

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

PRINTED: 02/08/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185236	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/26/2013
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NAME OF PROVIDER OR SUPPLIER  OWENSBORO PLACE CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD. OWENSBORO, KY 42303
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F 000	INITIAL COMMENTS  A recertification survey was conducted, on 01/23/13 through 01/25/13, to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest scope and severity of an "E".	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's handbook on resident's rights, it was determined the facility failed to promote care for one (1) resident (#2) in the selected sample of 24 residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality. On 01/23/13 at 3:25 PM during a skin assessment, Registered Nurse (RN) #1 failed to close the bedroom door and the curtain between Resident #2 and his/her roommate.  The findings include:  Review of the facility handbook, titled "Resident's Rights and Information for Resident's Living in Kentucky", revealed the following: "Each resident shall be treated with consideration, respect, and full recognition of his/her dignity and individuality, including privacy in treatment and in care for	F 241	1. Resident #2 was discharged from the facility on 1/29/2013. RN #1 was re-educated to providing residents privacy and maintaining/enhances resident dignity by the facility Administrator on 2/20/2013.  2. Rounds were conducted and documented on 1/24/2013 by the Director of Nursing, Assistant Director of Nursing and the Unit Managers to determine that privacy was provided for the facility residents to maintain or enhance each residents dignity during care. No other concerns were identified.  3. Re-education was provided to the nursing staff regarding residents rights, including the right to privacy and that the staff must promote care for residents that maintains or enhances dignity by the Staff Development Coordinator on 1/29/2013. Post test completed on 2/25/2013.  4. The Director of Nursing, Assistant Director of Nursing, and or the Unit Managers will complete an audit 2 times a week times 4 weeks then monthly times 5 months on 10 residents using the facility audit tool to observe body audits, dressing and treatments to ensure privacy is provided during care. Any concerns identified will be addressed at that time. A summary of the findings will be submitted by the director of Nursing to the Performance Improvement Committee monthly times 3 months for further review and recommendations.	3/10/13



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Wendell Smith</i>	TITLE <i>Administrator</i>	(X6) DATE <i>2/18/13</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	<p>Continued From page 1 his/her personal needs".</p> <p>Record review revealed Resident #2 was admitted to the facility on 10/06/12 with diagnoses to include Peripheral Vascular Disease, Chronic Kidney Disease, Pain and Anemia.</p> <p>Observation, on 01/23/13 at 3:25 PM, revealed Resident #2 was having a head to toe skin assessment by Registered Nurse (RN) #1. She entered the room and explained the procedure to the resident. She donned her gloves and pulled the resident's privacy curtain around to the right corner of his/her bed. RN #1 left the bedroom door open. RN #1 started looking at Resident #2's skin and left the privacy curtain between Resident #2 and his/her roommate open. Resident #2's roommate was seated in his/her geri chair at the foot of the bed and the resident was awake. RN #2 continued to look at Resident #2's body and she exposed his/her body to the roommate without providing privacy by pulling the curtain.</p> <p>An interview with RN #1, on 1/23/13 at 3:35 PM, revealed she did not realize she did not provide privacy for Resident #2 while she completed his/her skin assessment. She reported she should have moved the resident's roommate and pulled the curtain while conducting the skin assessment.</p> <p>An interview, on 1/25/13 at 11:50 AM with the Director of Nursing (DON), revealed staff are expected to close the door and pull both curtains when providing care to a resident. The DON stated the staff are to maintain the resident's privacy and not expose them to others.</p>	F 241			

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F 253 SS=D	<p><b>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</b></p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure a clean, safe and comfortable environment related to observations of the facility shower rooms which revealed a large number of broken and missing tiles in three of the facility's shower rooms. Additionally, carpet pieces were observed stuffed under the base of a commode.</p> <p>Findings include:</p> <p>Observation on 01/25/13 at 12:30 PM revealed the shower room located on the C Hall had tiles missing from the floor. The corners of the interior walls of the shower room also had tiles that were broken and missing.</p> <p>An interview with Certified Medication Aide (CMA) #1, conducted on 01/25/13 at the time of the observation, revealed the tiles had been in that condition for a length of time and maintenance should be aware. CMA #1 had not notified anyone of the condition of the tiles.</p> <p>An observation on 01/25/13 at 12:40 PM of the A Hall shower room revealed several broken tiles with sharp edges located on the outside corners of the shower stalls where residents entered and exited the shower. The #2 shower room also had</p>	F 253	<ol style="list-style-type: none"> <li>1. The 3 shower rooms on C and A Hall have had missing tiles from the floor and from the interior walls of the shower stalls replaced by the Maintenance Director on 2/14/2013. The carpet was removed from under the commode in the shower room on A Hall by the Maintenance Director on 2/14/2013.</li> <li>2. Facility rounds, including all other shower rooms, was completed and documented by the Maintenance Director to determine that the center was maintained in a sanitary, orderly, and comfortable manner on 2/14/2013. Any issues identified were corrected at the time they were identified.</li> <li>3. The Maintenance and Housekeeping Director was re-educated to the expectation that the facility must provide maintenance and housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior. Nursing, housekeeping, therapy, activity, and social services staff were re-educated to complete work orders to notify the Maintenance or housekeeping department of any concerns identified by the facility Administrator as of 3/10/2013.</li> <li>4. Audits will be conducted by the facility Maintenance Department and/or Administrator using the facility environmental rounding tool 2 times a week x1 month then monthly ongoing to determine that the center is maintained in an orderly, sanitary and comfortable manner. Any concerns identified will be corrected at that time. A summary of the findings will be submitted by the Maintenance Director to the Performance Improvement Committee monthly ongoing for further review and recommendations.</li> </ol>	3/10/13

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F 253	<p>Continued From page 3</p> <p>broken tiles on the walls. Additionally, there were pieces of indoor-outdoor carpeting sticking out from under the base of a commode located in the #2 shower room.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #2, on 01/25/13 at 12:40 PM (during the observation), revealed staff should turn in a work order to maintenance to have the tiles replaced but did not know if one had been turned in or not. LPN #2 felt the pieces of carpet under the commode were to keep the commode from moving and had been there for a while and it would be difficult to keep the area at the base of the commode sanitary.</p> <p>An interview, on 01/25/13 at 1:30 PM with the Maintenance Director, revealed he was aware tiles in some of the shower rooms were in disrepair and he thought he might have some tile pieces to repair the areas where tiles were broken or missing. The Maintenance Director stated staff usually put a work order in for things like that but he did not recall if one had been turned in for the broken and missing tiles. The Maintenance Director did not provide any information related to the pieces of carpet stuffed under the base of the commode.</p> <p>An interview with the Administrator, on 01/25/13 at 3:00 PM, revealed there was no supply of tiles to repair the areas in the resident shower rooms that were broken or missing and those areas were in need of repair.</p>	F 253		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged</p>	F 280		

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F 280	<p>Continued From page 4</p> <p>incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review it was determined the facility failed to revise the care plan for one resident (#3), in the selected sample of 24 residents related to the discontinuation of a safety belt to the wheelchair and the need for increased monitoring.</p> <p>The findings include:</p> <p>A record review revealed Resident #3 was admitted to the facility on 04/11/12 with diagnoses to include Alzheimer's Disease, Dementia with Behavioral Disturbances, Muscle Weakness, and</p>	F 280	<ol style="list-style-type: none"> <li>1. An order was obtained by the physician of Resident #3 to discontinue the self releasing seatbelt and chair alarm on 1/29/2013. The care plan for Resident #3 was revised by a licensed nurse to reflect the discontinuation of the self releasing seatbelt and chair alarm and then updated to reflect the new seating system on 1/29/2013</li> <li>2.. An audit of the care plans for current residents was completed on 2/15/2013 by the Assistant Director of Nursing and the facility Unit Managers to determine that resident care plans have been revised to reflect the residents current condition and interventions including therapy trials. Any concerns identified were corrected at that time.</li> <li>3. Licensed nurses, social services, activity and therapy staff have been re-educated by the facility Staff Development Coordinator on 2/20/2013 regarding the expectation that care plans are revised to reflect the residents current status and conditions including but not limited to therapy trials. Post test completed on 2/13/2013</li> <li>4. The Director of Nursing, Assistant Director of Nursing, and or the Unit Managers will complete and document an audit of the care plans for 5 residents receiving therapy x1 time a week times 4 weeks then monthly times 5 months. Any concerns identified will corrected at that time. A summary of the findings will be submitted by the Director of Nursing to the Performance Improvement Committee monthly times 6 months for further review and recommendations</li> </ol>	3/10/13

