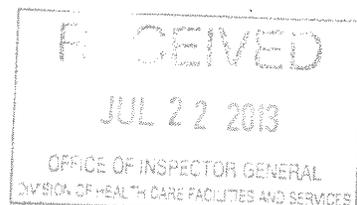
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K 018	<p>Continued From page 2</p> <p>The facility failed to ensure doors protecting the corridor would resist smoke, latch and were not blocked by furniture.</p> <p>The findings include:</p> <p>Observations, on 06/18/13 between 1:00 PM and 3:45 PM, with the Maintenance Supervisor and the Medical Records Clerk revealed the corridor doors to the resident rooms # 201, 207, and 413 would not resist the passage of smoke due to doors had a gap greater than ½ inch off the stop around the jamb. Further observation revealed the doors to resident room #204 would not latch. Further observation revealed the door to resident room #403 was blocked from closing due to the resident bed was located in the path of the door swing.</p> <p>Interviews, on 06/18/13 between 1:00 PM and 3:45 PM, with the Maintenance Supervisor and the Medical Records Clerk revealed they were not aware of the doors that had too large of a gap or would not latch. Further observation revealed they were not aware the bed to room #403 was blocking the door from closing.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the</p>	K 018	<p>The Maintenance Supervisor will inspect the facility monthly for six months to ensure that doors close and latch properly to prevent smoke penetration and report findings to the Performance Committee monthly for six months for review and further recommendations. Based on audit outcomes, the PI Committee will increase or decrease audits and implement further re-education and/or system evaluations as needed.</p> <p>Completion date</p>	07/19/13
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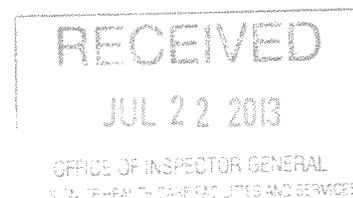
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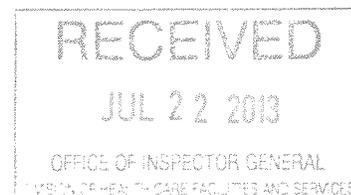
K 018	<p>Continued From page 3</p> <p>passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with</p> <p>19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.</p> <p>A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action</p>	K 018		
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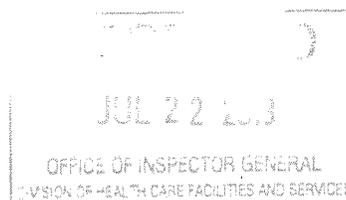
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2013
NAME OF PROVIDER OR SUPPLIER HILLSIDE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 PRIDE AVENUE MADISONVILLE, KY 42431		
(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 018	Continued From page 4 to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018			
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy one (71) beds, with a census of fifty two (52) on the day of the survey. The facility failed to maintain smoke partitions. The findings include: Observation, on 06/18/13 at 1:00 PM, with the Maintenance Supervisor revealed the smoke partitions extending above the ceiling located next	K 025	The smoke barriers were properly sealed above the ceiling located next to the Kitchen by Maintenance Supervisor to ensure they resist smoke per NFPA Standards on 07/02/13. The Maintenance Supervisor used material capable of maintaining the smoke resistance of the smoke barrier in compliance with NFPA Standard in room #408. The Maintenance Supervisor completed an inspection of smoke barriers on 07/01/13 to ensure that no other areas needed sealing and that material used was in compliance with NFPA Standard. No concerns noted. The Maintenance Supervisor was re-educated on NFPA Standard smoke barrier regulations by the Administrator on 06/18/13.		



