

**RECEIVED**

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

**FEB 27 2012** PRINTED: 01/31/2012  
FORM APPROVED  
OMB NO. 0938-0391

OFFICE OF INSPECTOR GENERAL  
HEALTH CARE FACILITIES ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185226</b>	(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/20/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CARMEL HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2501 OLD HARTFORD RD. OWENSBORO, KY 42303</b>
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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	<p><b>INITIAL COMMENTS</b></p> <p>A standard Health survey was conducted on 1/18-1/20/12 and the Life Safety Code survey was conducted on 01/18/12 with the highest scope and severity of an "F". The facility had the opportunity to correct before remedies would be imposed.</p>	F 000		
F 332 SS=D	<p><b>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</b></p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to administer medications with a medication error rate of less than 5% for one (1) of nine (9) sampled residents. The facility administered eyedrops to Resident #6 in the both eyes instead of the left eye as ordered and omitted a medication prescribed by the physician.</p> <p>The findings include: Review of the facility's policy, Medication Administration-General Guidelines, not dated, revealed medications are administered in accordance with written orders of the attending physician and at the end of each medication pass, the person administering the medications, reviews the Medication Administration Record (MAR) to ensure necessary doses were administered and documented.</p>	F 332	<p><b>Criteria 1:</b> Resident #6 receives the Alpha Lipoic acid and Alphagen eye drops as per MD orders, as observed by ADON and MDS Coordinator.</p> <p><b>Criteria 2:</b> Residents receive their medications as ordered with an error rate of less than 5%, as observed by the ADON and MDS Coordinator.</p> <p><b>Criteria 3:</b> Inservice education was provided for the medication administration staff on correct med administration by the ADON on Jan. 20, 2012 including but not limited to: -obtaining medications from the pharmacy that are not available on the cart; administering eye drops in accordance with MD</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *x A. M. Francis Teresa Scully* TITLE: *x Adm.* (X6) DATE: *x 02-27-12*

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

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NAME OF PROVIDER OR SUPPLIER  CARMEL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 OLD HARTFORD RD. OWENSBORO, KY 42303
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F 332 Continued From page 1  
Observation of a medication pass, on 01/19/12 at 9:30 AM, with CMT #2 revealed Alphagan 0.15% Ophthalmic drops was administered to Resident #6, one drop in each eye.

Review of Resident #6's clinical record revealed the most current physician orders instructed to give Alphagan 0.15%, one drop in left eye every twelve (12) hours. Further review revealed a physician order for Alpha Lipoic Acid 100 mg every day, which Resident #6 did not receive during the observed medication pass.

Review of Resident #6's MAR revealed the Alpha Lipoic Acid had been initialed as being administered every day in January.

Review of the medication dispensing record for Resident #6's Alpha Lipoic Acid from Danhauer Drugs revealed the last dispense for the medication was on 12/12/11 at which time thirty (30) tablets were dispensed. Had the medication been administered as ordered the last dose would have been given on or about 01/13/12. There were no further refills ordered from the pharmacy until 01/19/12 (after the medication error was discovered).

Interview with CMT #2, on 01/19/12 at 4:05 PM, revealed she signed the MAR indicating she had administered the Alpha Lipoic Acid however, when she checked the resident's medication there was no Alpha Lipoic Acid. CMT #2 stated she guessed she mistakenly initialed the MAR indicating the Alpha Lipoic Acid had been administered when in fact the resident did not have any of the medication available. She stated the consequences of missing multiple doses of

F 332 orders, and signing for medication administration correctly.

**Criteria 4: -Medication Administration observations were completed on all medication administration staff by the ADON, MDS Coordinator and Nurse consultant on Jan. 25, 2012 to determine that meds are administered with less than a 5% error rate.**

**-Medication administration observations will be conducted by the ADON or Pharmacy Consultant as part of the medication administration staff annual evaluations to determine ongoing compliance with less than 5% error rates.**

**-The CQI indicator for the monitoring of med pass administration will be utilized monthly X 2 months, and then quarterly as per the established CQI calendar, under the supervision of the ADON. This information will be reviewed by the QA committee in the March and April meetings, and then in the quarterly meetings there- after. Action plans will be developed**



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F 332	Continued From page 2 medication would be related to the medication missed but could have serious consequences.	F 332	and monitored by the committee for issues identified during the reviews.	
F 431 SS=D	Interview with the Assistant Director of Nursing (ADON), on 01/20/12 at 2:45 PM revealed nurses and Certified Medicine Technicians were supposed to administer medication as ordered by the physician and initial the MAR after the medication was administered. If a medication was not available for administration the pharmacy and physician would be notified. <b>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</b>  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	F 431	<b>Criteria 5:</b>  <b>Criteria 1:</b> The 2 bottles of alcohol and the culture tubes that were expired were thrown away.  <b>Criteria 2:</b> An inspection was done by the ADON and Charge Nurse on Jan. 20, 2012 of all supplies in the med room to verify products were properly stored and within expiration dates.  <b>Criteria 3:</b> Inservice education was provided by ADON on Jan. 27, 2012 for the licensed nurses on the monthly inspection of the med room to determine that all	Jan 26 2012



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**F 431** Continued From page 3  
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.

