

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

PRINTED: 12/16/2011  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185227	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/01/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  SUPERIOR CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001
--	--

(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  An annual survey was conducted on 11/29/11 through 12/01/11, and a Life Safety Code survey was conducted on 11/30/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S of an "E."	F 000	<p><b>Preparation and 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. This Plan of Correction is prepared and executed solely because it is required by federal and state laws. The facility reserves the right to revise/improve corrective actions as determined to be warranted.</b></p> <p><u>F253</u></p> <p>1) The graduated cylinder and high hat in room 101 and the urinal in room 109 have been discarded. The Resident Equipment Storage Policy has been updated. A covered measuring device has been placed for use in room 105 and follows the updated Resident Equipment Storage Policy. The nursing staff has been and will continue to be in-serviced during the next two scheduled monthly in-services by the DON or staff development nurse on necessary measures to maintain a sanitary, orderly and comfortable interior</p>	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy/procedure, it was determined the facility failed to provide housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by improper storage of urinals and graduated specimen containers.  The findings include:  A review of the facility's policy/procedure, "Patient Equipment Storage," undated, revealed "Urinals will be stored in the resident's night stand and on the resident's bed rail, if this is the resident's preference. After use, the urinal will be emptied."  1. Observations in Room #101, on 11/29/11 at 9:15 AM, on 11/30/11 at 2:30 PM, and on	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Heather Sims* TITLE: *Administrator* (X6) DATE: *1/10/12*

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.

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

PRINTED: 12/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185227	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  12/01/2011
NAME OF PROVIDER OR SUPPLIER  SUPERIOR CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001		
(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 253	Continued From page 2 who just transferred from another area. However, the resident did not have a urinary catheter and did not require a urinal for his/her care.  An interview with Housekeeper #1, on 12/01/11 at 9:50 AM, revealed the housekeeper's responsibility for the care of the urinals was to "clean it real good," and stated the urinals were not bagged. She was unaware whose responsibility it was to dispose of the urinals when no longer needed.  An interview with Licensed Practical Nurse (LPN) #4, on 12/01/11 at 10:00 AM, revealed the urinals and measuring devices were to be stored in the resident's bedside cabinet, unless there was a male resident who requested the urinal to be kept nearby on the bed rail. She was unaware the urinals and measuring devices were stored on the back of the commodes.  Interviews with Registered Nurse (RN) #6 and RN #7, on 12/01/11 at 10:27 AM, revealed the urinary catheter, for the resident in Room #101, was discontinued on 09/26/11. Neither resident in that room required the use of a measuring device. They were unsure why the urinals were stored on the back of the commodes, instead of the resident's bedside cabinet. Both RNs stated they expected the staff to label the measuring devices and store and dispose of them appropriately.	F 253	interior related to urinary measuring devices. (See attached policy)  4) Through the QA program, it will the responsibility of the housekeeping supervisor to check five rooms weekly to ensure that patient equipment is stored according to the Patient Equipment Storage Policy with all results being thru the QA program.  5) Correction completion date: January 6, 2012	1/6/12	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services:	F 328	<u>F328</u>  1) On 11/30/11, the facility began an hourly monitoring program to ensure that resident # 8 had O2 in place.		

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

PRINTED: 12/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185227	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  12/01/2011
NAME OF PROVIDER OR SUPPLIER  SUPERIOR CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001		
(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 328	<p>Continued From page 3</p> <p>Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and review of the facility's policy/procedure, it was determined the facility failed to ensure one resident (#8), in the selected sample of sixteen (16), received proper care for the use of special services to include continuous oxygen (O2) therapy. Observations, on 11/29/11 and 11/30/11, revealed Resident #8 was without his/her O2 therapy as ordered by the physician.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure "Respiratory Care Services," undated, revealed "It is the policy of MSP that all patient's requiring oxygen shall receive oxygen therapy in the prescribed manner, as dictated by the physician's order and the clinical needs of the patient."</p> <p>A record review revealed Resident #8 was admitted to the facility on 11/26/11 with diagnoses to include Pneumonia, Pulmonary Contusion, Rupture Diaphragm and Hemothorax.</p> <p>A review of a physician's order, dated 11/26/11;</p>	F 328	<p>2) All resident's receiving special services such as injections, parenteral and enteral fluids, colostomy, ureterostomy, ileostomy care, tracheostomy care, tracheal suctioning, respiratory care, foot care and prosthesis have the potential to be affected by this practice.</p> <p>3) Any resident receiving services such as injections, parenteral and enteral fluids, colostomy, ureterostomy, ileostomy care, tracheostomy care, tracheal suctioning, respiratory care, foot care and prosthesis will be documented on the Medication Administration Record (MAR) or Treatment Administration Record (TAR) according to the physician orders.</p> <p>4) The licensed staff will ensure that the treatment and care for special services are followed as evidenced by the documentation on the MAR or TAR according to the physician orders.</p> <p>5) Correction completion date: December 1, 2011</p>	12/1/11	

