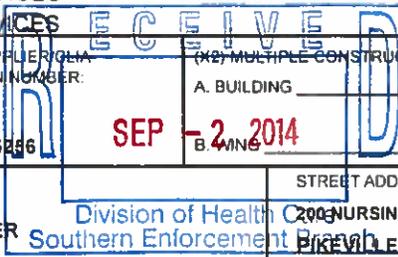


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185246	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/14/2014
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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

A standard health survey was conducted on 08/12/14 through 08/14/14. Deficient practice was identified with the highest scope and severity at "E" level.

F 315 483.25(d) NO CATHETER, PREVENT UTI, SS=E RESTORE BLADDER

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's urinary catheter policy, it was determined the facility failed to ensure six (6) of twenty-four (24) sampled residents (Residents #6, #8, #10, #15, #16, and #17) received appropriate treatment and services to prevent urinary tract infections and to restore as much bladder function as possible. Review of the facility's policy for urinary catheterization, revealed staff was required to secure indwelling urinary catheters (a tube inserted into the bladder to drain urine) to the resident's thigh to prevent "tugging." However, observations of Residents #6, #8, #10, #15, #16, and #17 revealed staff failed to ensure the catheter tubing was secured to the residents' thighs.

F 000

Parkview Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction, to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care and safety of the residents. The plan of correction is submitted as a written allegation of compliance. Parkview Nursing and Rehabilitation Center's response to this State of Deficiencies and Plan of Correction does not denote agreement with the statement of deficiencies, nor does it constitute an admission that any deficiency is accurate. Further, Parkview Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the state deficiencies on this statement of deficiencies through informal dispute resolution, formal appeal, and/or any other administrative or legal proceedings.

F 315

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rand Danner Administrator</i>	TITLE	(X5) DATE 09-02-14
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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 PARKVIEW NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501
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F 315 Continued From page 1 F 315 09/10/14

The findings include:

Review of the facility's policy titled, "Catheterization, Male and Female Urinary," dated 01/04/13, revealed staff was required to secure the tubing of the indwelling urinary catheter to the resident's thigh "to prevent tugging."

Review of the Resident Assessment Instrument (RAI) User Manual Version 3.0 revealed the assessment should include consideration of the risks and benefits of an indwelling (suprapubic or urethral) catheter and consideration of complications resulting from the use of an indwelling catheter.

1. Review of the medical record for Resident #10 revealed the facility admitted the resident on 12/12/13 with diagnoses that included Bilateral Prostatic Hypertrophy (enlarged prostate), Senile Dementia, Pressure Sores, and Urinary Retention.

Review of a quarterly Minimum Data Set (MDS) assessment for Resident #10 dated 06/24/14 revealed the resident had been assessed to have a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident's cognition was severely impaired. The facility had also assessed the resident to require total assistance of two staff persons for toileting and noted the resident had an indwelling urinary catheter.

Review of the physician's orders for Resident #10 revealed an order dated 06/10/14, for the resident to have an indwelling urinary catheter.

1. On 8/14/14, Resident #6, #8, #10, #15, #16, and #17 had their indwelling catheter tubing secured to their respective thighs per nursing staff.
2. Any resident with an indwelling catheter has the potential to be affected by the deficient practice. On 8/14/14, the Nurse Managers for each unit ensured that any resident with an indwelling catheter had the catheter secured to their respective thighs unless the resident chose not to have a leg strap applied.
3. a. By 9/5/14, the Director of Nursing reeducated the Licensed Nurses and the Nursing Assistants on the requirement to ensure a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and