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K 025	<p>Continued From page 5</p> <p>to the Kitchen had an unsealed pipe. Further observation revealed the smoke partition located above the ceiling next to room #408 had expandable foam installed to seal penetrations.</p> <p>Interview, on 06/18/13 at 1:00 PM, with the Maintenance Supervisor revealed he was not aware the penetration or the use of expandable foam.</p> <p>Reference: NFPA 101 (2000 edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. 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: (a) The space between the penetrating item and the smoke barrier shall</p>	K 025	<p>Maintenance Supervisor will conduct monthly inspections for 3 months and then at least quarterly inspections of smoke barriers to ensure no new penetrations of smoke barriers and material used is capable of maintaining the smoke resistance of the smoke barriers and report findings to the Performance Improvement Committee for review and further recommendations.</p> <p>Completion date _____</p>	07/19/13



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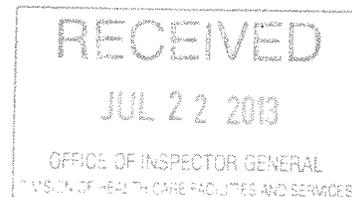
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K 025	<p>Continued From page 6</p> <p>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</p> <p>2. Be protected by an approved device designed for the specific purpose.</p> <p>(b) Where the penetrating 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 sieve shall</p> <p>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</p> <p>2. Be protected by an approved device designed for the specific purpose.</p> <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <p>1. Be made on either side of the smoke barrier, or</p> <p>2. Be made by an approved device designed for the specific purpose.</p> <p>19.3.7.4 Not less than 30 net ft² (2.8 net m²) per patient in a hospital or nursing home, or not less than 15 net ft² (1.4 net m²) per resident in a limited care facility, shall be provided within the aggregate area of corridors, patient rooms, treatment rooms, lounge or dining areas, and other low hazard areas on each side of the smoke barrier. On stories not housing bed or litterborne patients, not less than 6 net ft² (0.56 net m²) per occupant shall be provided on each side of the smoke barrier for the total number of occupants in adjoining compartments.</p> <p>19.3.7.5 Openings in smoke barriers shall be protected by fire-rated glazing; by wired glass panels and steel frames; by substantial doors, such as 13/4-in. (4.4-cm) thick, solid-bonded wood core doors; or by construction that resists fire for not less than 20 minutes. Nonrated factory- or field-applied</p>	K 025		
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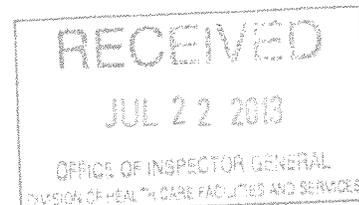


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K 025 K 027 SS=D	<p>Continued From page 7</p> <p>protective plates extending not more than 48 in. (122 cm) above the bottom of the door shall be permitted. Exception: Doors shall be permitted to have fixed fire window assemblies in accordance with 8.2.3.2.2.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy one (71) beds with a census of fifty two (52) on the day of the survey. The facility failed to ensure doors located in a smoke barrier would resist the passage of smoke.</p> <p>The findings include:</p>	K 025 K 027	<p>Door coordinators were re-installed to work properly on all three sets of cross corridor doors to ensure they meet NFPA Standards by the Maintenance Supervisor on 07/19/13.</p> <p>The Maintenance Supervisor completed facility inspection of smoke barrier doors on 06/18/13 and door coordinators were re-installed on 07/19/13 to ensure they meet NFPA 101 standards.</p> <p>Maintenance Supervisor was re-educated on need for door coordinators to meet compliance per NFPA 101 standard by Administrator on 06/18/13.</p> <p>Maintenance Supervisor will inspect the door coordinators on a monthly basis for 3 months and then at a quarterly basis and report findings to Performance Improvement Committee quarterly for review and further recommendations.</p> <p>Completion date</p>

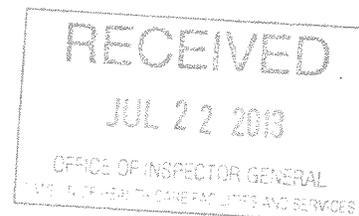
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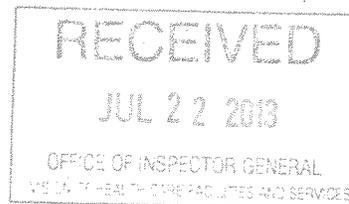
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K 027	Continued From page 8 Observation, on 06/18/13 at 2:09 PM, with the Maintenance Supervisor and the Medical Records Clerk revealed the cross corridor doors in the smoke barriers located in the 200 Hall had a gap greater than 1/8th of an inch and would not resist the passage of smoke. This was due to the coordinating device not being adjusted properly and held the door from closing. Interview, on 06/18/13 at 2:09 PM, with the Maintenance Supervisor and the Medical Records Clerk revealed he was not aware the doors had a gap too large but would have them adjusted to meet the requirement. Reference: NFPA 101 (2000 edition) 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. Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.	K 027			
K 029 SS=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	K 029	K029 Self closing devices were installed on all doors in Clean Linens Room located in the Laundry area on 06/27/13 by the Maintenance Supervisor.		