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F 280	<p>Continued From page 5</p> <p>Osteoarthritis. A review of the quarterly Minimum Data Set (MDS), dated 01/03/13, revealed the facility assessed the resident as cognitively severely impaired and required extensive assistance with transfers. The MDS revealed the resident did not ambulate and required a trunk restraint. A review of the Restrictive Device Consent, dated 05/18/12, revealed the facility assessed the resident for a safety release seat belt while up in the wheelchair for positioning and decreased safety awareness. Benefits of the device included improved positioning/posture, prevention of falls which might result in injury, and increased feeling of safety and security.</p> <p>A review of the resident's care plan, initiated 04/11/12, revealed the resident was assessed at risk for falls related to poor coordination, unsteady gait, pain, use of psychotropic medications, generalized weakness, and decreased safety awareness. An intervention was added 05/18/12 for the safety release seat belt while in the wheelchair.</p> <p>A review of the physical therapy's "Daily Notes and Weekly Progress Summary", dated 01/22/13, revealed Resident #3 was evaluated on 01/22/13 and fitted for a new seating system to decrease sacral sitting in the wheelchair. The notes revealed the resident was observed for thirty minutes without the use of the seat belt and clinical observation would continue for one week to ensure the new seating system was effective.</p> <p>An interview with the Therapy Program Manager, on 01/24/13 at 5:10 PM, revealed therapy was conducting a "trial" for a new chair for the resident</p>	F 280		
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F 280	<p>Continued From page 6</p> <p>as they did not feel he/she needed the seat belt. He expected therapy staff to obtain an order to discontinue the seat belt and communicate with nursing staff by documenting the information in the twenty four (24) hour report.</p> <p>Further review of the care plan, initiated 04/11/12, revealed there was no revision to the care plan to discontinue the safety release seatbelt and to provide increased supervision.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 01/24/13 at 4:45 PM, revealed she was not aware until 01/24/13 that physical therapy was evaluating the resident for a new wheelchair system and was not aware the resident would need to be monitored.</p> <p>Observations of Resident #3, on 01/23/13 at 1:20 PM, 3:20 PM, and 01/24/13 at 8:30 AM, 8:55 AM, 2:45 PM, and 4:30 PM, revealed the resident was sitting up in the wheelchair without a safety release seat belt with no evidence of increased supervision.</p> <p>An interview with Unit Manager #1, on 01/24/13 at 4:30 PM, revealed she was not aware physical therapy evaluated the resident.</p> <p>An interview with the Director of Nursing (DON), on 01/25/13 at 11:45 AM, revealed she expected therapy to communicate with nursing when changes were made. Therapy staff should have discontinued the seat belt or placed it "on hold" until the trial was completed.</p>	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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F 281	<p>Continued From page 7</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy it was determined the facility failed to ensure physician's orders were followed for one resident (#5), in the selected sample of twenty four residents. Resident #5 had physician orders for lotion to be applied every shift every day and a skin assessment was to be completed weekly; however, an observation on 01/24/13 revealed the resident's skin was dry and flaky and there was a bandage on the right heel, dated 01/18/13.</p> <p>The findings include:</p> <p>Review of facility policy titled, CHANGE IN CONDITION, dated January 2008, revealed Implementing Physician Orders - The Licensed Nurse/designee implements physician's orders.</p> <p>A record review revealed Resident #5 was admitted to the facility on 07/01/05 with diagnoses to include Alzheimer's Disease, Hyperthyroidism, Dementia and Diabetes Mellitus.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 12/18/12, revealed the facility had assessed the resident with cognitive impairment and required extensive assistance with activities of daily living.</p> <p>A review of the physician's order, dated 01/01/13</p>	F 281	<ol style="list-style-type: none"> <li>The kerlix dressing was removed from the residents right foot and a skin assessment was completed for Resident #5 on 1/24/2013 by a licensed nurse. No new skin concerns were identified. The physician for resident #5 was notified by a licensed nurse, on 1/24/2013, of the residents missed skin assessment with new orders given to discontinue the Cetaphil lotion and a new order given to apply moisturizing lotion to the resident's body as needed for dry skin. Registered Nurse #1 and #2 were re-educated and counseled regarding following physicians orders on 1-29-13 by the Director of Nursing Services..</li> <li>Audits were conducted and documented on 1/24/2013 by the Director of Nursing, Assistant Director of Nursing and the Unit Managers of current residents treatment records to determine that resident skin assessments were completed as scheduled and that treatments were available and provided as ordered. No other concerns were identified.</li> <li>Re-education was provided to the nursing staff on professional standards of care and following physicians orders by the facility Staff Development Coordinator on 1/29/2013. Post test given on 2/20/2013.</li> <li>The Director of Nursing, Assistant Director of Nursing, and/or the Unit Managers will complete an audit 2 times a week times 4 weeks then monthly times 5 months using the facility audit tool on 10 residents to determine that physicians orders are followed. Any concerns identified will be addressed at that time. A summary of the findings will be submitted by the Director of Nursing to the Performance Improvement Committee monthly times 6 months for further review and recommendations.</li> </ol>	3/10/13

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F 281	<p>Continued From page 8</p> <p>through 01/31/13, revealed Cetaphil moisturizing lotion every shift, every day and to apply to bilateral feet every day then wrap right foot with Kerlix for protection. The physician also ordered a weekly skin assessment.</p> <p>An observation, on 01/24/13 at 8:50 AM during a skin assessment, revealed Resident #5's skin to be very dry with flaking. The right foot was observed to have a gauze wrap on the ankle and heel area, dated 01/18/13. The skin under the dressing on the right foot was dry and flaky with no open areas.</p> <p>An interview with Registered Nurse #1, on 01/24/13 at 8:50 AM, revealed skin assessments were to be completed weekly; however, the last assessment documented was on 01/10/13. She stated skin assessments were scheduled to be completed on 01/18/13 and on 01/23/13; however, were not completed.</p> <p>An interview with RN #2, on 01/24/13 at 9:45 AM, revealed the gauze wrap was used to keep the lotion in place. The RN additionally stated the lotion could not have been applied with the dressing in place since 01/18/13. Observation at the time revealed no Cetaphil lotion for Resident #5 could be located on the medication cart.</p> <p>An interview with the Director of Nursing (DON), on 01/24/13 at 2:00 PM, revealed she expected physician's orders to be followed and gave no explanation as to why the lotion had not been applied to Resident #5's skin. The DON revealed the order for the Kerlix wrap to the right foot had been discontinued on 01/20/13; however, gave no explanation as to why the dressing dated</p>	F 281		

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F 281  F 314 SS=D	<p>Continued From page 9 01/18/13 was observed in place on 01/24/13.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy it was determined the facility failed to ensure one resident (#5), in the selected sample of twenty four residents was provided appropriate care and services related to preventative skin care.</p> <p>Findings include: Review of a facility policy titled SKIN CARE &amp; PRESSURE ULCER MANAGEMENT PROGRAM, dated January 2008, included: The standard was to Assess, Plan, Implement and Evaluate. The program relies on evidence based treatment protocols and standards of practice including; Prevention of pressure ulcer development and promoting healing and preventing infection when breakdown occurs. Weekly Evaluation outlined as; A Licensed Nurse performs head-to-toe skin check of the resident and documents the findings on the Treatment</p>	F 281  F 314	<p>1. The kerlix dressing was removed from the residents right foot and a skin assessment was completed for Resident #5 on 1/24/2013 by a licensed nurse. No new skin concerns were identified. The physician for resident #5 was notified by a licensed nurse, on 1/24/2013, of the residents missed skin assessment with new orders given to discontinue the Cetaphil lotion and a new order given to apply moisturizing lotion to the resident's body as needed for dry skin. Registered Nurse #1 and #2 were re-educated and counseled regarding completing skin assessments, having treatment supplies available and following physicians orders on 1-29-13 by the Director of Nursing Services.</p> <p>2. Audits were conducted and documented on 1/24/2013 by the Director of Nursing, Assistant Director of Nursing and the Unit Managers of current residents treatment records to determine that resident skin assessments were completed as scheduled and that treatment supplies were available and provided as ordered. No other concerns were identified.</p> <p>3. Re-education was provided to the facility nursing staff on completing weekly skin assessments, having treatment supplies available, and following physician orders by the facility Staff Development Coordinator on 1/29/2013. Post test given on 2/20/2013.</p> <p>4. The Director of Nursing, Assistant Director of Nursing, and or the Unit Managers will complete an audit 2 times a week times 4 weeks then monthly times 5 months using the facility audit tool on 10 residents to review the facility Skin Management program to determine that treatment supplies are available, skin assessments are completed, and physicians orders are followed. A summary of the findings will be submitted by the Director of Nursing to the Performance Improvement Committee monthly times 6 months for further review and recommendations.</p>	3/10/13