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F 315	<p>Continued From page 2</p> <p>Observation of catheter care for Resident #10 on 08/13/14 at 9:30 AM revealed after completing catheter care, State Registered Nurse Aide (SRNA) #1 draped the catheter tubing over Resident #10's left leg. The SRNA left the room and failed to secure the urinary catheter tubing to the resident's thigh.</p> <p>Interview conducted with SRNA #1 on 08/13/14 at 9:30 AM revealed she had been trained by the facility to use a leg strap to secure the urinary catheter tubing to the resident's thigh. The SRNA stated she had previously observed a leg strap on Resident #10's catheter tubing but was unsure why the leg strap was not in use at the time of the observation. The SRNA stated she should have used a leg strap to secure the indwelling catheter tubing to Resident #10's leg prior to leaving the resident's room.</p> <p>Interview conducted with Registered Nurse (RN) #1 on 08/14/14, at 2:00 PM, revealed staff was required to use leg straps to secure indwelling catheter tubing to the resident's leg. The RN stated SRNA #1 should have ensured a leg strap was in use to secure the catheter tubing to Resident #10's leg before she left the resident's room.</p> <p>2. Review of the medical record for Resident #8 revealed the facility admitted the resident on 06/23/07 with diagnoses that included Urinary Incontinence, Neurogenic Bladder, and Pressure Sores.</p> <p>Review of a quarterly MDS assessment dated 07/23/14 revealed the facility had assessed Resident #8 to have a BIMS score of 15, which indicated the resident's cognition was intact. The</p>	F 315	<p>services to prevent urinary tract infections and to restore as much normal bladder function as possible and on the policy concerning securing an indwelling catheter to a resident's thigh.</p> <p>b. On 8/14/14, the care plans of residents with indwelling catheters were reviewed and revised to include securing the tubing to the thigh. The Minimum Data Set Coordinator will ensure that care plans of new residents admitted with indwelling catheters include securing the tubing to the resident's thigh.</p> <p>c. By 8/29/14, Nursing assistant Kardexes of residents with indwelling catheters were reviewed and revised to include securing the tubing to the thigh. The Nurse Unit Managers will ensure that the Kardex includes securing the tubing to the thigh for any newly admitted resident with an indwelling catheter or any resident with a new indwelling catheter order. The Nurse Unit Manager will also update the care plan for any resident with a new order for an indwelling catheter.</p>	

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
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F 315	<p>Continued From page 3</p> <p>MDS also revealed the resident required the total assistance of two persons for toileting and had an indwelling urinary catheter.</p> <p>Review of the monthly physician orders for Resident #8 revealed an order dated 08/01/14 for Resident #8 to have an indwelling urinary catheter.</p> <p>Observation of catheter care for Resident #8 on 08/13/14 at 4:00 PM revealed Licensed Practical Nurse (LPN) #3 completed the catheter care, draped the catheter tubing over the resident's right leg, and left the room. However, the LPN failed to secure the urinary catheter to the resident's thigh.</p> <p>Interview conducted with LPN #3 on 08/14/14, at 3:30 PM, revealed she had been trained to use a leg strap to secure the catheter to the resident's thigh. The LPN stated she should have secured the indwelling urinary catheter tubing to Resident #8's thigh.</p> <p>3. Review of the medical record for Resident #6 revealed the facility admitted the resident on 01/26/09 with diagnoses that included Urinary Retention and Neurogenic Bladder.</p> <p>Review of an annual MDS assessment dated 06/17/14 revealed Resident #6 had a BIMS score of 14, which indicated the resident's cognition was intact. The MDS also revealed the resident required the extensive assistance of two staff persons for toileting and had an indwelling urinary catheter.</p> <p>Review of the physician's orders for Resident #6 revealed an order dated 08/01/14 for Resident #6</p>	F 315	<p>4. Nurse Unit Managers will observe five Licensed Nurses and/or Nursing Assistants per week for 4 weeks then two Licensed Nurses and/or Nursing Assistants per week for 2 months performing indwelling catheter care including securing the tubing to the thigh of the resident. Any discrepancies will be addressed immediately and the results of the observations reported to the Quality Assurance committee monthly for three months for development of an action plan as needed.</p>	