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K 029	<p>Continued From page 9</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy one (71) beds with a census of fifty two (52) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/18/13 at 3:10 PM, with the Maintenance Supervisor and the Medical Records Clerk revealed the Clean Linen Room located in the Laundry did not have a self-closing device installed on the door.</p> <p>Interview, on 06/18/13 at 3:10 PM, with the Maintenance Supervisor and the Medical Records Clerk revealed they were not aware the doors to hazardous rooms were required to be self-closing.</p>	K 029	<p>A facility audit was conducted on 06/18/13 by Maintenance Supervisor and no other doors in hazardous area were found to need self closing devices.</p> <p>Maintenance Supervisor was re-educated on the need of self closing devices in hazardous areas by the Administrator on 06/18/13.</p> <p>The Maintenance Supervisor will inspect the facility for Protection of Hazards in accordance with NFPA Standards including the need for self closing devices on a monthly basis for 3 months and then on a quarterly basis and report findings to the Performance Improvement Committee on a quarterly basis for six months.</p> <p>Completion date</p>	07/19/13



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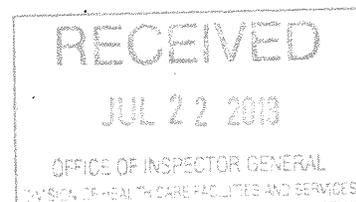
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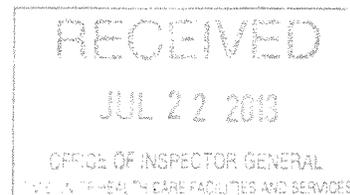
K 029	<p>Continued From page 10</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. <p>Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied</p>	K 029		
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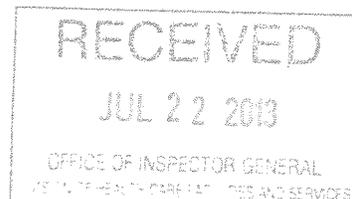
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K 029	Continued From page 11 protective plates extending not more than 48 in. (122 cm) above the bottom of the door. Reference: NFPA 101 Life Safety Code (2000 edition) Section 19.5 Building Services 19.5.2.2 Any heating device other than a central heating plant shall be designed and installed so that combustible material will not be ignited by the device or its appurtenances. If fuel-fired, such heating devices shall be chimney connected or vent connected, shall take air for combustion directly from the outside, and shall be designed and installed to provide for complete separation of the combustible system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure.	K 029			
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA	K 045	K045 A light fixture was installed to provide the required illumination for exit discharge from the Kitchen. A light fixture at the exit located in the 400 Hall to the Resident Smoking Area was changed from a one bulb fixture to a two bulb fixture by the Maintenance Supervisor on 06/28/13.		



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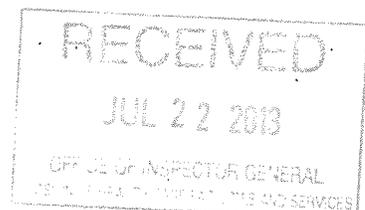
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K 045	<p>Continued From page 12</p> <p>standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy one (71) beds with a census of fifty two (52) on the day of the survey. The facility failed to provide required illumination outside an exit for discharge.</p> <p>The findings include:</p> <p>Observation, on 06/18/13 between 1:00 PM and 3:45 PM, with the Maintenance Supervisor and the Medical Records Clerk revealed the exit located in the Kitchen did not have a light fixture installed outside to provide the required illumination for exit discharge. Further observation revealed the exit located in the 400 Hall to the Resident Smoking had a light fixture installed with only one bulb.</p> <p>Interview, on 06/18/13 between 1:00 PM and 3:45 PM, with the Maintenance Supervisor and the Medical Records Clerk revealed they were not aware the exits did not have the required illumination for egress lighting.</p> <p>Reference NFPA 101 (2000 edition)</p> <p>18.2.7 Discharge from Exits.</p> <p>Discharge from exits shall be arranged in accordance with Section 7.7.</p>	K 045	<p>The Maintenance Supervisor completed a facility inspection on 06/18/13 to ensure the exits had lights containing two bulbs. No concerns were noted.</p> <p>The Maintenance Supervisor was re-educated by the Administrator on 06/18/13 to ensure the facility has appropriate means of egress lighting in compliance with NFPA Standard.</p> <p>The Maintenance Supervisor will inspect facility for appropriate means of egress lighting monthly for six months and report findings to the Performance Committee for six months for review and further recommendations. Based on audit outcomes, the PI Committee will increase or decrease audits and implement further re-education and/or system evaluations as needed.</p> <p>Completion date</p> <p>07/19/13</p>



