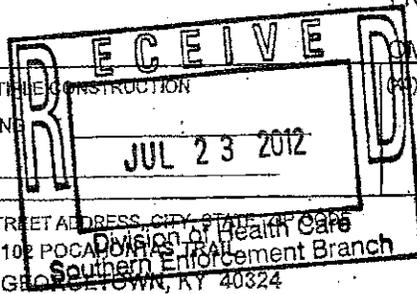


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/13/2012  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185141	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  06/28/2012
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF GEORGETOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONAS TRAIL GEORGETOWN, KY 40324
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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
F 000	INITIAL COMMENTS	F 000	Signature HealthCARE of Georgetown does not believe and does not admit that any deficiencies existed, either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 281 SS=D	<p>A standard health survey was conducted on 06/26-28/12. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to follow physician's orders for two of fourteen sampled residents (Resident #4 and Resident #9). Resident #4 had a physician's order dated 06/01/12, for oxygen to be administered at two liters per minute by nasal cannula. However, observation on 06/26/12 and 06/27/12, revealed facility staff failed to ensure the resident's oxygen was administered in accordance with the physician's orders. Resident #9 had a physician's order dated 05/25/12, for oxygen to be administered at two liters per minute by nasal cannula. However, observation on 06/28/12, revealed facility staff failed to ensure the oxygen was administered as ordered by the physician.</p> <p>The findings include:</p> <p>A review of the facility's policy titled, "Physician's Orders," which contained no date, revealed a copy of any new order would be sent to the Director of Nursing (DON) and to Medical Records, and copies of the new order would be</p>	F 281		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Nikki Schilly NHA</i>	TITLE  Administrator	(X6) DATE  7-23-12
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	INITIAL COMMENTS	F 000		
F 281 SS=D	<p>A standard health survey was conducted on 06/26-28/12. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to follow physician's orders for two of fourteen sampled residents (Resident #4 and Resident #9). Resident #4 had a physician's order dated 06/01/12, for oxygen to be administered at two liters per minute by nasal cannula. However, observation on 06/26/12 and 06/27/12, revealed facility staff failed to ensure the resident's oxygen was administered in accordance with the physician's orders. Resident #9 had a physician's order dated 05/25/12, for oxygen to be administered at two liters per minute by nasal cannula. However, observation on 06/28/12, revealed facility staff failed to ensure the oxygen was administered as ordered by the physician.</p> <p>The findings include: A review of the facility's policy titled, "Physician's Orders," which contained no date, revealed a copy of any new order would be sent to the Director of Nursing (DON) and to Medical Records, and copies of the new order would be</p>	F 281	<p><b>F 281 483.20(k)(3)(i) Services provided meet professional standards</b></p> <p><b>Corrective Action for Residents Affected:</b></p> <p>1. Resident #4 respiratory status was assessed with findings reported to the physician and POA on 6/27/12, by the Unit Manager. New order was received to change the oxygen to PRN and transcribed to the treatment administration record (TAR).</p> <p>2. Resident #9 respiratory status was assessed with findings reported to the physician by Unit Manager on 6/27/12. Resident is own responsible party. New order was received to change the oxygen to PRN and transcribed to the TAR.</p>	7-14-2012