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F 315	<p>Continued From page 4</p> <p>to have an indwelling urinary catheter.</p> <p>Observation of catheter care for Resident #6 on 08/14/14 at 10:10 AM revealed LPN #2 completed the catheter care, draped the catheter tubing over Resident #6's right leg, and left the room. However, the LPN failed to secure the urinary catheter tubing to the resident's thigh.</p> <p>Interview conducted with LPN #2 on 08/14/14 at 3:20 PM revealed he had been trained to use a leg strap to secure the catheter to the resident's thigh, but stated he only used them for residents who he felt would pull on the catheter and did not use them for all residents who had an indwelling catheter.</p> <p>4. Review of the medical record for Resident #16 revealed the facility admitted the resident on 01/30/14 with diagnoses that included Dementia, Failure to Thrive, and Urinary Retention.</p> <p>Review of a quarterly MDS assessment for Resident #16 dated 07/21/14 revealed the resident had a BIMS score of 4, which indicated the resident's cognition was severely impaired. The MDS also revealed the resident required the extensive assistance of two staff persons for toileting and had an indwelling urinary catheter.</p> <p>Observation of Resident #16 on 08/14/14 at 1:00 PM revealed the indwelling catheter tubing was draped over the resident's left leg and not secured to the resident's thigh.</p> <p>Interview conducted with SRNA #1 on 08/14/14 at 1:05 PM revealed she was not aware the indwelling catheter tubing was to be secured to the resident's thigh, and had never observed the</p>	F 315	

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501
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F 315 Continued From page 5

F 315

indwelling catheter secured to the resident's thigh.

Interview conducted with RN #1 on 08/14/14 at 2:00 PM revealed SRNA #1 should have used a leg strap to secure Resident #16's catheter tubing. RN #1 stated she was unaware Resident #16 did not have a leg strap in place.

5. A review of the medical record for Resident #15 revealed the resident was readmitted to the facility on 07/19/14 with diagnoses that included a pressure ulcer to the coccyx that required the use of an indwelling urinary catheter to aid in wound healing due to the resident's incontinence.

A review of the most recent MDS assessment completed for Resident #15 dated 06/22/14 revealed the resident's cognition was severely impaired and he/she required the use of an indwelling urinary catheter.

Observation of Resident #15's catheter on 08/14/14 at 1:05 PM revealed the catheter tubing was not secured to the resident's leg.

An interview conducted with LPN #5 on 08/14/14 at 1:08 PM revealed the facility did not have a means to secure catheter tubing to a resident's leg to prevent pulling. According to LPN #1, she had only seen devices to secure residents' catheters when the devices were placed at the hospital.

6. Review of Resident #17's medical record revealed the facility admitted Resident #17 on 02/18/14 with diagnoses that included Neurogenic Bladder, Brain Injury, Senile Dementia, and Depressive Disorder.

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F 315	<p>Continued From page 6</p> <p>A review of Resident #17's Comprehensive Care Plan revealed Resident #17 was incontinent of bladder and required an indwelling catheter. Review of Resident #17's most recent quarterly MDS assessment dated 05/21/14 revealed Resident #17 was assessed to have a BIMS score of 13, which indicated that Resident #17's cognition was intact. Further review of Resident #17's most recent MDS assessment revealed Resident #17 was assessed to need the assistance of one person with toileting.</p> <p>Observation of catheter care for Resident #17 on 08/14/14 at 12:00 PM revealed the catheter tubing was not secured to the resident's leg.</p> <p>Interview with LPN #1 on 08/14/14 at 12:00 PM revealed the facility did not utilize leg straps to secure the resident's catheter tubing but the resident "probably should have one on."</p> <p>Interview with RN #1 on 08/14/14 at 12:05 PM revealed Resident #17 had been observed to pull on his/her catheter on a regular basis. RN #1 stated Resident #17 should have had a leg strap to secure the resident's catheter tubing to his/her leg.</p> <p>Interview conducted with the Director of Nursing (DON) on 08/14/14 at 4:05 PM revealed she did not know if the facility's policy addressed how to secure indwelling urinary catheters. However, according to the DON, all residents who had indwelling urinary catheters should have a leg strap in place to secure the catheter to the resident's thigh to prevent pulling and accidental trauma. The DON stated she had observed catheter care at the facility but had not identified</p>	F 315		