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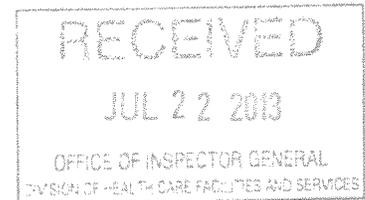
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 045	Continued From page 13 18.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8. 7.7 DISCHARGE FROM EXITS 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23. 7.7.2 Not more than 50 percent of the required number of exits, and not more than 50 percent of the required egress capacity, shall be permitted to discharge through areas on the level of exit discharge, provided that the criteria of 7.7.2(1) through (3) are met: (1) Such discharge shall lead to a free and unobstructed way to the exterior of the building, and such way is readily visible and identifiable from the point of discharge from the exit. (2) The level of discharge shall be protected throughout by an approved, automatic sprinkler system in accordance with Section 9.7, or the portion of the level of discharge used for this purpose shall be protected by an approved,	K 045		



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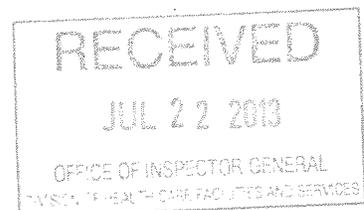
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K 045	Continued From page 14 automatic sprinkler system in accordance with Section 9.7 and shall be separated from the nonsprinklered portion of the floor by a fire resistance rating meeting the requirements for the enclosure of exits (see 7.1.3.2.1). Exception: The requirement of 7.7.2(2) shall not apply where the discharge area is a vestibule or foyer meeting all of the following: (a) The depth from the exterior of the building shall not be more than 10 ft (3 m) and the length shall not be more than 30 ft (9.1 m). (b) The foyer shall be separated from the remainder of the level of discharge by construction providing protection not less than the equivalent of wired glass in steel frames. (c) The foyer shall serve only as means of egress and shall include an exit directly to the outside. (3) The entire area on the level of discharge shall be separated from areas below by construction having a fire resistance rating not less than that required for the exit enclosure. Exception No. 1: Levels below the level of discharge shall be permitted to be open to the level of discharge in an atrium in accordance with 8.2.5.6. Exception No. 2: One hundred percent of the exits shall be permitted to discharge through areas on the level of exit discharge as provided in Chapters 22 and 23. Exception No. 3: In existing buildings, the 50 percent limit on egress capacity shall not apply if the 50 percent limit on the required number of exits is met. 7.7.3	K 045		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is	K 056		