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

TITLE

(X6) DATE

*Rikki Schley N/A*

*Administrator*

*7-23-12*

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F 281	<p>Continued From page 1</p> <p>taken to the daily clinical meeting to be reviewed to ensure for accuracy. The policy also revealed the DON would designate a nurse to review all resident charts daily to ensure physician's orders were not missed.</p> <p>1. A review of the medical record for Resident #4 revealed the facility admitted the resident on 06/01/12, with diagnoses including Chronic Respiratory Failure and Sick Sinus Syndrome. A review of the physician's orders for Resident #4 dated 06/01/12, revealed the resident was to receive oxygen at 2 liters by nasal cannula. A review of the admission Minimum Data Set (MDS) for Resident #4 dated 06/08/12, revealed the facility had assessed the resident to have moderately impaired cognition.</p> <p>Observation of Resident #4 on 06/26/12, at 1:00 PM, 3:00 PM, 4:50 PM, and 5:50 PM, and on 06/27/12, at 9:30 AM, 10:30 AM, 11:15 AM, 1:10 PM, 2:00 PM, and 3:00 PM, revealed oxygen was not administered to the resident.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #1 on 06/27/12, revealed it had been her responsibility to ensure physician's orders were being followed for Resident #4. The LPN further stated Resident #4 frequently took off the oxygen him/herself. However, the LPN revealed the physician had not been notified of the resident's noncompliance with wearing the oxygen.</p> <p>An interview conducted on 06/27/12, at 4:30 PM, with the Unit Manager (UM) of the 100, 200, and 300 Nursing Units revealed the UM was responsible to make rounds every "couple of</p>	F 281	<p><b>Identification of Residents with potential to be affected:</b></p> <p>1. All resident physician orders were audited by the Unit Manager, Director of Nursing (DON), Medical Records Director, and Staff Development Coordinator (SDC) on 6-29-12 to ensure that physician orders were being followed.</p> <p>2. No other residents were identified.</p> <p><b>Measures or systems changes to prevent reoccurrence:</b></p> <p>1. All licensed nursing staff were educated on the proper procedure in following physician orders, documentation, and notification of non-compliance by the DON and SDC. Education completed 7-14-12.</p> <p>2. All new physician orders will be reviewed in the clinical meeting, five times per week.</p>		

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F 281	<p>Continued From page 2</p> <p>hours" to ensure the residents were being provided the care they required. The UM also revealed Resident #4 took off his/her oxygen him/herself. The UM stated the resident's oxygen saturation levels remained within acceptable parameters but acknowledged there was no evidence the physician had been notified of the resident's status without oxygen.</p> <p>An interview conducted with the DON on 06/28/12, at 10:15 AM, revealed nurses were expected to follow physician's orders and notify the physician if a resident was noncompliant with the care being provided. The DON stated Resident #4 takes off the oxygen him/herself and the nurse should have notified the physician of the resident's noncompliance with wearing the oxygen and of the resident's oxygen saturation levels.</p> <p>2. A review of the medical record for Resident #9 revealed the resident was admitted by the facility on 01/31/12, with diagnoses including Atrial Fibrillation and Chronic Kidney Disease. A review of the most recent quarterly MDS assessment for Resident #9 dated 05/02/12, revealed the facility had assessed the resident to be independent with decision making ability.</p> <p>Resident #9 acknowledged in interview conducted on 06/28/12, at 1:55 PM, that he/she takes off the oxygen. The resident revealed he/she did not wear the oxygen all the time and just needed it when he/she became short of breath.</p> <p>An interview with LPN #1 on 06/28/12, at 6 2:10 PM, revealed Resident #9 did not wear his/her</p>	F 281	<p>3. Following clinical meeting, Unit Manager/DON reviews medication administration record (MAR), TAR and chart for new order accuracy. Non-compliance will be corrected immediately and reported/reviewed in weekly At Risk meeting by the DON/Unit Manager.</p> <p>4. 11-7 shift nurse review all charts daily to ensure no orders were missed. Any discrepancies identified will be corrected immediately and reported to the DON for further follow-up, interventions, and/or education.</p> <p><b>Monitoring changes/systems to ensure no deficient practice:</b></p> <p>1. Medical Records, Unit Manager, and/or SDC will audit all oxygen orders for compliance, weekly for four weeks, bi-weekly for four weeks, and then monthly. Any discrepancies will be corrected and reported to the DON for further follow-up, interventions, and/or education.</p>		

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F 281	Continued From page 3 oxygen all the time and the LPN had not been aware Resident #9 was to use the oxygen on a continuous basis. The LPN stated she had been responsible for ensuring Resident #9 wore the oxygen as ordered by the physician and that she should have notified the physician of the resident's noncompliance with the oxygen use.  An interview conducted on 06/27/12, at 4:30 PM, with the Unit Manager (UM) of the 100, 200, and 300 Nursing Units revealed she was responsible to make rounds every "couple of hours" to ensure the residents were being provided the care they required. The UM stated Resident #9 took off his/her oxygen him/herself. According to the UM, the physician should be notified whenever a resident was noncompliant with physician's orders but there was no evidence in the medical record to show the physician had been notified of Resident #9's noncompliance.  An interview conducted with the DON on 06/28/12, at 3:20 PM, revealed the nurse was responsible for checking the treatment sheets and the care plan daily to ensure the residents were receiving the care they required. The DON stated they discussed Resident #9 refusing to wear the oxygen as ordered by the physician in the morning clinical meeting a couple of weeks prior but failed to notify the physician at that time. The DON stated the physician should have been notified immediately.	F 281	2. Findings of the audits will be reviewed in the Quality Assurance meeting monthly for 3 months and then at the discretion of the QA committee.  3. The QA committee consists of the following: Medical Director, Administrator, Director of Nursing (DON), Minimum Data Set Coordinator (MDS), Social Service Director (SSD), Human Resource Director (HR), Business Office Manager (BOM), Dietary Manager, Rehab Services Manager (RSM), Medical Records, Maintenance Director, Housekeeping Director, Quality of Life Director (QoL), Chaplain.		
F 371 SS=B	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371			