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NAME OF PROVIDER OR SUPPLIER  OWENSBORO PLACE CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD. OWENSBORO, KY 42303
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F 314	<p>Continued From page 10</p> <p>Administration Record (TAR). The Licensed Nurse documents "Y" for skin intact and "N" for not intact.</p> <p>Record review revealed Resident #5 was admitted to the facility on 07/01/05 with diagnoses to include Alzheimer's Disease, Hyperthyroidism, Dementia and Diabetes Mellitus.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 12/18/12, revealed the facility had assessed the resident with cognitive impairment and required extensive assistance with activities of daily living and was at risk for skin break down.</p> <p>A review of a physician's order, dated 01/01/13 through 01/31/13, revealed Cetaphil moisturizing lotion every shift every day and skin assessments weekly. A review of Resident #5's Comprehensive Care Plan revealed the lotion was to be applied to the resident's skin every shift, every day.</p> <p>An observation of Resident #5's skin, on 01/24/13 at 8:50 AM, revealed the resident's skin was very dry and flaky and a gauze wrap, dated 01/18/13, was in place on the resident's right foot.</p> <p>An interview with Registered Nurse #1, on 01/24/13 at 8:50 AM, revealed skin assessments were to be completed weekly; however, the last assessment documented was on 01/10/13. She stated skin assessments were scheduled to be completed on 01/16/13 and on 01/23/13; however, were not completed.</p> <p>An interview with Registered Nurse (RN) #2, on</p>	F 314		
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F 314	Continued From page 11 01/24/13 at 9:45 AM, revealed the lotion could not have been applied as a dressing on the resident's right foot, dated 01/18/13, was still in place. Observation at the time revealed no Cetaphil lotion was available for Resident #5 on the medication cart.	F 314		
F 315 SS=D	Interview with the Director of Nursing (DON), on 01/24/13 at 2:00 PM, revealed she expected staff to follow resident's physician's orders and care plans for preventative skin care as . 483.25(d) NO CATHETER, PREVENT UTI, 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 facility's Peri Care/Incontinence competency skill test it was determined the facility failed to provide quality care for one resident (#14) in the selected sample of twenty-four (24) residents and one resident (#25) not in the selected sample. Observations revealed staff failed to use the proper infection control technique when conducting perineal (peri) care to prevent urinary tract infections for Resident #14	F 315	1. Resident #14 and #25 we assessed by a licensed nurse on 2/18/2013 to determine any signs or symptoms of infection and perineal care completed in the expected manner. No evidence of infection was identified, CNA #1 was provided with counseling on providing perineal care with a return demonstration on 2/20/2013 by The Assistant Director of Nursing and also shared strategies of performing care with confidence when being supervised or observed.  2. An assessment of incontinent, current residents was completed by the facility licensed nurses on 2/20/2013 to determine any evidence of infection with no concerns identified.  3. Peri care re-education was provided to the nursing staff by the Staff Development Coordinator on 1/29/2013 and return demonstrations of perineal care was completed by The facility Staff Development Coordinator on 1/29/2013. Nursing staff were re-educated by the Director of Nursing on 2/20/2013 related to strategies in performing care with confidence when being supervised or observed.	3/10/13

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F 315	<p>Continued From page 12 and #25.</p> <p>The findings include:</p> <p>A review of the Peri Care/Incontinence Care Competency Skill Test for females, no date, revealed the staff are to wipe in the direction from the perineum to the rectum. Repeat on opposite side using separate section of washcloth. With dominant hand, wash downward from pubic area toward rectum in one smooth stroke. Use separate section of cloth for each stroke.</p> <p>1. Observation on 01/23/13 at 10:00 AM during the initial tour of the facility, revealed Certified Nursing Assistant (CNA) #1 performed peri care for Resident #25. CNA #1 cleaned the resident by using wipps soaked with peri wash and wiping back and forth in each side of the groin with out changing areas of the wipe with each swipe.</p> <p>2. Observation on 01/24/13 at 9:41 AM, revealed Resident #14 had an indwelling urinary catheter attached to a leg bag and draining clear, yellow urine. Observation of CNA #1 performing peri and catheter care, revealed the CNA performed the peri care by using wash cloths soaked with peri wash and wiping back and forth in the left groin area and down the middle of the vagina without changing areas of the wash cloth.</p> <p>A review of CNA #1's Peri Care/Incontinence Care Competency Skill Test (female) revealed she was signed off on the skill on 0/03/12 by staff. Further review of the competency skill test revealed she met all the steps during observation of peri care.</p>	F 315	<p>4. The Director of Nursing, Assistant Director of Nursing, and or the Unit Managers will complete an audit 2 times a week times 4 weeks then monthly times 5 months on 5 staff members using the facility audit tool to review the facility peri care program. Any concerns identified will be addressed at that time. A summary of the findings will be submitted by the director of Nursing to the Performance Improvement Committee monthly times 6 months for further review and recommendations.</p>	

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F 316	<p>Continued From page 13</p> <p>Interview with CNA #1, on 01/25/13 at 10:50 AM, revealed she had received training and in-services from the facility and knew the proper technique for performing peri and catheter care. She stated she knew she was suppose to change areas of the cloth with each wipe. Additionally, she stated she knew to wipe from front to back with peri care and away from the resident's body with catheter care. She explained, "I get nervous when someone watches me". She further stated the importance of properly performing peri and catheter care was to keep germs out of the vagina.</p> <p>Interview with the Unit Manager for Hall A &amp; C, on 01/25/13 at 11:14 AM, revealed the CNAs were recently inserviced on incontinent care. The management team divided the CNAs amongst themselves and watched the aides provide care to the resident. He stated there were no issues identified during their observation of the aides. The Unit Manager revealed wiping back and forth with the same area of the wash cloth while performing incontinent care was inappropriate and verbalized it could cause increased infections.</p> <p>Interview with the Director of Nursing (DON), on 01/25/13 at 11:50 AM, revealed incontinent care was reviewed in orientation with staff. All staff were checked off on incontinent care two months ago by the Assistant DON and Staff Development Coordinator. There were no issues identified during the check off of the staff and it was inappropriate for staff to wipe back and forth using the same area of the cloth during the performance of incontinent care.</p>	F 315		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=E	<p>Continued From page 14 <b>HAZARDS/SUPERVISION/DEVICES</b></p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure the residents' environment remained as free of accident hazards as is possible related to observation of an unsecured medication room and hazardous items left unsupervised on top of a medication cart that was sitting on the resident hall area. The facility had identified twelve (12) residents with wandering behaviors. In addition, the facility failed to provide adequate supervision for one resident (#3), in the selected sample of 24 residents, related to Rehab not communicating the discontinuation of a safety release seatbelt and the need for increased supervision.</p> <p>The findings include:</p> <p>1. Observation during the initial tour on 01/25/13 starting at 1:10 PM, revealed a medication cart parked by the nursing station on the E Wing. There was a pair of scissors, a syringe of saline (for flushing) and a large container of germicidal wipes used for sanitizing glucometers on top of the cart. Further observation revealed the cart</p>	F 323	<p>1. The scissors, needless saline flush syringe and the germicidal wipes were removed from the top of the E wing medication cart by a licensed nurse on 1/25/2013. LPN #1 and RN #1 received counseling from the Director of Nursing on 1-28-13 regarding leaving items on top of the med cart. The E wing medication room door was locked by a licensed nurse on 1-23-13. The Director of Nursing removed the Proventil inhaler from Resident #2's bedside table on 1/25/2013. Resident #2 was assessed by a licensed nurse with no changes in condition identified and also notified the resident and the resident's physician regarding the medication being found and removed from bedside on 1/25/2013. Counseling was provided to LPN #2 related to medications being left at bedside by the Director of Nursing on 1-28-13. The physician for Resident #3 was notified by a licensed nurse and new orders received to discontinue the self releasing seat belt on 1/29/2013. Resident #3 was assessed by a licensed nurse on 1/24/2013 with no injuries or change in condition noted. Therapy staff were re-educated to the process for communicating changes to the residents plan of care including trial restraint reductions by the Therapy Manager on 1/24/2013. LPN #1 was counseled by the Director of Nursing on 1-28-13 regarding the initialing of the TAR without validating the presence of the self releasing seat belt.</p> <p>2. A environmental safety round of the facility on 1/25/2013 was completed and documented by the Unit Managers to determine that the residents environment was free of hazards including that all residents had the appropriate safety devices in place as ordered, medications are not at bedside, medication rooms were locked, and that hazardous materials were secured appropriately. No other areas of concern was identified.</p>	3/10/13
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F 323	<p>Continued From page 15</p> <p>was left unattended from 1:10:PM until 1:20 PM. A number of residents were in the area of the nursing station.</p> <p>An interview with Licensed Practical Nurse (LPN) #3, on 01/25/13 at 1:10 PM, revealed she had left the scissors, saline flush and germicidal wipes unsecured on top of the medication cart. RN #1 stated she did not normally leave the scissors unsecured and must have forgotten when called away for something. The RN removed the scissors at 1:10 PM and secured them but left the germicidal wipes and saline flush on top of the medication cart and walked away.</p> <p>An interview with the Unit Manager, on 01/25/13 at 1:20 PM, revealed scissors, saline flushes and germicidal wipes were not to be left unattended and unsecured on top to the medication cart because it would be a safety hazard.</p> <p>2. Observation during the initial tour of the facility, on 01/23/13 at 9:05 AM, revealed the medication room door on the E-wing was open and not secure. Further observation revealed the door was unlocked from 9:05 AM-9:20 AM with no staff around. Observation inside the medication room revealed there were no staff in the room and there was 2 unlock cabinets and two unlocked refrigerators.</p> <p>Cabinet #1 contained the following medications: 14 bottles of Lactulose Solution 10g/15ml, 473ml, 8 bottles of Miralax powder 527 gram bottle, one (1) bottle of Miralax powder 225 gram bottle, and one (1) bottle of Milk of Magnesia 16 oz.</p> <p>Cabinet #2 contained the following medications: 12 vials of Albuterol Sulfate Inhalation Solution, 6</p>	F 323	<p>3. Re-education was provided to the nursing staff by the facility Staff Development Coordinator on 1/29/2013 related to the requirement of maintaining an environment free of accident hazards which included making sure medication rooms are locked, that assistive devices are in place, medications are not left at bedside, and keeping items such as scissors, saline syringes, and germicidal wipes secured. Licensed nurses were also re-educated on 1-29-13 by the facility Staff Development Coordinator that items documented on the resident Treatment Administration Record should only be initialed once it has been completed or determined to be in place and that it is not acceptable to document if the task or treatment has not been completed. Post test completed on 2/22/2013.</p> <p>4. The Director of Nursing, Assistant Director of Nursing, and/or the Unit Managers will complete an audit 2 times a week times 4 weeks then monthly times 5 months using the facility audit tool to observe environmental safety to ensure residents environment remains free of accident hazards including that medication room doors are locked, hazardous items are secured, that medications are not left at bedside and that each resident receives adequate supervision and assistance devices to prevent accidents. Any concerns identified will be addressed at that time. A summary of the findings will be submitted by the Director of Nursing to the Performance Improvement Committee monthly times 6 months for further review and recommendations.</p>	