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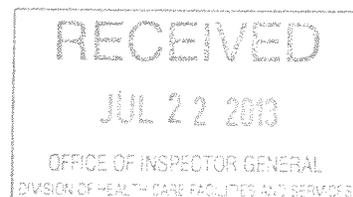
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K 056	<p>Continued From page 15</p> <p>installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 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</p> <p>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 installed, in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy one (71) beds with a census of fifty two (52) on the day of the survey. The facility failed to ensure the facility sprinkler heads were not blocked by light fixtures, and were of the same temperature rating in a compartment.</p> <p>The findings include:</p> <p>Observation, on 06/18/13 between 1:00 PM and 3:45 PM, with the Maintenance Supervisor and the Medical Records Clerk revealed a light fixture installed within twelve (12) inches of a sprinkler</p>	K 056	<p>K056</p> <p>On 06/26/13 the Maintenance Supervisor moved the light fixture in the Wing 2 Nutrition Room and the light fixture in the bathroom of room #412 to ensure that the fixtures were not within (12) inches of a sprinkler head. The center has entered an agreement with a contractor to install sprinkler heads with the same temperature rating in the 300 Hall corridor and the exit hall in the Kitchen on 07/11/13 which are in the same compartment to ensure compliance with NFPA Standards.</p> <p>An audit was conducted by Maintenance Supervisor on 06/18/13 to ensure all sprinkler heads match in each compartment and all light fixtures were not within (12) inches of a sprinkler head. No concerns were noted.</p> <p>The Maintenance Supervisor was re-educated on 07/02/13 by the Administrator on the sprinkler system requirements in accordance with NFPA standards.</p> <p>The Maintenance Supervisor will inspect the facility for proper sprinkler protection on a quarterly basis and report findings to the Performance Improvement Committee on a quarterly basis for six months for review and further recommendations.</p> <p>Completion date</p>
			<p>(X5) COMPLETION DATE</p> <p>07/19/13</p>



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K 056	<p>Continued From page 16</p> <p>head located in the Wing 2 Nutrition Room, and the bathroom of room #412. Further observation revealed sprinkler heads were installed within the same compartment that was not the same temperature rating. The sprinkler heads were mixed ratings of 155 degree F, and 165 degree F. The location of the mixed response sprinkler heads were the 300 Hall corridor, and the exit hallway in the Kitchen.</p> <p>Interview, on 06/18/13 between 100 PM and 3:45 PM, with the Maintenance Supervisor and the Medical Records Clerk revealed they were not aware of the light fixtures blocking the sprinkler heads or the mixed sprinkler heads located within the same compartment.</p> <p>Reference: NFPA 13 (1999 Edition) 5-13 8.1</p> <p>Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.</p> <p>Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The</p>	K 056		



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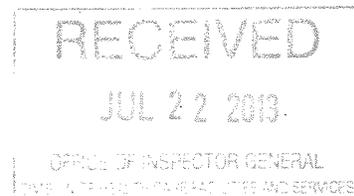
K 056

Continued From page 17.
requirements for spacing, location, and position of sprinklers shall be based on the following principles:
(1) Sprinklers installed throughout the premises
(2) Sprinklers located so as not to exceed maximum protection area per sprinkler
(3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.

Reference: NFPA 13 (1999 ed.)
5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures.
Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)

Maximum Allowable Distance	
Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)	of Deflector Obstruction (in.)
Less than 1 ft	0
1 ft to less than 1 ft 6 in.	2 1/2
1 ft 6 in. to less than 2 ft	3 1/2
2 ft to less than 2 ft 6 in.	5 1/2
2 ft 6 in. to less than 3 ft	7 1/2
3 ft to less than 3 ft 6 in.	9 1/2
3 ft 6 in. to less than 4 ft	12
4 ft to less than 4 ft 6 in.	14
4 ft 6 in. to less than 5 ft	16 1/2

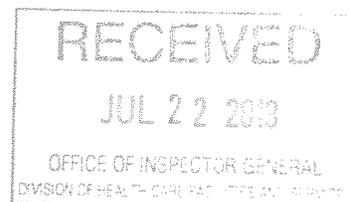
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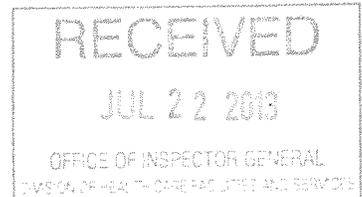
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K 056	Continued From page 18 5 ft and greater 18 For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall. Reference: NFPA 13 (1999 Edition) 7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same 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 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	K 056		



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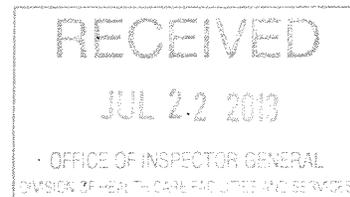
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K 056	Continued From page 19 temperature-rated sprinklers, standard response sprinklers shall be permitted to be used. Reference: NFPA 101 (2000 edition) 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception:* Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill; (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.	K 056			
K 062 SS=D	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	K 062	K062 All items were removed from resident room #412 closet on 06/18/13 by the Maintenance Supervisor to ensure 18 inches clearance was maintained from sprinkler head.		