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

PRINTED: 12/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185227	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/01/2011
NAME OF PROVIDER OR SUPPLIER  SUPERIOR CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001	
(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 328	Continued From page 4 revealed "continuous oxygen (O2) at 1.5 liters per nasal cannula and to keep oxygen (O2) saturation levels at 90% or greater."  Observations of Resident #8, on 11/29/11 at 10:00 AM, on 11/30/11 at 7:49 AM, 9:30 AM, and 10:00 AM, revealed Resident #8's O2 was not in place, as ordered by the physician.  An interview with Registered Nurse (RN) #5, on 11/30/11 at 4:00 PM, revealed the resident required continuous O2 and the physician's order revealed the resident should have O2 on at all times.  An interview with Licensed Practical Nurse (LPN) #3, on 11/30/11 at 4:05 PM, revealed Resident #8's O2 was ordered by the physician to wear continuously, and the resident should have O2 in place at all times.  An interview with the resident's physician, on 12/01/11 at 10:05 AM, revealed the resident was to have continuous O2, and to keep the resident's O2 saturation at 90 percent (%) or greater. The physician further stated Resident #8 just returned from the hospital on 11/26/11, where he/she was treated for Pneumonia.	F 328		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program	F 441	<u>F441</u> 1) During the licensed staff's scheduled in-service on 12/7/11 done by the DON, proper hand sanitation was reviewed.  2) All resident's have the potential to be affected when proper hand sanitation is not performed.	

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

PRINTED: 12/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185227	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/01/2011
NAME OF PROVIDER OR SUPPLIER  SUPERIOR CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001	
(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 441	Continued From page 5 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy/procedure review, it was determined the facility failed to ensure staff utilized appropriate handwashing during a medication pass for three residents (#3, #5, and #6), in the selected sample	F 441	3) Licensed staff was in-serviced by the DON on 12/7/11 and will be in-serviced during the next two monthly scheduled in-services as to appropriate hand sanitation during the medication pass.  4) Three partial medication passes a month will be monitored thru the QA process to ensure that proper hand sanitation is being performed for duration of three months.  5) Correction completion date: December 7, 2011	12/7/11 12/8/11 Per H. Sims, Adm. (Cm)

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

PRINTED: 12/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185227	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/01/2011
NAME OF PROVIDER OR SUPPLIER  SUPERIOR CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001	
(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 441	<p>Continued From page 6 of sixteen (16), and for four residents (#17, #18, #19, and #20), not in the selected sample.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure "Handwashing," revised 10/02, revealed "employees must perform appropriate twenty-second handwashing procedures under the following conditions: before medications were prepared or handled, and after gloves were removed."</p> <p>A review of the facility's policy/procedure "Standard Infection Precautions," revised 10/02, revealed "hands should be washed immediately after gloves were removed to avoid transfer of microorganisms to other residents or environments."</p> <p>An observation of a medication pass, on 11/29/11 at 3:45 PM, revealed Licensed Practical Nurse (LPN) #1 did not wash his hands prior to the preparation of medications. LPN #1 prepared and administered medication to Resident #6 at 3:50 PM, but did not wash his hands after administration. He then prepared and administered medication to Resident #18 at 3:55 PM, but did not wash his hands after administration. He then prepared and administered medication to Resident #20 at 4:00 PM, but did not wash his hands after administration. LPN #1 then prepared and administered medication to Resident #19. He donned gloves prior to the administration of the resident's eye drops; however, he did not wash his hands after the gloves were removed. He then prepared and administered medication to</p>	F 441		

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

PRINTED: 12/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185227	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  12/01/2011
NAME OF PROVIDER OR SUPPLIER  SUPERIOR CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001		
(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 441	<p>Continued From page 7</p> <p>Resident # 17 at 4:15 PM, but did not wash his hands after administration. Next, he prepared and administered medication to Resident #5 at 4:20 PM, but did not wash his hands after administration. LPN #1 then prepared and administered medication to Resident #3 at 4:25 PM. He donned gloves prior to the administration of the resident's nasal spray, but did not wash his hands after the gloves were removed.</p> <p>An interview with LPN #1, on 11/29/11 at 4:30 PM, revealed he "thought" he washed his hands once during the med-pass. He revealed he should have washed his hands (or used alcohol gel) after every three residents and after gloves were removed. No further explanation was provided.</p> <p>An interview with the Director of Nursing (DON), on 12/01/11 at 12:45 PM, revealed during a medication pass, staff should wash their hands (or use alcohol gel) between each resident. She expected the staff to wash their hands after the removal of gloves.</p>	F 441			