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F 315 F 371 SS=E	Continued From page 7 any concerns related to catheter care. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 315 F 371	F 371 1. On 8/12/14, the Dietary Manager reeducated the cook and dietary aide #1 on when and how to sanitize their hands and when to change gloves. 2. All residents who receive a tray have the potential to be affected by the deficient practice. 3. a. On 8/12/14, the Dietary Manager reeducated the dietary staff on when and how to sanitize hands and when to change gloves. b. By 9/5/14, the Dietary Manager reeducated the Dietary staff on the requirement that the facility must procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute, and serve food under sanitary conditions. c. On 8/13/14, two foot-levered garbage cans were purchased , one was placed by the hand sink near the steam table and one placed at the end of the
	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, review of the facility's policy, and a review of the 2013 Food and Drug Administration (FDA) Food Code it was determined the facility failed to distribute and serve food under sanitary conditions. During the evening meal service on 08/12/14 from 5:15 to 6:36 PM, dietary staff was observed not to wash their hands after retrieving items from the floor and disposing of trash, and when changing gloves.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Handwashing Employee Guidelines-Infection Control Practices," undated, revealed employees associated with the handling of food were required to wash their hands after handling garbage or touching anything that could contaminate the hands. There was no evidence the policy addressed washing of hands before or</p>		09/10/14

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F 371 Continued From page 8
after the use of gloves.

A review of the FDA Food Code 2013, Chapter 2-301.13(H) revealed employees were required to wash their hands before donning gloves to initiate a task that involved working with food.

Observations of the tray line during the evening meal service on 08/12/14 at 5:15 PM revealed the cook retrieved Styrofoam bowls from the floor for disposal, removed her gloves, and donned clean gloves without washing her hands, before returning to the tray line to serve food. Additional observation at 6:10 PM revealed Dietary Aide #1 retrieved a paper towel from the floor she had dropped. She changed gloves without washing her hands prior to returning to the tray line to prepare trays and silverware for the tray line.

An interview conducted with the cook on 08/12/14 at 6:36 PM revealed the cook stated she forgot to wash her hands after retrieving the bowls from the floor and changing gloves.

An interview with Dietary Aide #1 on 08/12/14 at 6:37 PM revealed the Dietary Aide did not realize she needed to wash her hands after retrieving the paper towel from the floor and changing gloves.

An interview with the Dietary Manager (DM) on 08/14/14 at 3:30 PM revealed the Dietary Manager monitored the tray line daily to observe for concerns with hand washing and glove use. Further interview revealed the DM conducted weekly audits of the tray line for hand washing when doing test trays for food palatability, and had not identified any concerns with glove use or hand washing.

F 371 steam table in an attempt to reduce the chance of staff touching anything considered dirty or potentially contaminated when their hands/gloves are clean.

4. The Dietary Manager will observe the tray line 4 x weekly for one month, then 2 x weekly for two months to ensure staff follow sanitation guidelines. Any discrepancy will be addressed immediately and results of the observations will be reported monthly for three months to the Quality Assurance Committee for development of an action plan as needed.