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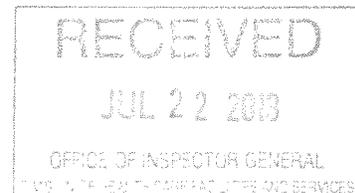
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K 062	<p>Continued From page 20</p> <p>This STANDARD is not met as evidenced by: Based on observation, and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy one (71) beds with a census of fifty two (52) on the day of the survey. The facility failed to ensure eighteen (18) inches of clearance was maintained from sprinkler heads.</p> <p>The findings Include:</p> <p>Observations, on 06/18/13 at 3:39 PM, with the Maintenance Supervisor and the Medical Records Clerk revealed storage within eighteen (18) inches of the sprinkler heads located in the closet of room #412.</p> <p>Interview, on 04/18/13 at 3:39 PM, with the Maintenance Supervisor and the Medical Records Clerk revealed they were not aware of the closet storage being within eighteen (18) inches of the sprinkler head.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development.</p>	K 062	<p>The Maintenance Supervisor completed facility inspection on 06/18/13 to ensure nothing was stored within 18" of sprinkler heads. No concerns were noted.</p> <p>The Maintenance Supervisor was re-educated on 06/18/13 by the Administrator, and the staff were re-educated by the Maintenance Supervisor and the Staff Development Coordinator on 07/09/13 to ensure that storage has 18 inches clearance from sprinkler heads.</p> <p>Maintenance Supervisor will inspect facility monthly for six months for 18" sprinkler clearance and report findings to Performance Committee for 6 months for review and further recommendations. Based on audit outcomes, the Performance Improvement Committee will increase or decrease audits and implement further re-education and/or system evaluations as needed.</p> <p>Completion date</p>	07/19/13



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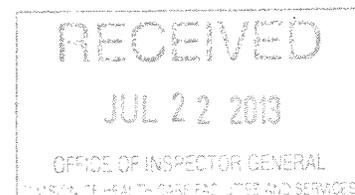
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K 062	Continued From page 21 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.	K 062		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking	K 066	Metal containers with self closing cover devices were placed in smoking areas on 06/28/13 by the Maintenance Supervisor. The Maintenance Supervisor completed a facility inspection on 06/18/13 to ensure the smoke areas were equipped with metal containers with self closing cover devices. No concerns were noted. The Maintenance Supervisor was re-educated by Administrator on 06/18/13 to ensure compliance with NFPA Standard. The Maintenance Supervisor will inspect facility monthly for six months to ensure that the smoke areas are equipped with metal containers with self closing devices and report findings to the Performance Committee for six months for further review and recommendations. Based on audit	



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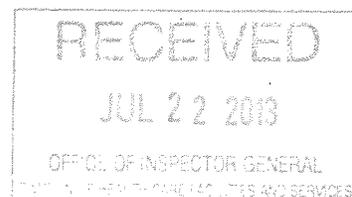
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K 066	Continued From page 22 area, in accordance with NFPA standards. The deficiency had the potential to affect smokers, staff and visitors. The facility is certified for seventy one (71) beds with a census of fifty two (52) on the day of the survey. The facility failed to ensure the smoking areas had a metal container with a self-closing lid to dump ashtrays. The findings include: Observation, on 06/18/13 at 3:24 PM, with the Maintenance Supervisor and the Medical Records Clerk revealed the facility failed to provide a metal container with a self-closing lid to dump the ashtrays, located in the designated smoking areas. Interview, on 06/18/13 at 3:24 PM, with the Maintenance Supervisor and the Medical Records Clerk revealed they were not aware the smoking area did not have the required metal container with a self-closing lid for dumping ashtrays. Reference: NFPA Standard 101 (2000 Edition). 19.7.4 Smoking (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066	outcomes, the Performance Improvement Committee will increase or decrease audits and implement further re-education and/or system evaluations as needed. Completion date	07/19/13
K 068 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2	K 068	K68 Wing two Water Heater Room combustion pipes were vented to the outside on 07/10/13 by a licensed contractor.	