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F 323	<p>Continued From page 16</p> <p>vials of Ibatropium Bromide/Albuterol, and 3 bottles of Lactulose solution 8 oz. Larger refrigerator contained the following unsecured medications: 135 Dulcolax suppositories, 42 Phenergan suppositories, 10 flex pens of Levemir Insulin, 4 flex pens of Humalog Insulin, and 10 flex pens of Novolog Insulin.</p> <p>A second smaller refrigerator contained: 10 Bud Light 12 oz beer cans</p> <p>Interview with the staff nurse, on 01/23/13 at 9:30 AM, revealed she was not aware of the medication door being open. She stated the door should always be locked, no exceptions, and stated she did not know how it happened.</p> <p>An interview with the Director of Nursing (DON), on 01/25/13 at 1:50 PM revealed her expectations are the medication rooms should be locked and secured at all times.</p> <p>3. A review of the policy entitled "Self Administering Medications", dated 12/01/07 and revised 05/10/10, revealed the facility should comply with Facility policy, Applicable Law and State Operations Manual with respect to resident Self-Administration of medications. Facility, in conjunction with the Interdisciplinary Care Team, should assess and determine with respect to each resident, whether Self-Administration of medications is safe and appropriate. Facility should educate residents to ensure that a resident is able to: state the name, dose, strength, frequency and purpose for use of his/her medications; understand the possible side effects of his/her medications and that he/she</p>	F 323		

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F 323	<p>Continued From page 17</p> <p>should notify Facility staff if he/she experiences any such side effects; correctly administer medication and correctly store his/her medications in a locked compartment.</p> <p>Observations on 01/23/13 at 10:30 AM, 1:13 PM, and 3:25 PM and on 01/24/13 at 8:25 AM, 9:50 AM, and 10:59 AM revealed a Proventil inhaler lying on his/her bedside table.</p> <p>Record review revealed Resident #2 was admitted to the facility, on 10/06/12, with diagnoses to include Peripheral Vascular Disease, Pain, Chronic Obstructive Pulmonary Disease (COPD) and Varicose Veins of Lower Extremities with Ulcer.</p> <p>A review of the admission Minimum Data Set assessment, dated 10/19/12, revealed the resident was assessed as moderately impaired in his/her cognition. A review of the Evaluation for Self-Administration of Medication, dated 10/06/12, revealed the facility assessed Resident #2 as unable to self-administer medications.</p> <p>A review of the physician's orders, dated 01/01/13 to 01/31/13, revealed an order for Proventil HFA (Albuterol Sulfate) 108 (90) Micrograms (MCG)/ Actvis (ACT) Aerosol Solution Inhalation as needed 2 puffs. Further review revealed no order for Resident #2 to self administer medications.</p> <p>An interview with Licensed Practical Nurse (LPN) #2, on 01/25/13 at 9:35 AM, revealed she was unaware the resident had the inhaler. She reported there were no residents on the unit that self administered their medications. LPN #2 stated all residents were assessed upon</p>	F 323		

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F 323	<p>Continued From page 18</p> <p>admission for self administration of medications and if determined they can, then staff would obtain an order from the physician. Also if a resident wanted to give their own medications, then they would be re-evaluated for self administration. She could not explain how the resident obtained the inhaler.</p> <p>An interview with the DON, on 01/25/13 at 11:50 AM, revealed she did not know anything about the resident having medications at the bedside. She revealed the resident had a friend to bring the inhaler to him/her. Staff have instructed families when they bring in items to the residents to stop by the desk to have the items added to the inventory list. She reported there was no policy for keeping medications at the bedside and the residents had to be assessed to administer their own medications. She revealed they did not have any residents on the unit that had been determined to administer their own medications.</p> <p>3. A review of the Accidents/Incidents policy, dated 01/08, revealed the facility would identify each resident at risk for accidents and/or falls, and adequately plan care and implement procedures to prevent accidents.</p> <p>A record review revealed Resident #3 was admitted to the facility on 04/11/12 with diagnoses to include Alzheimer's Disease, Dementia with Behavioral Disturbances, Muscle Weakness, and Osteoarthritis. A review of the quarterly Minimum Data Set (MDS), dated 01/03/13, revealed the facility assessed the resident as cognitively severely impaired and required extensive assistance with transfers. The MDS revealed the resident did not ambulate and</p>	F 323		

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F 323	<p>Continued From page 19 required a trunk restraint.</p> <p>A review of the physician's orders, dated 01/01/13 through 01/31/13, revealed an order for the safety release seat belt while up in the wheelchair. A review of the Restrictive Device Consent, dated 05/18/12, revealed the facility assessed the resident for a safety release seat belt while up in the wheelchair for positioning and decreased safety awareness. Benefits of the device included improved positioning/posture, prevention of falls which might result in injury, and increased feeling of safety and security. A review of the resident's care plan, initiated 04/11/12, revealed the resident was assessed at risk for falls related to poor coordination, unsteady gait, pain, use of psychotropic medications, generalized weakness, and decreased safety awareness. An intervention was added 05/18/12 for the safety release seat belt while in the wheelchair.</p> <p>A review of the physical therapy's "Daily Notes and Weekly Progress Summary", dated 01/22/13, revealed Resident #3 was evaluated on 01/22/13 and fitted for a new seating system to decrease sacral sitting in the wheelchair. The notes revealed the resident was observed for thirty minutes without the use of the seat belt and clinical observation would continue for one week to ensure the new seating system was effective.</p> <p>An interview with the Therapy Program Manager, on 01/24/13 at 5:10 PM, revealed therapy was conducting a "trial" for a new chair for the resident as they did not feel he/she needed the seat belt. He expected therapy staff to obtain an order to discontinue the seat belt and communicate with nursing staff by documenting the information in</p>	F 323		

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F 323	<p>Continued From page 20</p> <p>the twenty four (24) hour report. Further review of the physician's orders revealed there was no physician's order to discontinue the seat belt.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 01/24/13 at 4:45 PM, revealed she was not aware until 01/24/13 that physical therapy was evaluating the resident for a new wheelchair system and was not aware the resident would need to be monitored.</p> <p>Observations of Resident #3, on 01/23/13 at 1:20 PM, 3:20 PM, and 01/24/13 at 8:30 AM, 8:55 AM, 2:45 PM, and 4:30 PM, revealed the resident was sitting up in the wheelchair without a safety release seat belt; however, review of the January 2013 Treatment Administration Record (TAR) revealed staff continued to initial the TAR indicating the safety release seat belt was in place and functioning on 01/22/13 at 8:00 AM, 10:00 AM, 12:00 AM, 2:00 PM, 4:00 PM, 6:00 PM, and on 01/23/13 at 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, and 6:00 PM.</p> <p>Further interview with LPN #1, on 01/24/13 at 4:45 PM, revealed she initialed the TAR from 8:00 AM-2:00 PM on 01/22/13 and 01/23/13; however, she did not check the placement and functioning of the seat belt. She revealed "I just signed my initials."</p> <p>An interview with Unit Manager #1, on 01/24/13 at 4:30 PM, revealed she was not aware the resident had an order for a safety release seat belt to the wheelchair and she was not aware of physical therapy evaluating the resident.</p> <p>An interview with the Director of Nursing (DON),</p>	F 323		