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F 371	<p>Continued From page 4 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure sanitation was maintained in the dish room area. Observation of the dish room floor on 06/26/12, at 5:45 PM, revealed the dietary staff had placed five dishwasher racks directly on the soiled kitchen floor.</p> <p>The findings include:</p> <p>An interview conducted with the Dietary Manager on 06/26/12, revealed the facility had not developed a policy for the storage of dishwasher racks.</p> <p>Observation of the Dietary Department at 5:45 PM on 06/26/12, revealed five dishwasher racks had been placed on the soiled floor of the dish room adjacent to the facility dishwasher.</p> <p>An interview conducted with the facility's dietary cook revealed the facility did not have shelf space to keep the racks stored six inches off the soiled dietary floor.</p> <p>An interview was conducted with the Dietary Manager on 06/26/12, at 6:00 PM. The Dietary Manager also stated there was not enough shelf</p>	F 371	<p><b>F 371 483.35(i) Food Procure. Store/Prepare/Serve - Sanitary</b></p> <p><b>Corrective Action for Residents Affected:</b></p> <p>1. No residents identified as affected.</p> <p><b>Identification of Residents with potential to be affected:</b></p> <p>1. All residents receiving meals served out of the dietary kitchen have the potential to be affected.</p> <p><b>Measures or systems changes to prevent reoccurrence:</b></p> <p>1. An additional shelving unit was added to the kitchen 6-27-12 to allow for storage of the dishwasher racks to be at least six inches off the dietary floor.</p> <p>2. All dietary staff were educated on the proper storage of the dishwasher racks, sanitation, proper storage of food, cleaning schedules by the Regional Dietary Consultant and facility Registered Dietician on 6-27-12 and 6-28-12.</p>	7-14-2012

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F 371	Continued From page 5 space to store the dish racks off the soiled dish room floor.	F 371	3. The Dietary Manager, Registered Dietician (RD), and/or Administrator will monitor the proper storage of the dishwasher racks weekly for four weeks, bi-weekly for a month, and then monthly to ensure compliance with dishwasher rack storage.		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	<b>Monitoring changes/systems to ensure no deficient practice:</b>  1. Findings of the dishwasher rack storage audit will be reviewed for compliance in the QA Committee meeting monthly for 3 months and then at the discretion of the QA committee.  F431 483.60(b),(d),(e) Drug records, label/store drugs & biologicals  <b>Corrective Action for Residents Affected:</b>  1. No residents identified as affected.	7-14-2012	

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F 431	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure all medications were stored at proper temperatures. Observations on 06/27/12, revealed staff did not have access to thermometers in the medication storage rooms and, as a result, failed to ensure medications were stored in accordance with manufacturer's recommendations. In addition, three medication carts were observed to be soiled with dust and grit on top of the carts and inside the drawers.</p> <p>The findings include:</p> <p>An interview with the Director of Nursing (DON) on 06/27/12, at 4:45 PM, revealed the facility did not have a policy related to monitoring temperatures in the medication rooms or cleaning the medication carts.</p> <p>Observations on 06/27/12, at 4:00 PM, revealed the medication storage room located on the Transitional Unit did not have a thermometer in the room for staff to use to monitor the room temperatures. Further observation revealed medications stored in the medication room such as antibiotics which, based on the manufacturer's recommendations, required storage temperatures below 77 degrees Fahrenheit.</p> <p>An interview with the Transitional Unit Manager at 4:05 PM, revealed the only thermometer in the room was located inside the refrigerator. The Unit Manager stated she was unaware of a need to monitor the medication room temperature.</p>	F 431	<p><b>Identification of Residents with potential to be affected:</b></p> <p>1. All residents have the potential to be affected if medications are not maintained at proper temperatures or the medication carts are soiled.</p> <p><b>Measures or systems changes to prevent reoccurrence:</b></p> <p>1. Thermometers were placed in both medication rooms 6-29-12, by the Maintenance Director. A monitoring log for daily temperatures was also implemented on 7-11-12 by the SDC and DON. If the medication room temperature exceeds the medication guideline, the medications will be relocated to the Med Cart storage room, located on the 200 hall. This room routinely maintains temperatures within normal range, and will be monitored as well to ensure compliance maintained. Maintenance and Administrator will be notified immediately for follow-up.</p>		

