

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

PRINTED: 11/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185118	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/27/2010
NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview on 10/27/10, it was determined the facility failed to ensure there were no impediments to the closing of the corridor fire/smoke doors.	K 018	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> K018 I. How corrective action will be accomplished for those affected. Wheelchair was immediately removed from corridor. II. How corrective action will be accomplished for those residents having potential to be affected. Facility staff have been trained to remove medication carts, lifts, soiled and clean linen carts from corridors are unobstructed and unimpeded for proper closure. Areas in the facility having the potential to be affected by the same practice will be identified by daily rounds for one week, then weekly for 4 weeks, then monthly thereafter. III. What measures will be put in place/systemic changes made to ensure correction. Quarterly rounds will be done by the Maintenance Director or qualified designee to ensure this practice does not re-occur.	11/22/10

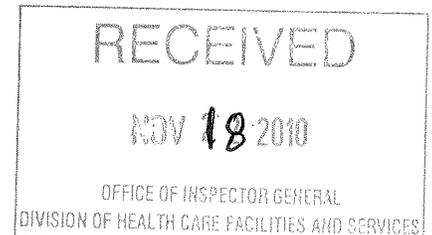
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
 Executive Director 11/18/10

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

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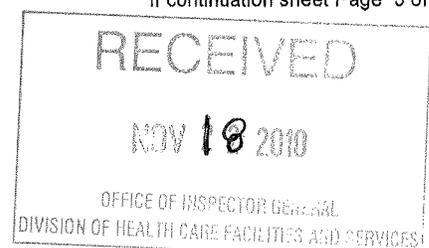
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K 018	Continued From page 1 The findings include: Observation on 10/27/10 at 11:30am with the Maintenance Director revealed one of the fire/smoke doors separating the South Front and North Front Hallways was blocked from closing by a wheelchair. Interview with the Maintenance Director on 10/27/10, indicated they would inform staff to keep all fire/smoke doors free of any impediment to the closing of the doors.	K 018	<hr/> IV. How the facility plans to monitor its performance to make sure that solutions are sustained. Results of rounds will be addressed by the facility Performance Improvement Committee monthly.	11/22/10
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview on 10/27/10, it was determined the facility failed to ensure the building had a complete sprinkler system, according to NFPA standards. The findings include:	K 056	K056 I. How corrective action will be accomplished for those affected. Facility will obtain a quote from a vendor related to installing proper sprinkler coverage to comply with regulation. II. How corrective action will be accomplished for those residents having potential to be affected. Sprinkler system will be installed by Koorsen Protection Service on the porch area identified during survey. III. What measures will be put in place/systemic changes made to ensure correction. The facility maintenance director will monitor all overhangs and porch areas for compliance with NFPA 13. IV. How the facility plans to monitor its performance to make sure that solutions are sustained. Facility Executive director will monitor with maintenance director and review at monthly PI meetings.	



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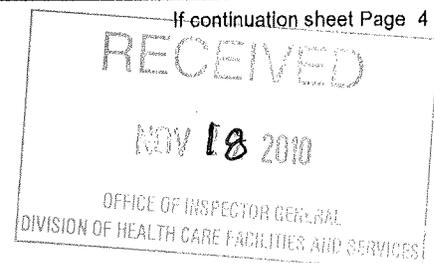
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K 056	Continued From page 2 Observation on 10/27/10 at 12:00pm with the Maintenance Director, revealed a large canopy over the South Lobby exit extending around to the South Wing exit. The canopy was not sprinkled with combustible construction. Interview with the Maintenance Director on 10/27/10 at 12:00pm revealed he was not aware that the canopy needed sprinklers.	K 056		11/22/10
K 072 SS=E	Reference NFPA 13/1999 (Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft. (1.2m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction. NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview conducted on 10/27/10, it was determined the facility failed to ensure the corridors were maintained free from obstructions in the case of fire or other emergencies. The findings include:	K.072	<u>K072</u> I. How corrective action will be accomplished for those affected. Medication carts, lifts, wheelchair and other obstructions were removed from corridors. II. How corrective action will be accomplished for those residents having potential to be affected. Facility staff have been trained to remove medication carts, lifts, soiled and clean linen carts from corridors when not in use to ensure corridors are unobstructed. Areas in the facility having he potential to be affected by the same practice will be identified by daily rounds for one week, the weekly for 4 weeks, then monthly there after.	



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K 072	Continued From page 3	K 072		
K 073 SS=E	<p>Observation on 10/27/10 at 1:45pm with the Maintenance Director revealed an empty wheelchair next to resident rooms numbered 48 and 46 on the South Hallway. Further observation revealed a Hoyer lift next to room #4 and an empty wheelchair next to rooms #15 and #17 on the North Hallway.</p> <p>Interview with the Maintenance Director on 10/27/10 at 1:45pm, indicated that this problem would be addressed.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview on 10/27/10, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards.</p> <p>The findings include:</p> <p>Observation on 10/27/10 at 11:20am with the Maintenance Director, revealed eight resident rooms with hanging decorations on the doors that were not flame retardant. The resident rooms were numbered 1, 12, 15, 22 31, 41, 44, and 46.</p> <p>Interview with the Maintenance Director on 10/27/10 at 11:20am, revealed they were unaware of the requirement that the decorations had to be flame retardant.</p>	K 073	<p>III. What measures will be put in place/systemic changes made to ensure correction.</p> <p>Quarterly rounds will be done by the Maintenance Director or qualified designee to ensure this practice does not re-occur.</p> <p>IV. How the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>Results of rounds will be addressed by the facility Performance Improvement Committee monthly. Preventive Maintenance Logs will be reviewed by the PI committee quarterly to ensure continued compliance for one year following the noted issue.</p> <p>K073</p> <p>I. How corrective action will be accomplished for those affected. Decoration were removed from egress hallways to insure compliance with life safety code.</p> <p>II. How corrective action will be accomplished for those residents having potential to be affected. Facility Maintenance Director will make weekly rounds to insure any decoration not meeting code will be promptly addressed.</p> <p>III. What measures will be put in place/systemic changes made to ensure correction. Facility Maintenance Director will report any finding on his weekly rounds to facility Administrator to insure proper compliance with said code.</p>	11/22/10



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K 073	Continued From page 4 NFPA Standard NFPA 101.2000 Edition 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073	IV. How the facility plans to monitor its performance to make sure that solutions are sustained. Preventive Maintenance Logs will be reviewed by the PI committee quarterly to ensure continued compliance for one year following the noted issue.	11/22/10	