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F 323	Continued From page 21 on 01/25/13 at 11:45 AM, revealed she expected therapy to communicate with nursing when changes were made. Therapy staff should have discontinued the seat belt or placed it "on hold" until the trial was completed. She expected nursing staff to ensure a treatment was in place prior to documentation on the TAR.	F 323		
F 441 SS=D	<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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted</p>	F 441	<p>1. Resident #3 and #7 were assessed by a licensed nurse on 2/18/2013 for any signs of infection with no concerns identified. The positioning wedge and privacy curtain in the room of Resident's #3 and #7 were disinfected by housekeeping staff on 1/25/2013. CNA #1 was counseled by the Director of Nursing on 2/20/2013 regarding infection control practices including cross contamination and hand washing.</p> <p>2. A resident surveillance assessment was completed on all current residents by the facility licensed nurses on 2/20/2013 to assess for any complications related to infection control procedures specifically cross contamination and hand washing. No concerns were identified.</p> <p>3. Re-education was provided to nursing staff on Infection control practices, including cross contamination and washing hands during resident care on 1/29/2013. A post test was given on 2/20/13.</p> <p>4. The Director of Nursing, Assistant Director of Nursing, and or the Unit Managers will complete an Infection Control audit tool which will include 10 resident care observations to validate infection control practices including avoidance of cross contamination and hand washing 2 times a week times 4 weeks then monthly times 5 months. Any concerns identified will be addressed at that time. A summary of the findings will be submitted by the Director of Nursing to the Performance Improvement Committee monthly times 6 months for further review and recommendations.</p>	3/10/13

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F 441	<p>Continued From page 22 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, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure a safe, sanitary environment for two residents (#3 and #7), in the selected sample of 24 residents. Staff cross contaminated Resident #3's positioning device and did not wash their hands after direct contact with Resident #3 and #7.</p> <p>The findings include: A review of the "Peri Care/Incontinence Care Competency Skill Test", undated, revealed to wash hands after the completion of incontinence care.</p> <p>1. An observation of Resident #3, on 01/24/13 at 8:55 AM, revealed Certified Nurse Aide (CNA) #1 performed incontinent care for the resident. After incontinent care, CNA #1 did not remove her soiled gloves. She obtained a positioning wedge from the resident's roommate and used the wedge for Resident #3. She placed soiled items in a plastic bag and pulled the resident's privacy curtain back, while wearing soiled gloves. She removed the gloves and left the resident's room without washing her hands.</p>	F 441		

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F 441	<p>Continued From page 23</p> <p>2. An observation of Resident #7, on 01/24/13 at 8:40 AM, revealed CNA #1 provided incontinent care to the resident. She placed a barrier cream to the resident's buttocks. Afterwards, she fastened the resident's brief and brushed her hair out of her face wearing soiled gloves. She removed the soiled gloves, placed soiled items in a plastic bag, and left the resident's room without washing her hands.</p> <p>An interview with Certified Nurse Aide (CNA) #1, on 01/24/13 at 11:55 AM, revealed she should remove her gloves and wash her hands after incontinent care. She revealed she should not use a positioning device between two residents.</p> <p>An interview with the Director of Nursing (DON), on 01/25/13 at 11:45 AM, revealed she expected staff to wash their hands before care and before leaving the resident room and when contaminated. Staff should not use a positioning device for two residents unless it is sanitized before use.</p>	F 441		

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K 000	INITIAL COMMENTS  Building: 01 Plan Approval: 1966, 1999 Survey under: NFPA 101 (2000 edition) Chapter 19 Facility type: SNF/NF Type of structure: Type III (200) Smoke Compartment: 9 Fire Alarm: Complete fire alarm. Panel upgraded in 2001 Sprinkler System: Complete automatic dry sprinkler system upgraded in 2012. Generator: Type II, Natural Gas, facility unsure of installation date. A standard Life Safety Code survey was conducted on 01-23-13 and 01-24-13. Owensboro Place Care and Rehabilitation Center was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for One-Hundred Forty-Five (145) beds with a census of One-Hundred Thirty-Seven (137) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire) Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 018 SS=F	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 1/4 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	K 018		

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

*Mendell Smith*

TITLE

*Administrator*

(X6) DATE

*2/18/13*

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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K 018	<p>Continued From page 1</p> <p>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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors of resident rooms were in accordance with NFPA standards. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, all residents, staff and visitors. The facility is certified for One-Hundred Forty-Five (145) beds with a census of One-Hundred Thirty-Seven (137) on the day of the survey. The facility failed to ensure resident doors could be closed with a single motion, and doors would properly latch.</p> <p>The findings include:</p> <p>Observations, on 01/23/13 between 1:00 PM and 4:00 PM with the Maintenance Supervisor, revealed the corridor doors to the resident rooms were blocked from closing. The rooms affected by this were rooms # c-3 blocked by the bed, c-6</p>	K 018	<p>1. Beds were realigned in rooms C-3, C-6, C-12, C-15, C-14, D-12, D-2, E-4, and E-10 and wheelchairs in rooms C-5 and C-11 were relocated by Maintenance staff on 1-23-13. The corridor doors for rooms C-5, C-11, D-12, D-3, D-4, D6, D-5, and A-20 were adjusted by the maintenance supervisor on 1/27/13 so that the doors would latch properly. The gap at the door jam for the doors to rooms E-10 and A-9 were corrected by Maintenance staff on 2/13/13.</p> <p>2. The Maintenance staff completed and documented facility rounds on 2/18/13 to determine that corridor doors of resident rooms were in accordance with NFPA standards including that the path of door closure is clear, and that doors could be closed with a single motion and would properly latch. No other concerns were identified.</p> <p>3. Nursing, dietary, therapy, housekeeping, and administrative staff will be re-educated by the administrator with completion by 3/10/13 to the NFPA standard regarding the requirement that the corridor doors of resident rooms must maintain a clear path of closure and can be closed with a single motion and properly latch and further instructed that if concerns are identified to clear the path of closure and complete a work order to notify maintenance staff of repair needs. Nursing, therapy, dietary, housekeeping, and administrative staff will be re-educated as of 3/10/13 by the Administrator to the NFPA standard regarding the requirement that the corridor doors of residents room must maintain a clear path of closure and can be closed with a single motion and properly latch and to clear the path of closure when and if concerns are identified or to complete a work order to notify maintenance staff of repair needs.</p>	3/11/13

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K 018	<p>Continued From page 2</p> <p>blocked by the bed, c-5 blocked by a wheelchair, c-11 blocked by a wheelchair, c-12 blocked by the bed, c-15 blocked by the bed, c-14 blocked by the bed, d-12 blocked by the bed, d-2 blocked by the bed, e-4 blocked by the bed, and e-10 blocked by the bed.</p> <p>Interviews, on 01/23/13 between 1:00 PM and 4:00 PM with the Maintenance Supervisor, revealed he was unaware the items were blocking the doors from closing properly.</p> <p>Observations, on 01/23/13 between 1:00 PM and 4:00 PM with the Maintenance Supervisor, revealed the corridor doors to rooms # c-5, c-11, d-12, d-3, d-4, d-6, d-5, and a-20 would not latch properly. Further observation revealed the doors to e-10 and a-9 had a gap larger than 1/2 inch at the door jamb.</p> <p>Interview, on 01/23/13 between 1:00 PM and 4:00 PM with the Maintenance Supervisor, revealed he was unaware these doors were not latching properly. The Maintenance Supervisor was aware that all resident room doors must latch in the event of an emergency.</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</p>	K 018	<p>4. The Administrator, Assistant Administrator and or Maintenance Supervisor will complete an audit of corridor doors of resident rooms to determine that the path of closure is clear, the doors can be closed in a single motion and that the doors latch weekly x4 weeks and then monthly x5 months. Any concerns will be corrected at that time. A summary of findings will be submitted to the Performance Improvement Committee by the Administrator or Maintenance Supervisor monthly x6 months for further review and recommendation.</p>	
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K 018	Continued From page 3 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. 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  19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.	K 018		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¼-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in	K 027		