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F 431	Continued From page 7 In addition, observations of the medication rooms located on the 100, 200, and 300 Nursing units on 06/27/12, revealed medications stored in the room but there was no thermometer to monitor the room temperature of the medication room.  Licensed Practical Nurse (LPN) #2 acknowledged in interview conducted on 06/27/12, at 4:50 PM, there was not a thermometer located in the medication rooms and she was unaware of the need to ensure the room temperature was maintained at a temperature in accordance with the manufacturer's recommendations, e.g., below 77 degrees Fahrenheit for antibiotics.  In addition, observation of the medication carts located in the medication rooms located on the 100, 200, and 300 Nursing units revealed the carts were soiled with dust, grit, and pill debris.  An interview with the Director of Nursing (DON) on 06/27/12, at 4:45 PM, revealed medication aides were to clean the medication carts, but there was no schedule for cleaning and the DON had not monitored the carts recently.	F 431	2. All medication carts were cleaned and all grit and soiled substance removed on 6-27-12 by the MDS, SDC, and Unit Managers.  3. A medication/treatment cart cleaning schedule has been implemented by the DON on 7-05-12 and a completion check-off created to ensure that the schedule is being followed.  4. All licensed nursing staff were educated by the SDC and DON on proper procedures for maintaining medications at the proper temperature; documenting, notification, and interventions of temperatures out of compliance; process for cleaning carts. Education completed 7-14-12.	
F 456 SS=B	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION  The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.  This REQUIREMENT is not met as evidenced by: Based on interview and observation it was determined the facility failed to ensure the facility ice cream freezer was maintained clean and frost	F 456	<b>Monitoring changes/systems to ensure no deficient practice:</b>  1. The SDC and/or DON will audit the cleaning schedule and temperature log weekly and will validate for completion for three months.	7-14-2012

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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	
F 456	<p>Continued From page 8</p> <p>free. Observation of the facility chest-type freezer on 06/28/12, located in the facility basement revealed a layer of frost buildup on the interior one-quarter inch thick. The frost had the potential to cross-contaminate the stored ice cream.</p> <p>The findings include:</p> <p>A review of the facility policy (undated) revealed the facility equipment would be free of food, grease, or soil. The policy also indicated the Dietary Manager would be responsible for the major equipment cleaning.</p> <p>During the final sanitation audit conducted on 06/28/12, at 11:30 AM, the freezer was observed to have a one-quarter-inch layer of frost buildup on the interior of the chest-type ice cream freezer. The frost had the potential to contaminate the ice cream stored in the ice cream freezer.</p> <p>An interview was conducted with the Dietary Manager on 06/28/12, at 11:25 AM. The Dietary Manager stated there was not a formal cleaning schedule for the freezer to be defrosted and cleaned. The Dietary Manager further stated there was no way to determine when the freezer was previously cleaned and defrosted.</p>	F 456	<p>2. Findings of the weekly audits will be reviewed in the Quality Assurance meeting monthly for 3 months and then at the discretion of the QA committee.</p> <p>F 456 483.70(c)(2) Essential Equipment, Safe operating condition</p> <p><b>Corrective Action for Residents Affected:</b></p> <p>1. No residents identified as affected.</p> <p><b>Identification of Residents with potential to be affected:</b></p> <p>1. All residents receiving items from the freezer have the potential to be affected.</p> <p><b>Measures or systems changes to prevent reoccurrence:</b></p> <p>1. The freezer identified was defrosted and cleaned on 6-29-12 by the Dietary Manager.</p>	7-14-2012	

**F 456 Continued**

**Measures or system changes to prevent reoccurrence - continued:**

2. All other freezers were inspected by the Dietary Manager ensure defrosted and cleaned on 6-29-12. The ice cream freezer was defrosted on 6-27-12 and cleaning completed 6-29-12, by the Dietary Manager.
3. A freezer cleaning schedule was re-implemented by the Dietary Manager on 6-29-12 and a completion check-off created to ensure that the schedule is being followed.
4. All dietary staff were educated on the cleaning schedule by the Registered Dietician, Dietary Manager, and Regional Dietary Consultant. Education completed 6-29-12.
5. The Dietary Manager, Registered Dietician, and/or Administrator will monitor the freezers weekly for three months and will validate the cleaning completion monthly.