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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1989 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: Five story, Type II (222) SMOKE COMPARTMENTS: 13 COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (WET SYSTEM) EMERGENCY POWER: Type II diesel generator A life safety code survey was initiated and concluded on 08/13/14. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	Parkview Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction, to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care and safety of the residents. The plan of correction is submitted as a written allegation of compliance. Parkview Nursing and Rehabilitation Center's response to this State of Deficiencies and Plan of Correction does not denote agreement with the statement of deficiencies, nor does it constitute an admission that any deficiency is accurate. Further, Parkview Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the state deficiencies on this statement of deficiencies through informal dispute resolution, formal appeal, and/or any other administrative or legal proceedings.	
K 029 SS=E	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	K 029		

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

TITLE

(X6) DATE

Rand Danner Administrator

09-02-14

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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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185256	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2014
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(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 029	Continued From page 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, the facility failed to ensure that doors to hazardous areas would self-close and latch as required. This deficient practice affected six (6) of thirteen (13) smoke compartments, staff, and other occupants of the building. The facility has the capacity for 120 beds with a census of 116 on the day of the survey. The findings include: During the Life Safety Code tour on 08/13/14 at 10:15 AM, with the Director of Maintenance (DOM), a corridor door to the second floor Conference/File room was observed not to close and latch as required. In addition, the first floor unfinished storage room door, two mechanical room corridor doors, and a storage room door were observed not to close and latch. Further, two second floor kitchen doors, the dishwashing corridor door, the Dietary corridor door, and the third and fifth floor corridor doors to the Break/Storage rooms were observed not to close and latch. Corridor doors to hazardous areas must be able to close and latch when the door is	K 029	1. By 9/5/14, the Maintenance Department corrected the door to the conference room, the first floor unfinished storage room door, two mechanical room corridor doors, a storage room door, the dishwashing corridor door, the Dietary corridor door and the 3 rd and 5 th floor corridor doors to the Break/Storage rooms. 2. All residents have the potential to be affected by the deficient practice. On 8/15/14, the Director of Maintenance tested all facility doors to ensure all worked properly. No problems were noted. 3. a. By 9/5/14, the facility Administrator reeducated the maintenance department on the	09/10/14	

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K 029	Continued From page 2 released from the open position. An interview with the DOM on 08/13/14 at 10:15 AM revealed he was not aware corridor doors to hazardous areas should be able to close and latch when released. The findings were revealed to the Administrator upon exit.	K 029	requirement for NFPA 101 Life Safety Code Standard for K 029. b. Checking facility doors for closing properly has been added to the weekly maintenance checklist.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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, the facility failed to conduct fire drills to ensure that staff was prepared to respond to an incidence of fire under different staffing levels and conditions to include resident levels of alertness. This failure affected all residents and staff in the facility. The facility has the capacity for 120 beds with a census of 116 on the day of the survey. The findings include: During the Life Safety Code survey on 08/13/14	K 050	4. Results of the weekly checks by the maintenance department will be reported monthly for three months to the Quality Assurance Committee for development of an action plan as needed.	
		K 050	1. No corrective action could be taken for past fire drills. 2. All residents have the potential to be affected by the deficient practice.	09/10/14

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K 050	<p>Continued From page 3</p> <p>at 12:30 PM an interview and record review with the Director of Maintenance (DOM) revealed the facility had not performed fire drills at unexpected times and varying conditions on the first and second shifts. Review of documentation revealed the facility conducted two fire drills on the second shift from 04/30/14 through 07/08/14 between 10:10 PM and 10:30 PM. From 12/23/13 to 03/31/14, two fire drills on the first shift were conducted at 2:30 PM.</p> <p>An interview with the DOM on 08/13/14 at 12:30 PM revealed he was not aware he should perform fire drills at unexpected times and under varying conditions.</p> <p>The findings were revealed to the Administrator upon exit.</p>	K 050	<p>3. a. By 9/5/14, the Administrator reeducated the maintenance department on NFPA Life Safety Code Standard for K 050.</p> <p>b. The Administrator will initial all fire drill reports to ensure they are being performed at unexpected times and under varying conditions.</p> <p>4. Any discrepancies in the Administrator's review of the fire drill times and conditions will be addressed with reeducation immediately and reported to the Quality Assurance Committee for development of an action plan as needed.</p>