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K 027	<p>Continued From page 4</p> <p>accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke doors that would self-close and resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of nine (9) smoke compartments, one-hundred thirty (130) residents, staff and visitors. The facility is certified for One-Hundred Forty-Five (145) beds with a census of One-Hundred Thirty-Seven (137) on the day of the survey. The facility failed to ensure the doors in the smoke barriers would self-close. This is a repeat deficiency from the survey last year on 10/20/11.</p> <p>The findings include:</p> <p>Observation, on 01/23/13 between 10:00 AM and 11:30 AM with the Maintenance Supervisor, revealed that the doors in the attic smoke barriers next to B-2, C-1, D-1, E-1, and E-14 would not close and latch with the current hardware installed. The doors were equipped with closing hardware but the doors would not close and latch. Further observation of the homemade doors revealed they were not a rated door and would not resist the passage of smoke.</p> <p>Interview, on 01/23/13 between 10:00 AM and 11:30 AM with the Maintenance Supervisor, revealed that he was not aware the doors were</p>	K 027	<p>K 027 E</p> <ol style="list-style-type: none"> <li>The smoke barrier doors giving access to the attic next to B-2, C-1, D-1, E-1, and E-14 will be eliminated by Pierce Construction. Attic access points that are not metal will be replaced with manufactured, rated doors that will resist the passage of smoke and additional access points will be added allowing the smoke barrier doors in the attic to be eliminated by Pierce Construction as soon as the access panels arrive. Pierce was verbally awarded the work on 2/18/13 and will supply the new access panels. Coordinating devices were installed on the cross-corridor doors in D-South, D-North, E-South, E-North, and both doors in the connecting hallway with the work being completed on 2/13/13 by Maintenance staff. The gap between the doors on A-wing was corrected on 2/1/13 by Maintenance staff.</li> <li>The Maintenance staff completed and documented an inspection of the attic and cross-corridor doors in the facility on 1/28/13 to determine that all smoke barriers are intact and functioning properly. No other concerns identified.</li> <li>The Administrator and Maintenance staff were re-educated by the Regional Property Manager to the NFPA standard of maintaining smoke doors that will resist the passage of smoke and self close on 2/15/13.</li> <li>The Maintenance Department complete and document an inspection of smoke doors to determine that smoke doors are maintained to resist the passage of smoke and are self closing weekly x4 weeks and then monthly. Any concerns identified will be addressed at that time. A summary of findings will be submitted by the Administrator or Maintenance Director to the Performance Improvement and Safety Committee meeting monthly x6 months for review and further recommendation.</li> </ol>	3/11/13	

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NAME OF PROVIDER OR SUPPLIER  OWENSBORO PLACE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD. OWENSBORO, KY 42303		
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K 027	<p>Continued From page 5</p> <p>not of a proper type. The Maintenance Supervisor was under the impression these were the correct doors since they were checked on the revisit from last year's survey and were accepted.</p> <p>Interview, on 01/24/13 at 9:41 AM with the Administrator, revealed the doors were replaced after the survey last year with ones made at the facility and springs were added to close the doors. The previous surveyor came back on a revisit and accepted the doors as a proper replacement. The facility submitted a Plan of Correction that detailed this and the plan was accepted. He was unaware the doors were still not the proper type.</p> <p>Observation, on 01/23/13 between 1:00 PM and 4:00 PM with the Maintenance Supervisor, revealed the cross-corridor doors located at the d-wing south, d-wing north, both sets on e-wing, e-wing south, and e-wing north would not close completely when tested. This was due to the doors not having a coordinating device installed on the doors. Further observation revealed the doors on a-wing had a gap larger than 1/8 inch and would not resist the passage of smoke.</p> <p>Interview, on 01/23/13 between 1:00 PM and 4:00 PM with the Maintenance Supervisor, revealed he was unaware the doors needed a coordinating device to ensure the door without the astragal would always close first. Further interview revealed he was unaware the doors on a-wing had a gap larger than 1/8 inch.</p> <p>This is a repeat deficiency.</p> <p>NFPA Standard: NFPA 101 (2000 ed.),</p>	K 027			

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K 027	Continued From page 6 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.  Reference: NFPA 80 (1999 Edition)  2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 027			
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 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in	K 029			

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K 029	<p>Continued From page 7</p> <p>accordance with NFPA Standards. The deficiency had the potential to affect five (5) of nine (9) smoke compartments, ninety-three (93) residents, staff and visitors. The facility is certified for One-Hundred Forty-Five (145) beds with a census of One-Hundred Thirty-Seven (137) on the day of the survey. The facility failed to ensure eleven (11) rooms with hazardous storage had the proper separation.</p> <p>The findings include:</p> <p>Observation, on 01/23/13 between 1:00 PM and 4:00 PM with the Maintenance Supervisor, revealed:</p> <ol style="list-style-type: none"> <li>1) The dietary office had substantial combustibles and was over 50 square feet.</li> <li>2) The dietary utility room had substantial combustibles and was over 50 square feet.</li> <li>3) The Dry Storage room for the kitchen did not have a door installed and was not separated from the kitchen.</li> <li>4) The dry storage room had a door that went to the corridor of the facility with no door closer installed due to storage.</li> <li>5) The e-wing central supply closets had substantial combustibles and were over 50 square feet.</li> <li>6) Resident room d-17 had a substantial amount of combustibles in the room making the room hazardous.</li> <li>7) The room d-20 had substantial combustibles and was over 50 square feet.</li> <li>8) The room d-19 had substantial combustibles and was over 50 square feet.</li> <li>9) The bookkeeping area had substantial combustibles stored in an area larger than 50</li> </ol>	K 029	<ol style="list-style-type: none"> <li>1. A door well be installed in the Dry Storage room for the kitchen by Maintenance staff by 2/22/13. Self closers have been ordered from HD Supply on 2/18/13 and will be installed by Maintenance staff on the Dietary Office door, the Dietary utility room, the new door between the kitchen and dry storage, the dry storage corridor door, the E-wing central supply closets, the D-20 door, the D-19 door, the room identified as Therapy storage on A-wing, and the Housekeeping storage door on A-wing upon arrival to the facility. Combustibles in the bookkeeping area were removed by office and Medical Records staff on 2/13/13. The combustibles in D-17 have been removed, stored and the resident and family notified on 2/15/13 by Social Services.</li> <li>2. The Maintenance Director completed and documented an inspection of the facility to determine that hazardous storage had the proper separation in accordance with NFPA standards on 2/15/13.</li> <li>3. The Maintenance Director was re-educated by the Regional Property Manager on 2/15/13 regarding the protection of hazards thus requiring a door, self closer and separation in accordance with NFPA standards. Nursing, dietary, housekeeping, therapy, and administrative staff will be re-educated by the Administrator and will be completed by 3/10/13 regarding the protection of hazards thus requiring a door, self closer and separation in accordance with NFPA standards and reporting any concerns to maintenance if identified.</li> <li>4. The Maintenance Director, Administrator and/or the Assistant Administrator will complete and document an inspection of the facility to determine that hazardous storage has the proper separation in accordance with NFPA standards weekly x4 weeks and then monthly x5 months. Any concerns identified will be corrected at that time. A summary of findings will be submitted by the Administrator or Maintenance Director to the Safety Committee and Performance Improvement Committee monthly x6 months for further review and recommendation.</li> </ol>	3/11/13

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K 029	<p>Continued From page 8</p> <p>square feet and is open to the corridor.</p> <p>10) The therapy storage room had substantial combustibles and was over 50 square feet.</p> <p>11) The housekeeping storage room on a-wing had substantial combustibles and was over 50 square feet.</p> <p>Interview, on 01/23/13 between 1:00 PM and 4:00 PM with the Maintenance Supervisor, revealed he was not aware the rooms listed above were considered hazardous storage thus requiring a door, a self-closer, and separation.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <p>(1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft<sup>2</sup> (4.6 m<sup>2</sup>),</p>	K 029		

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K 029	Continued From page 9 including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.  This STANDARD is not met as evidenced by: Based on interview and facility record review, it was determined the facility failed to provide emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, thirty-two (32) residents, staff and visitors. The facility is certified for One-Hundred Forty-Five (145) beds with a census of One-Hundred Thirty-Seven (137) on the day of the survey. The facility failed to ensure they conducted annual emergency lighting testing for the minimum requirement of Emergency lighting of at least 1-1/2 hour duration and 30 second monthly testing on battery lights.  The findings include:  Observation and record review, on 01/23/13 at	K 046		