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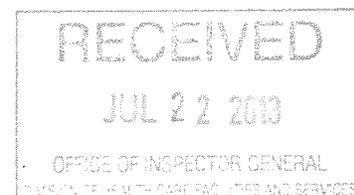
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K 068	<p>Continued From page 23</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure combustion air and ventilation for boilers, incinerators, and water heater rooms were installed in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy one (71) beds with a census of fifty two (52) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/18/13 at 3:06 PM, with the Maintenance Supervisor and the Medical Records Clerk revealed the fresh air vents located in the Wing 2 Hot Water Heater Room were open to the attic and not vented to the outside.</p> <p>Interview, on 06/18/13 at 3:06 PM with the Maintenance Supervisor and the Medical Records Clerk revealed they were not aware the vents were open to the attic.</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition)</p> <p>Section 19.5 Building Services</p> <p>19.5.2.2 Any heating device other than a central heating plant shall be designed and installed so that</p>	K 068	<p>The Maintenance Supervisor completed an inspection of the facility on 06/18/13 to ensure all other water heaters were in compliance with NFPA Standard. No concerns noted.</p> <p>On 07/08/13 the Maintenance Supervisor was re-educated by the Administrator to ensure that the combustion and ventilation air boilers, incinerators, and water heater rooms were in compliance with NFPA Standard.</p> <p>The Maintenance Supervisor will inspect the facility for proper combustion and ventilation for air boilers, incinerators, and water heater room quarterly for 6 months and report findings to the Performance Committee on a quarterly basis for 6 months for review and further recommendations.</p> <p>Completion date</p>	07/19/13



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/18/2013
NAME OF PROVIDER OR SUPPLIER HILLSIDE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 PRIDE AVENUE MADISONVILLE, KY 42431	
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K 068 K 144 SS=F	Continued From page 24 combustible material will not be ignited by the device or its appurtenances. If fuel-fired, such heating devices shall be chimney connected or vent connected, shall take air for combustion directly from the outside, and shall be designed and installed to provide for complete separation of the combustible system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure. NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation, generator testing record review, and interview, it was determined the facility failed to ensure the emergency generator was maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy one (71) beds with a census of fifty two (52) on the day of the survey. The facility failed to ensure the battery charger for the emergency generator was not connected directly	K 068 K 144	The wires from the battery charger were removed from the Generator battery and were relocated to the engine block (negative) and engine starter (positive) on 07/15/13. The Maintenance Supervisor completed a facility inspection and no other generators were found. The Maintenance Supervisor was re-educated on 06/18/13 by the Administrator to ensure that the emergency generator is maintained in accordance with NFPA Standard. The Maintenance Supervisor will complete an inspection on the correct location of the battery charging cables monthly for six



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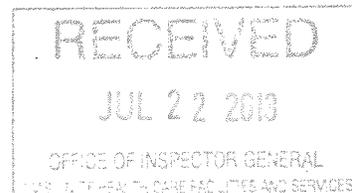
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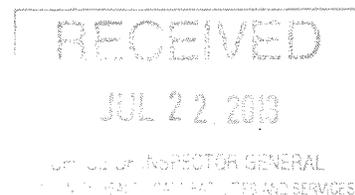
K 144	Continued From page 25 to the battery. The findings include: Observation, on 06/18/13 at 3:46 PM, with the Maintenance Supervisor and the Medical Records Clerk revealed the battery charger for the facilities emergency generator was connected directly to the battery. Interview, on 06/18/13 at 3:46 PM, with the Maintenance Supervisor and the Medical Records Clerk revealed they were not aware the battery charger could not connect directly to the battery of the generator. Reference: NFPA 110 (1999 Edition). 5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers' recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.	K 144	months and report findings to the Performance Improvement Committee for six months for review and further recommendations. Based on audit outcomes, the Performance Improvement Committee will increase or decrease audits and implement further re-education and/or system evaluations as needed. Completion date	07/19/13
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	K 147		