This REQUIREMENT is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure supplies for resident use were not expired. During observation of the medication room there were expired bottles of alcohol rub and expired culture tubes for one (1) of one (1) medication rooms.

The finding include:  
The facility could not provide a written policy related to checking for expired supplies.

Observation during tour of the medication room, on 01/19/12 at 2:00 PM, revealed two bottles of alcohol rub that were expired. One bottle expired October, 2008 and one expired January 2010. Tour of the nurses medication room, on 01/19/12 at 5:00 PM, revealed six (6) of twelve (12) culture tubes expired in June, 2011.

Interview with LPN #1, on 01/19/12 at 5:00 PM, revealed it was the night shift's responsibility to check for expired supplies and clean the cabinets in both medication rooms. She stated using expired alcohol rub and culture tubes could have an adverse effect for residents.

**F 431**

supplies are stored properly and within expiration dates. All expired products will be properly disposed of. The third shift nursing staff will inspect the med room at least one time during the last week of each month to determine compliance. This will be recorded on the Medication Room Inspection Form.

**Criteria 4:** The CQI indicator for the monitoring of proper storage and dating of the med room supplies will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the ADON. This information will be reviewed by the QA committee in the March and April meetings, and then in the quarterly meetings hereafter. Action plans will be developed and monitored by the committee for issues identified during the reviews.

**Criteria 5:**

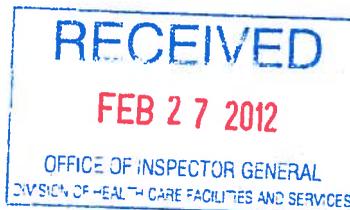
Jan 28, 2012



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F 431	Continued From page 4	F 431			
F 441 SS=F	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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.</p>	F 441	<p><b>Criteria 1:</b> Facility staff handle resident food items, for the identified Residents, in accordance with dietary infection control standards of care, preventing contact with their bare hands, as determined by meal service observations conducted weekly X 2 weeks, then monthly thereafter as performed by the ADON, CDM, RD, or foodservice personnel.</p> <p><b>Criteria 2:</b> Facility staff handle resident food items for all Residents, in accordance with dietary infection control</p>		



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F 441	<p>Continued From page 5</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview and and review of the FDA Food Code 2005, it was determined the facility failed to provide a sanitary environment for the residents during food service. Certified Nursing Assistants (CNAs) were observed touching six (6) of thirty-four (34) resident's food with their bare hands during breakfast in the dining room.</p> <p>The findings include: The facility could not provide a policy that addressed the prohibition of handling resident's food with bare hands.</p> <p>Review of the Food and Drug Administration, Food Code 2005, Chapter 2, 2-103.11 (K) ...prevent employees from cross contamination of food with bare hands. Chapter 3, 3-301.11..bare hand contact is to be avoided with ready to eat foods.</p> <p>Observation during breakfast service, on</p>	F 441	<p>standards of care, preventing contact with their bare hands, as determined by meal service observations conducted weekly X 2 weeks, then monthly thereafter as performed by the ADON, CDM, RD, or foodservice personnel.</p> <p><b>Criteria 3:</b> The nursing staff have received inservice education on handling of food items in accordance with dietary infection control standards of care, preventing contact with their bare hands, as provided by the RD, CDM, and ADON on Jan. 27, 2012.</p> <p><b>Criteria 4:</b> The CQI indicator for the monitoring of meal pass in accordance with dietary infection control standards of care will be utilized monthly as per the established CQI calendar under the supervision of the Dietary Manager. This information will be reviewed by the QA committee in the March meeting initially, and then in the quarterly meetings thereafter. Action plans will be developed</p>	