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K 046	<p>Continued From page 10</p> <p>9:30 AM with the Maintenance Supervisor, revealed that the emergency lights, with battery backup, located in the A-wing resident bathrooms had not been tested for 1-1/2 hours within the last year. Further observation revealed the lights were not functioning in the resident bathrooms on A-Wing.</p> <p>Interview, on 01/23/13 at 9:30 AM with the Maintenance Supervisor, revealed he was unaware the lighting had to be tested annually for 1-1/2 hours. Further interview revealed he was unaware the lights were not functioning in the resident bathrooms of A-wing.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for</p>	K 046	<ol style="list-style-type: none"> <li>1. The Emergency lighting will be tested for the minimum requirement of Emergency lighting of at least 1-1/2 hour duration on 2/22/13 by Maintenance staff. The bathroom lights on A wing were repaired and function restored on 2/18/13 by Maintenance staff.</li> <li>2. The Maintenance Director will complete and document an inspection of the facility emergency lighting on 2/22/13 to determine that required testing is completed and lights are functioning properly on other concerns.</li> <li>3. The Maintenance Director was re-educated on 2/15/13 by the Regional Property Manager to the NFPA standard that emergency lighting must provided and tested for 1 1/2 hours and that function tests be done annually as well as a 30-second function test done at a 30-day interval. The 30-second monthly test of the emergency lights with battery backup was added to monthly Maintenance inspections by the Administrator on 2/15/13. The scheduled load test of the generator was revised to 90-minutes each year by the Administrator on 2/15/13. A record of all the tests will be kept in the Maintenance Department. Repairs will be made as the need is identified.</li> <li>4. The Maintenance Director will complete the 30-second function test monthly and the 1 1/2 hour test annually ongoing. Results of the inspections and repairs performed will submitted by the Maintenance Director and reviewed in the monthly Safety Committee meeting and by the Performance Improvement committee monthly x12 months for further review and recommendation.</li> </ol>	3/11/13

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K 046	Continued From page 11 not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.  Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046		
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 observations and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to	K 056		

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K 056	<p>Continued From page 12</p> <p>affect nine (9) of nine (9) smoke compartments, all residents, staff and visitors. The facility is certified for One-Hundred Forty-Five (145) beds with a census of One-Hundred Thirty-Seven (137) on the day of the survey. The facility failed to ensure the sprinkler heads were not blocked by light fixtures.</p> <p>The findings include:</p> <p>Observations, on 01/23/13 between 1:00 PM and 4:00 PM with the Maintenance Supervisor, revealed the sprinkler heads located in resident room c-1, c-3, C-hall central bath, c-5, c-7, c-9, c-15, d-9 bathroom, d hall center head, d wing med room, e wing corridor, e wing med room, a-4, a wing central bath, a-6, a-8, a-9, a-10, a-12, a-11, a-15, a-17, a-14, a-16, a-19, and a-18 bathroom were blocked by light fixtures, within 1 foot of the sprinkler head, extending below the sprinkler heads.</p> <p>Interview, on 01/23/13 between 1:00 PM and 4:00 PM with the Maintenance Supervisor, revealed he was unaware that the light fixtures could block the spray pattern of the sprinkler head and was unaware the sprinklers spray pattern was blocked.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns,</p>	K 056	<ol style="list-style-type: none"> <li>1. The light fixtures in room C-1, C-3, C-hall central bath, C-5, C-7, C-9, C-15, D-9 bathroom, D hall center head, D wing med room, E wing corridor, E wing med room, A-4, A wing central bath, A-6, A-8, A-9, A-10, A-12, A-11, A-15, A-17, A-14, A-16, A-19, and A-18 bathroom will be replaced by 3/10/13 by Maintenance staff with fixtures that do not extend below the sprinkler heads or repositioned to meet the requirements in relation to the location of the sprinkler heads.</li> <li>2. The Maintenance Director inspected the center to determine that sprinkler heads were not blocked by light fixtures and complete sprinkler coverage in accordance with NFPA standards on 2/5/13. No other concerns were identified.</li> <li>3. The Maintenance Director was re-educated by the Regional Property Manager on 2/15/13 to the requirement that sprinkler heads can complete coverage in accordance with NFPA standards including that sprinkler heads are not blocked by light fixtures.</li> <li>4. The Maintenance Director will complete an inspection of the facility sprinkler heads to determine that they can complete coverage in accordance with NFPA standards monthly x6 months. A summary of findings will be submitted by the Maintenance Director to the Safety Committee and the Performance Improvement Committee monthly x6 months for further review and recommendation.</li> </ol>	3/11/13

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K 056	<p>Continued From page 13 and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="1"> <thead> <tr> <th>Distance from Sprinklers to above Bottom of Side of Obstruction (A)</th> <th>Maximum Allowable Distance of Deflector Obstruction (in.) (B)</th> </tr> </thead> <tbody> <tr><td>Less than 1 ft</td><td>0</td></tr> <tr><td>1 ft to less than 1 ft 6 in.</td><td>2 1/2</td></tr> <tr><td>1 ft 6 in. to less than 2 ft</td><td>3 1/2</td></tr> <tr><td>2 ft to less than 2 ft 6 in.</td><td>5 1/2</td></tr> <tr><td>2 ft 6 in. to less than 3 ft</td><td>7 1/2</td></tr> <tr><td>3 ft to less than 3 ft 6 in.</td><td>9 1/2</td></tr> <tr><td>3 ft 6 in. to less than 4 ft</td><td>12</td></tr> <tr><td>4 ft to less than 4 ft 6 in.</td><td>14</td></tr> <tr><td>4 ft 6 in. to less than 5 ft</td><td>16 1/2</td></tr> <tr><td>5 ft and greater</td><td>18</td></tr> </tbody> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).</p>	Distance from Sprinklers to above Bottom of Side of Obstruction (A)	Maximum Allowable Distance of Deflector Obstruction (in.) (B)	Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	16 1/2	5 ft and greater	18	K 056		
Distance from Sprinklers to above Bottom of Side of Obstruction (A)	Maximum Allowable Distance of Deflector Obstruction (in.) (B)																									
Less than 1 ft	0																									
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4 ft 6 in. to less than 5 ft	16 1/2																									
5 ft and greater	18																									
K 062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect nine (9) of nine (9)</p>	K 062																								

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185236	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0101 B. WING _____	(X3) DATE SURVEY COMPLETED  01/24/2013
NAME OF PROVIDER OR SUPPLIER  OWENSBORO PLACE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD, OWENSBORO, KY 42303	
(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 062	<p>Continued From page 14</p> <p>smoke compartments, all residents, staff and visitors. The facility is certified for One-Hundred Forty-Five (145) beds with a census of One-Hundred Thirty-Seven (137) on the day of the survey. The facility failed to ensure the gauges on the sprinkler riser had been replaced or recalibrated within the past five (5) years.</p> <p>The findings Include:</p> <p>Observation and record review, on 01/23/13 at 9:24 AM with the Maintenance Supervisor, revealed the facility failed to provide documentation that the gauges on the sprinkler riser had been calibrated or replaced within the last 5 years.</p> <p>Interview, on 01/23/13 at 9:24 AM with the Maintenance Supervisor, revealed he was not aware the gauges on the sprinkler riser had not been replaced within the last five (5) years. He was under the impression that the sprinkler vendor would have taken care of that.</p> <p>Observations, on 01/24/13 at 9:10 AM with the Maintenance Supervisor, revealed the sprinkler heads at the front entrance and the kitchen area had corrosion buildup on the sprinkler heads.</p> <p>Interview, on 01/24/13 at 9:10 AM with the Maintenance Supervisor, revealed he was unaware the sprinkler heads had begun to corrode in these areas.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum</p>	K 062	<ol style="list-style-type: none"> <li>The gauges on the sprinkler riser will be replaced by 2/28/13 by Ohio Valley Sprinkler. New sprinkler heads that are designed for high humidity areas have been ordered by Ohio Valley Sprinkler from their supplier on 2/11/13 for the front entrance and kitchen area. These sprinkler heads will be installed by Ohio Valley Sprinkler upon arrival.</li> <li>The Maintenance Director inspected and documented the facility sprinkler heads to determine that sprinkler system was maintained in accordance with NFPA standards on 2/8/13. No other issues were identified.</li> <li>The Maintenance Director was re-educated by the Regional Property Manager on 2/15/13 regarding sprinkler system maintenance according to NFPA standards including the calibration or replacement of sprinkler risers within 5 years. Replacement of the riser gauges will be added to our automated maintenance scheduler by the Maintenance Director by 2/22/13 to ensure that they are replaced or calibrated within 5 years according to the NFPA requirements. Quarterly inspections of the sprinkler heads will be added to our automated maintenance scheduler by Maintenance Director by 2/22/13.</li> <li>The Maintenance Director will complete an inspection of sprinkler heads and gauges quarterly x12 months to determine compliance with NFPA standards. Any concerns identified will be corrected at that time. A summary of findings will be submitted to the Safety Committee and the Performance Improvement Committee monthly x12 months by the Maintenance Director for further review and recommendations.</li> </ol>	3/11/13

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K 062	Continued From page 15 requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.  Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1	K 062		

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K 062	Continued From page 16 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10  Reference: NFPA 25 (1998 Edition). 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062		
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the installed fire extinguishers in accordance with NFPA standards. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, all residents, staff and	K.064		