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

PRINTED: 12/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185227	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  11/30/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  SUPERIOR CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001
--	--

(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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: Unknown</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (000) Unprotected</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (Dry SYSTEM)</p> <p>EMERGENCY POWER: Type I LP Generator.</p> <p>A life safety code survey was initiated and concluded on 11/30/11. 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. The facility is licensed for eighty-eight (88) beds and the census was seventy-six (76) the day of the survey.</p> <p>Deficiencies were cited with the highest deficiency identified at "E" level.</p>	K 000	<p><b>Preparation and 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. This Plan of Correction is prepared and executed solely because it is required by federal and state laws. The facility reserves the right to revise/improve corrective actions as determined to be warranted.</b></p> <p><u>K038</u></p> <p>1) The blinds will be removed from the east and west hallway doors.</p> <p>2) All resident's have the potential to be affected by exit doors that are not clearly recognizable.</p> <p>3) The blinds will be removed from the east and west hallway doors and replaced with a gray frost film.</p> <p>4) The Maintenance Director has been informed not to place blinds on exit doorways.</p> <p>5) Correction completion date: January 6, 2011</p>	
-------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *T. J. Fair* TITLE: Administrator (X6) DATE: 12/23/11

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.

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

PRINTED: 12/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185227	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  11/30/2011
NAME OF PROVIDER OR SUPPLIER  SUPERIOR CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001	
(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 038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access and exit doors were maintained to be clearly recognizable as a means of egress, per NFPA standards. The deficiency has the potential to affect two(2) of three(3) smoke compartments sixty-four(64) residents, staff and visitors. The facility is licensed for eighty-eight(88) beds and the census the day of survey was seventy-six(76).</p> <p>The findings include:</p> <p>Observation on 11/30/11 between 10:00 AM and 2:30 PM revealed mini blinds on the exit doors at both ends of the east hallway, also both ends of the west hallway. This could cause confusion of the direction of egress in the event of fire or disaster. This was confirmed by the Maintenance Director.</p> <p>Interview on 11/30/11 at 2:30 PM with the Maintenance Director revealed they did not know they could not use a mini blind on the door. They stated it was just to keep the sunlight from coming in and privacy.</p>	K 038		

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

PRINTED: 12/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185227	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  11/30/2011
NAME OF PROVIDER OR SUPPLIER  SUPERIOR CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001	
(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 038	Continued From page 2  7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.	K 038	<u>K069</u> 1) A manual activation device for the kitchen hood system has been installed to meet the required standard. 2) All residents have the potential to be affected by not having a manual an activation device for the kitchen 3) A manual activation device for the kitchen hood system has been installed. 4) The manual activation device for the kitchen hood system will be inspected semi-annually according to code. 5) Correction completion date: December 8, 2011	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure manual activation devices, for the kitchen hood system,	K 069		

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

PRINTED: 12/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185227	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  11/30/2011
NAME OF PROVIDER OR SUPPLIER  SUPERIOR CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001	
(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 069	<p>Continued From page 3</p> <p>was readily available. The deficiency had the potential to affect one (1) of three (3) smoke compartments, and kitchen staff.</p> <p>The findings include:</p> <p>Observation on 11/30/11 at 2:17 PM revealed that there was no manual activation device for the kitchen hood system. This was confirmed with the Maintenance Director.</p> <p>Interview on 11/30/11 at 2:17 PM with Maintenance Director, revealed he was not aware of the manual activation device being required.</p> <p>Reference: NFPA 96 (1998 edition) 7-5.1 A readily accessible means for manual activation shall be located between 42 in. and 60 in. (1067 mm and 1524 mm) above the floor, located in a path of exit or egress, and clearly identify the hazard protected. The automatic and manual means of system activation external to the control head or releasing device shall be separate and independent of each other so that failure of one will not impair the operation of the other.</p> <p>Exception No. 1: The manual means of system activation shall be permitted to be common with the automatic means if the manual activation device is located between the control head or releasing device and the first fusible link.</p> <p>Exception No. 2: An automatic sprinkler system.</p>	K 069		