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F 441	<p>Continued From page 6</p> <p>01/19/12 at 7:40 AM, revealed CNA #1 picked up a resident's toast and bacon and folded the toast over the bacon to make a sandwich for the resident. CNA #2 and #5 picked up both toast and bacon and handled with their bare hands prior to serving the food to the residents. CNA #3 picked up a resident's toast to spread butter and jelly on the toast and then handed the toast to a resident. CNA #4 picked up a piece of toast with her bare hands and placed it on a resident's tray, buttered the toast and then handed it to a resident.</p> <p>Interview with CNA #1, on 01/20/12 at 1:44 PM, revealed she was taught it was okay to handle foods with bare hands as long as her hands were clean. She stated she did not know another way to butter toast except to pick it up with her hands.</p> <p>Interview with CNA #2, on 01/20/12 at 2:05 PM, revealed she knows not to touch food with her bare hands. She stated "my bad", usually she holds toast with a napkin while she butters it. She stated by touching food with bare hands it could spread infection.</p> <p>Interview with CNA #3, on 01/20/12 at 2:10 PM, revealed she knows better than to touch food with her bare hands. She stated she was aware that she had made a mistake as soon as she picked up the toast. She revealed it was important not to touch food with bare hands because of contamination and germs that can be spread to other residents.</p> <p>Interview with CNA #4, on 01/20/12 at 2:15 PM, revealed she was told at this facility that you should not touch food normally except for bread</p>	F 441	<p>and monitored by the committee for issues identified during the reviews.</p> <p><b>Criteria 5:</b></p>	<p>Jan 28, 2012</p>
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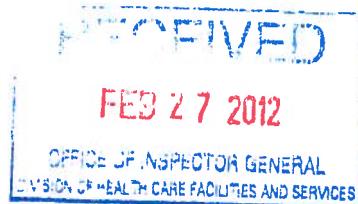
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F 441	<p>Continued From page 7 and toast. She stated that handling food barehanded could make a resident sick and you should not do it out of respect of the resident.</p> <p>Interview with ADON, on 01/20/12 at 2:45 PM, revealed she was unaware that staff should not handle food barehanded.</p>	F 441		



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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: 1984, 1986</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type II Protected.</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke 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 01/18/12. Carmel Home was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for thirty-six (36) beds and the census was thirty-six (36) on the day of the survey.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X. Francis Teresa Scully</i>	TITLE <i>X. Adm</i>	(X8) DATE <i>X 02-27-12</i>
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K 000	Continued From page 1 The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000		
K 018 SS=D	Deficiencies were cited with the highest deficiency identified at F level. 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 1 3/4 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, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, according to NFPA	K 018	<b>Criteria 1:</b> Resident corridor doors to rooms 170 and 175 were repaired so that they would latch properly to resist the passage of smoke.  <b>Criteria 2:</b> All resident corridor doors were inspected by the Maintenance Supervisor to determine they resist the passage of smoke.  <b>Criteria 3:</b> The Maintenance Supervisor has received inservice education on the inspection of resident corridor doors for proper latching to resist the passage of smoke as provided by the Administrator on Feb. 8, 2012.  <b>Criteria 4:</b> The CQI indicator for the monitoring of resident corridor doors will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the	



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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 018	<p>Continued From page 2</p> <p>standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, approximately twenty (20) residents, staff, and visitors. The facility is licensed for thirty-six (36) beds and the census was thirty-six (36) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 01/18/12 between 11:00 AM and 11:05 AM, with the Maintenance Director revealed the Resident's corridor doors to rooms 170 and 175 did not latch when tested.</p> <p>Interviews, on 01/18/12 between 11:00 AM and 11:05 AM, with the Maintenance Director revealed a confirmation that the doors would not latch and resist the passage of smoke.</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 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>	K 018	<p>supervision of the Director of Maintenance.</p> <p><b>Criteria 5:</b></p>	Feb 9, 2012	



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

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NAME OF PROVIDER OR SUPPLIER  <b>CARMEL HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2601 OLD HARTFORD RD. OWENSBORO, KY 42303</b>
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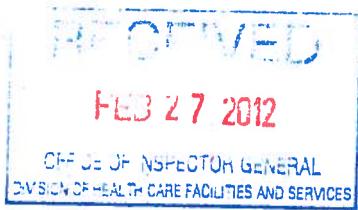
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**K 018** Continued From page 3  
Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.  
Exception No. 2: In smoke compartments protected 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.  
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 19.3.5.2.  
Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.  
Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.  
  
19.3.6.3.3\*  
Hold-open devices that release when the door is pushed or pulled shall be permitted.