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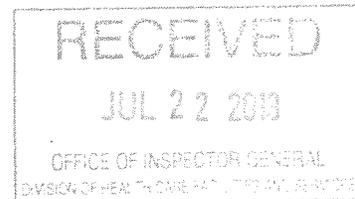
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K 147	Continued From page 26 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, residents, staff, and visitors. The facility is certified for seventy one (71) beds with a census of fifty two (52) on the day of the survey. The facility failed to maintain proper use of junction boxes, power strips, multi plug adaptor, and extension cords. The findings include: Observations, on 06/18/13 between 1:00 PM and 3:45 PM, with the Maintenance Supervisor and the Medical Records Clerk revealed the following locations had misuse of junction boxes, power strips, multi plug adaptors, and extension cords. 1) An oxygen concentrator was plugged into a power strip located in room #109. 2) A hair dryer was plugged into a multi plug adaptor located in the Beauty Shop. 3) An open junction on the power cord of an Air Conditioning Unit Fan located in the 300 Hall Medicine Room. 4) A vending machine was plugged into a power strip located in the Staff Lounge. 5) A television was plugged into an extension cord located in room #410. 6) A resident bed and air conditioner were	K 147	K147 The oxygen concentrator in room #109 was removed from the power strip and plugged into the appropriate electrical receptacle on 06/18/13 by the Maintenance Supervisor. The power strip was removed from the facility. In the Beauty Shop, the hair dryer was unplugged from the multi plug adaptor. The duplex receptacle was changed to a double duplex receptacle and plugged into the appropriate electrical receptacle on 07/01/13 by the Maintenance Supervisor. A closed junction was completed with an approved electrical junction box with cover in 300 Hall Med Room by Maintenance Supervisor on 07/01/13. On 06/28/13 the vending machine was unplugged from the power strip and a duplex receptacle was changed to a double duplex receptacle and the vending machine was plugged into the appropriate electrical receptacle by the Maintenance Supervisor. On 07/01/13 the television located in room #410 was unplugged from the extension cord and a duplex receptacle was changed to a double duplex receptacle and the television was plugged into the appropriate electrical receptacle by the Maintenance Supervisor. On 07/01/13 a resident bed and air conditioner was	



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K 147	Continued From page 27 plugged into a multi plug adaptor located in room #410. Interview, on 06/18/13 between 1:00 PM and 3:45 PM, with the Maintenance Supervisor and the Medical Records Clerk revealed they were not aware of the misuse of junction boxes, power strips, multi plug adaptors, or extension cords. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. Reference: NFPA 101 (2000 Edition) 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.	K 147	unplugged from the multi plug adaptor located in room #410 and a duplex receptacle was changed to a double duplex receptacle and the resident bed and the air conditioner were plugged into the appropriate electrical receptacle by the Maintenance Supervisor. The Maintenance Supervisor completed facility inspection on 06/18/13 to ensure the electrical wiring and equipment was in compliance with NFPA Standard. No concerns noted. Maintenance Supervisor was re-educated by Administrator on 06/18/13 and the Maintenance Supervisor and the Staff Development Coordinator in-serviced the staff on 07/09/13 to ensure electrical wiring and equipment is in compliance with NFPA Standard. The Maintenance Supervisor will inspect facility monthly for six months to ensure that electrical wiring and equipment is in accordance with NFPA Standard and report findings to the Performance Committee for six months for review and further recommendations. Based on audit	



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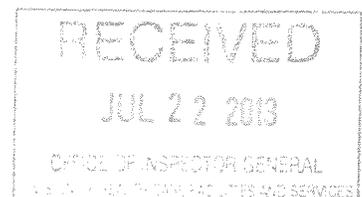
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K 147	<p>Continued From page 28</p> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key; shall be considered accessible to qualified persons.</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>370.28(c) Covers.</p> <p>All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric.</p> <p>Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p>	K 147	<p>outcomes, the Performance Improvement Committee will increase or decrease audits and implement further re-education and/or system evaluations as needed.</p> <p>Completion date</p>	07/19/13
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K 147	Continued From page 29 Reference: NFPA 70 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147		