**Monitoring changes/systems to ensure no deficient practice**

1. Findings of the weekly audit and monthly validation will be reviewed in the Quality Assurance meeting monthly for 3 months and then at the discretion of the QA committee.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185141	<div style="border: 2px solid black; padding: 5px; text-align: center;"> <b>RECEIVED</b>                  JUL 23 2012                  Division GEORGETOWN, KY 40324                  Southern Enforcement Branch             </div>	(X3) DATE SURVEY COMPLETED  06/27/2012
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF GEORGETOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 04/13/76</p> <p>SURVEY UNDER: NFPA 101 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story Type II (200)</p> <p>SMOKE COMPARTMENTS: 7</p> <p>FIRE ALARM: Complete fire alarm system (upgraded in September 2011)</p> <p>SPRINKLER SYSTEM: Complete (wet) sprinkler system added new dry system in September 2011</p> <p>GENERATOR: One Type II Diesel generator. New in September 2011</p> <p>A standard Life Safety Code survey was conducted on 06/27/12. Signature Healthcare of Georgetown was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for 65 beds with a census of 55 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> <p>Deficiencies were cited with the highest</p>	K 000	<p><b>K 029 NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p><b>Corrective Action for Residents Affected:</b></p> <ol style="list-style-type: none"> <li>1. No residents identified as affected.</li> <li>2. Door closures added to the identified doors on 6-27-12 by the Maintenance Director and Maintenance Assistant.</li> </ol> <p><b>Identification of Residents with potential to be affected:</b></p> <ol style="list-style-type: none"> <li>1. All residents have the potential to be affected by not having the proper closures on rooms considered hazardous areas.</li> <li>2. Maintenance Director and Maintenance Assistant conducted a review of all other doors on 6-27-12 to determine proper</li> </ol>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Nikki Schrey MHA</i>	TITLE  Administrator	(X6) DATE  7-23-12
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF GEORGETOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324	
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K 000 K 029 SS=D	Continued From page 1 deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were protected according to National Fire Protection Association (NFPA) standards.  The findings include:  Observation on 06/27/12, between 10:00 AM and 1:00 PM, with the Maintenance Director revealed the door leading into the central supply storage room did not have a self-closing device installed per the NFPA Life Safety Code. In addition, observations revealed the Sprinkler room was being used to store medical records. The amount of combustibles stored in the Sprinkler room required the room to be considered a storage area and, as such, required a door closing device. However, observations revealed the door	K 000 K 029	<p>closures. No other doors identified.</p> <p><b>Measures or systems changes to prevent reoccurrence:</b></p> <ol style="list-style-type: none"> <li>1. The Maintenance Director, Maintenance Assistant and Administrator reviewed the NFPA code on 6-27-12.</li> <li>2. Maintenance Director and/or Maintenance Assistant will conduct a monthly audit to ensure doors have proper closure. Any findings will be corrected immediately and reported to the monthly Safety Committee for review and follow-up.</li> </ol> <p><b>Monitoring changes/systems to ensure no deficient practice:</b></p> <ol style="list-style-type: none"> <li>1. Results of the door closure audit will be forwarded to the QA Committee, by the Safety Committee, for review by the Administrator monthly x 3 months and then at the discretion of the QA Committee.</li> </ol>	7-14-2012

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K 029	<p>Continued From page 2</p> <p>leading into the Sprinkler room did not have a door closing device as required.</p> <p>Interview on 06/27/12, between 10:00 AM and 1:00 PM, with the Maintenance Director revealed he was unaware of the above noted requirements. The Administrator also acknowledged during the exit interview conducted on 06/27/12, at 1:15 PM, that he was unaware of these requirements.</p> <p>Reference: NFPA 101 (2000 Edition).</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> <ul style="list-style-type: none"> <li>(1) Boiler and fuel-fired heater rooms</li> <li>(2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>)</li> <li>(3) Paint shops</li> <li>(4) Repair shops</li> <li>(5) Soiled linen rooms</li> <li>(6) Trash collection rooms</li> <li>(7) Rooms or spaces larger than 50 ft<sup>2</sup> (4.6 m<sup>2</sup>), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction</li> </ul>	K 029		