**K 018**

**K 050** NFPA 101 LIFE SAFETY CODE STANDARD.

**K 050**



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K 050 SS=F	Continued From page 4  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted at unexpected times under varied conditions in accordance with NFPA standards. The deficiency had the potential to affect each of the four (4) smoke compartments, residents, staff and visitors. The facility is licensed for thirty-six (36) beds and the census was thirty-six (36) on the day of the survey.  The findings include:  Record review, on 01/18/12 at 11:45 AM, with the Maintenance Director revealed the fire drills were not being conducted quarterly per shift, at unexpected times under varied conditions, within the Skilled Nursing Facility (SNF) wings of the facility. Of the twelve (12) fire drills required annually, only two (2) were conducted within the SNF. The other ten (10) documented were conducted within the Personal Care (PC) wings of the facility, separated from the SNF by a two-hour	K 050	<b>Criteria 1 and 2:</b> Fire drills are conducted every month; on each shift quarterly on the certified unit of the facility under the supervision of the Administrator.  <b>Criteria 3:</b> The Director of Maintenance has received inservice education on the need to conduct a fire drill on each shift monthly on the certified unit as provided by the Administrator on Feb. 8, 2012.  <b>Criteria 4:</b> The CQI indicator for the monitoring of conduction of fire drills will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Administrator.  <b>Criteria 5:</b>	Feb 9, 2012



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K 050	Continued From page 5 fire barrier.	K 050		
K 072 SS=F	<p>Interview, on 01/18/12 at 11:45 AM, with the Maintenance Director, and at the 1:00 PM Exiting Conference with the Administrator, revealed they were not aware the fire drills were not being conducted as required for a Skilled Nursing Facility.</p> <p>Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect each of the four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for thirty-six (36) beds and the census was thirty-six (36) on the day of the survey.</p>	K 072		

Feb 27 2012  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

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K 072	Continued From page 6  The findings include:  Observations, on 01/18/12 between 9:15 AM and 10:50 AM, with the Maintenance Director revealed resident 's wheelchairs, walkers, lifts, and chairs aligning one side of the corridors in the Long Hall, Short Hall and the Priest Wing for over a thirty (30) minute period of time. The items located in the corridors were obstructing the use of the handrails and would have impeded egress in the event of an emergency.  Interviews, on 01/18/12 between 9:15 AM and 10:50 AM, with the Maintenance Director revealed the facility routinely stored wheelchairs, walkers, lifts and chairs in the corridors because the facility lacks in storage space.  Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.  NFPA 101 LIFE SAFETY CODE STANDARD  Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 072	Criteria 1 and 2: Resident equipment is stored in storage areas when not in use.  Criteria 3: Facility staff have received inservice education as provided by the Maintenance Supervisor and ADON on Jan. 27, 2012 on the proper storage of resident equipment when not in use.  Criteria 4: The CQI indicator for the monitoring of proper storage of resident equipment when not in use, will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Administrator.  Criteria 5:	Jan 28, 2012
K 076 SS=D		K 076		



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K 076 Continued From page 7

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure oxygen cylinders were stored according to NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for thirty-six (36) beds and the census was thirty-six (36) on the day of the survey.

The findings include:

Observation, on 01/18/12 at 10:30 AM, with the Maintenance Director revealed two (2) oxygen cylinders located within the oxygen storage room, were not placed in a rack to prevent falling or being knocked over and not separated or identified as empty or full, as required by Code.

Interview, on 01/18/12 at 10:30 AM, with the Maintenance Director and a Nurse, confirmed the observation of the oxygen cylinders not being stored properly.

Reference: NFPA 99 (1999 Edition).

4-3.1.1.2  
3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation.  
8. When cylinder valve protection caps are

K 076

**Criteria 1 and 2:** -Full oxygen canisters are separated from empty canisters. -Oxygen canisters are stored in containers designated for this purpose, to prevent them from falling..

**Criteria 3:** Facility nursing staff have received inservice education on Jan. 27, 2012 on the separating system for distinguishing between full and empty oxygen canisters and the secure storage of oxygen canisters in the containers designated for this purpose.

**Criteria 4:** The CQI indicator for the monitoring of proper separating and storage of oxygen canisters will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Maintenance Supervisor.

**Criteria 5:**

Jan 28, 2012





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K 130	Continued From page 9  1. A slide bolt on each of the two (2) doors to the Kitchenette located in the Priest Wing. 2. A slide bolt on each of the two (2) doors to the Restrooms located adjacent to the Kitchenette.  Interviews, on 01/18/12 between 10:35 AM and 10:45 AM, with the Maintenance Director revealed he was aware of the locks installed on the door; however, he was not aware the locks were prohibited by Code.  Reference: NFPA 101 (2000 Edition)  19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130	Criteria 1: The sliding locking latches on the kitchenette and bathroom doors have been removed.  Criteria 2: All facility doors have been inspected by the Maintenance Supervisor for sliding locking latches, with no other devices identified.  Criteria 3: The Maintenance Supervisor has received inservice education on the inspection for and removal of locking latches on the NFPA 101 19.2.2.2.4 requirements, including but not limited to the inspection for, removal of, and prevention of further placement of locking latches on facility doors, on facility doors, as provided by the Administrator on Feb. 8, 2012  Criteria 4: The CQI indicator for the monitoring of locking latches on facility doors will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Director of Maintenance.  Criteria 5:	Feb 9, 2012	