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K 052 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: Based on interview and fire alarm inspection review, the facility failed to test the fire alarm system quarterly per NFPA standards. The deficiency had the potential to affect seven of seven smoke compartments, all residents, staff, and visitors. The facility is licensed for 65 beds with a census of 55 on the day of the survey.</p> <p>The findings include:</p> <p>Fire alarm inspection review on 06/27/12, at 12:45 PM, with the Maintenance Director revealed the facility failed to provide documentation to show the fire alarm had been tested in the first quarter of 2012.</p> <p>Interview on 06/27/12, at 12:45 PM, with the Maintenance Director revealed the company that</p>	K 052	<p><b>K 052 NFPA 101 Life Safety Code Standard</b></p> <p><b>Corrective Action for Residents Affected:</b></p> <ol style="list-style-type: none"> <li>1. No residents were affected by this practice.</li> <li>2. The fire system was inspected 4-10-12 by Century Fire, a new provider.</li> </ol> <p><b>Identification of Residents with potential to be affected:</b></p> <ol style="list-style-type: none"> <li>1. All residents have the potential to be impacted by this practice</li> </ol> <p><b>Measures or systems changes to prevent reoccurrence:</b></p> <ol style="list-style-type: none"> <li>1. Maintenance Director has a tracking log established to identify scheduled inspections and due dates. This log will be reviewed with the Safety Committee monthly.</li> <li>2. Maintenance Director, Maintenance Assistant and Administrator reviewed the</li> </ol>	7-14-2012

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K 052	Continued From page 4 performed the inspections terminated the contract agreement on 03/21/12, with the facility and the earliest date that another company could inspect the system was 04/10/12. This was also confirmed by the Administrator in the exit conference.  NFPA Standard: NFPA 101, 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.	K 052	process on 6-27-12 to ensure that inspection dates complied with. Any compliance issues will be immediately addressed.  Monitoring changes/systems to ensure no deficient practice:	
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  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained as required. The deficiency had the potential to affect one smoke compartment in the basement, and staff. The facility is licensed for 65 beds with a census of 55 on the day of the survey.  The findings include:  Observation on 06/27/12, between 10:00 AM and 1:00 PM, in the sprinkler riser room with the Maintenance Director revealed medical records stored within 18 inches of sprinkler heads. This	K 062	1. Maintenance Director will continue to keep facility records on scheduled visits and track compliance. This will be reviewed monthly with the Safety Committee, with any identified issues and resolutions determined. The results will be forwarded to the QA Committee for review monthly, unless otherwise determined by the QA committee.  K 062 NFPA 101 Life Safety Code Standard  Corrective Action for Residents Affected:  1. No residents were identified as being affected	7-14-2012

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K 062	Continued From page 5. practice would prevent the sprinkler pattern from fully developing.  Interview on 06/27/12, between 10:00 AM and 1:00 PM, with the Maintenance Director revealed he was aware of the storage requirements.  Reference: NFPA 13 (1999 Edition).  5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 5-5.5.2.	K 062	<b>Identification of Residents with potential to be affected:</b>  1. All residents have the potential to be affected by the deficient practice.  2. The medical records stored within 18 inches of the sprinkler heads were corrected on 6-27-12 by Maintenance Director and Maintenance Assistant.  <b>Measures or systems changes to prevent reoccurrence:</b>  1. All sprinkler heads audited by the Maintenance Director and Maintenance Assistant to ensure 18 inch standard met on 6-27-12. No others identified.  2. Education on ensuring sprinkler heads were maintained as required was conducted with the department team by the Maintenance Director and Administrator on 6-29-12.		

**K 62 Continued**

**Measures or system changes to prevent reoccurrence - continued:**

3. The monthly maintenance checklist, conducted by the Maintenance Director and/or Assistant will review all sprinkle heads to ensure 18 inch standard maintained. Any identified non-compliance will be corrected immediately by the Maintenance team and communicated to the Administrator and appropriate department manager for further follow-up and education. Findings will be reported to the Safety Committee for follow-up.

**Monitoring changes/systems to ensure no deficient practice**

1. The results of the monthly maintenance checklist will be reviewed with the QA committee monthly for three months then thereafter as determined by the QA committee.