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K 064	<p>Continued From page 17</p> <p>visitors. The facility is certified for One-Hundred Forty-Five (145) beds with a census of One-Hundred Thirty-Seven (137) on the day of the survey. The facility failed to ensure the fire extinguishers in the facility had their six (6) year maintenance.</p> <p>Findings include:</p> <p>Observation, on 01/23/13 between 1:00 PM and 4:00 PM with the Maintenance Supervisor, revealed a fire extinguisher in the c-hall, c-utility, d sitting area, resident smoking area, dining room hall, both in the kitchen area, short d, front utility room, front office, and the boiler room with the last six (6) year maintenance performed in December of 2006.</p> <p>Interview, on 01/23/13 between 1:00 PM and 4:00 PM with the Maintenance Supervisor, revealed the facility was not aware the portable fire extinguishers had not been serviced properly, by their extinguisher service company.</p> <p>Observations, on 01/23/13 at 2:50 PM with the Maintenance Supervisor, revealed the wall mounted, portable fire extinguishers located at the boiler room, the kitchen area, and the resident smoking area were mounted above the maximum allowable height of five (5) feet above the finish floor.</p> <p>Interview, on 01/23/13 at 2:50 PM with the Maintenance Supervisor, revealed that he was unaware of the height limitations for wall mounted portable fire extinguishers and acknowledged that they were mounted above the height of five (5) feet above the finish floor.</p>	K 064	<ol style="list-style-type: none"> <li>The fire extinguishers in C-hall, C-utility, D sitting area, resident smoking area, dining room hall, both in the kitchen area, short D, front utility room, front office, and the boiler room received the 6-years maintenance service on 1/25/13 by Vanguard Service and Sales. The fire extinguishers in the boiler room, the kitchen area, and the resident smoking area were lowered to comply with the 5 foot maximum height on 2/1/13 by Maintenance staff.</li> <li>The 6 year maintenance-service was completed on all facility fire extinguishers on 1/25/13 by Vanguard Service and Sales. The Maintenance Director completed and documented an inspection on 2/14/13 of the center fire extinguishers to determine that they were mounted in accordance with NFPA standards.</li> <li>The Regional Property Manager re-educated the Maintenance Director on 2/15/13 regarding the maintenance of fire extinguishers in the center including the requirement of a 6 year maintenance-service and height limitations for wall mounted portable fire extinguishers. The 6-year fire extinguisher maintenance will be added to our automated maintenance scheduler by Maintenance Director by 2/22/13.</li> <li>The Maintenance Director will complete an inspection of the facility fire extinguishers quarterly x2 to determine that the 6 year maintenance service is completed and that fire extinguishers are mounted and maintained according to NFPA standards. A summary of findings will be submitted to The Safety Committee and the Performance Committee by the Maintenance Director monthly x6 months for further review and recommendations.</li> </ol>	3/11/13
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K 064	Continued From page 18  Reference: NFPA 10 (1998 ed.) Actual NFPA Standard: NFPA 10, 4-4.3*. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. The removal of agent from halon agent fire extinguishers shall only be done using a listed halon closed recovery system. When the applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall begin from that date. Exception: Non-rechargeable fire extinguishers shall not be hydrostatically tested but shall be removed from service at a maximum interval of 12 years from the date of manufacture. Non-rechargeable halon agent fire extinguishers shall be disposed of in accordance with 4-3.3.3. Actual NFPA Standard: NFPA 10, 4-4.4*. Each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed and that identifies the person performing the service. Actual NFPA Standard: NFPA 10, 4-4.4.1*. Fire extinguishers that pass the applicable 6-year requirement of 4-4.3 shall have the maintenance information recorded on a suitable metallic label or equally durable material having a minimum size of 2 in. by 3 1/2 in. (5.1 cm 8.9 cm). The new label shall be affixed to the shell by a heatless process, and any old maintenance labels shall be removed. These labels shall be of the self-destructive type when removal from a fire extinguisher is attempted. The label shall include the following information; (a) Month and year the maintenance was	K 064		

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K 064	<p>Continued From page 19</p> <p>performed, indicated by a perforation such as is done by a hand punch</p> <p>(b) Name or initials of person performing the maintenance and name of agency performing the maintenance</p> <p>Actual NFPA Standard: NFPA 10, 4-4.4.2*. Each extinguisher that has undergone maintenance that includes internal examination or that has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch.</p> <p>Exception No. 1: Fire extinguishers undergoing maintenance before January 1, 1999.</p> <p>Exception No. 2: Cartridge/cylinder-operated fire extinguishers do not require a "Verification of Service" collar.</p> <p>Reference NFPA 10 (1998 Edition).</p> <p>1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the</p>	K 064		
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K 064	Continued From page 20 bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:  (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.  (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.  (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.  (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays at an entrance, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of nine (9) smoke compartments, thirty-one (31) residents, staff and	K 066	1. Metal, self closing ashtrays has been installed in the front of C Wing on by Maintenance staff on 2/7/13. No smoking signage will be added in the back of C Wing by Maintenance staff on 2/19/13.  2. The Maintenance Director completed rounds of the center perimeter to determine that proper ashtrays are in place at all smoking areas on 2/7/13. No other concerns were identified.  3. The Maintenance Director was re-educated to the Smoking regulations in accordance with NFPA standards including the use of proper ashtrays and posting signage to designate approved smoking areas by the Administrator on 2/1/13. Nursing, dietary, therapy, housekeeping, and administrative staff will be re-educated with a completion date of 3/10/13 by the administrator to the smoking regulations and the requirement of proper ashtrays and the importance only smoking in the designated area.  4. The Maintenance Director will complete an audit of the facility perimeter and designated smoking areas to determine that approved ash trays are in place and that smoking occurs in designated smoking areas only in accordance with NFPA standards weekly x4 weeks and then monthly x5 months. Any concerns identified will be addressed at that time. The Maintenance Director will submit a summary of findings to the Safety Committee and the Performance Committee monthly x6 months for further review and recommendation.	3/11/13

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K 068	<p>Continued From page 21</p> <p>visitors. The facility is certified for One-Hundred Forty-Five (145) beds with a census of One-Hundred Thirty-Seven (137) on the day of the survey. The facility failed to ensure proper ashtrays were provided at all smoking areas.</p> <p>The findings include:</p> <p>Observation, on 01/23/13 at 1:15 PM with the Maintenance Supervisor, revealed the areas at the front of c-wing and the back of c-wing are being used as a smoking area due to all the cigarette butts on the ground and in the flower pot on the patio. The area did not provide an approved ashtray and is not listed as a smoking area at the facility.</p> <p>Interview, on 01/23/13 at 1:15 PM with the Maintenance Supervisor, revealed they were not aware of the requirements to make an area an approved area for smoking.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions; (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited</p>	K 066			

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K 066	Continued From page 22 and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066			
K 068 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure combustion air and ventilation for boilers, incinerators, and heater rooms were installed in accordance with NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, two (2) residents, staff and visitors. The facility is certified for One-Hundred Forty-Five (145) beds with a census of	K 068			

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NAME OF PROVIDER OR SUPPLIER  OWENSBORO PLACE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD. OWENSBORO, KY 42303	
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K 068	<p>Continued From page 23</p> <p>One-Hundred Thirty-Seven (137) on the day of the survey. The facility failed to ensure the two (2) rooms with fuel fired furnaces were properly vented.</p> <p>The findings include:</p> <p>Observation, on 01/23/12 at 3:40 PM with the Maintenance Supervisor, revealed the front utility room contained a fuel fired hot water heater that was not directly vented to the outside of the facility. Further observation revealed the front furnace room had a fuel fired unit with no ventilation to the outside of the facility.</p> <p>Interview, on 01/23/12 at 3:40 PM with the Maintenance Supervisor, revealed he was unaware the rooms were not properly vented.</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition)</p> <p>Section 19.5 Building Services</p> <p>19.5.2.2 Any heating device other than a central heating plant shall be designed and installed so that combustible material will not be ignited by the device or its appurtenances. If fuel-fired, such heating devices shall be chimney connected or vent connected, shall take air for combustion directly from the outside, and shall be designed and installed to provide for complete separation of the combustible system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure.</p>	K 068	<ol style="list-style-type: none"> <li>1. Additional ventilation will be added to the front utility room that is occupied by the hot water heater by Ernie Davis and Sons on 2/19/13. The ventilation will provide "make up" air both high and low as required. The front furnace room is occupied by a Trane XE 90 furnace with a 90% efficiency rating with ventilation for combustion provided through PVC piping. Ernie Davies and Sons, a licensed dealer, certified on 2/11/13 that the installation is correct for a furnace with a 90% efficiency rating.</li> <li>2. Maintenance staff will inspect and documented findings of rooms with hot water heaters and furnaces to determine that ventilation has not become blocked and there is adequate air flow for combustion and discharged to outside air on 2/20/13.</li> <li>3. The Maintenance Director was re-educated by the Regional Property Manager on 2/15/13 regarding the NFPA standard that combustion and ventilation air for boiler, incinerator, and heater rooms is taken from and discharged to the outside air.</li> <li>4. The Maintenance Director will inspect combustion and ventilation air for boiler, incinerator and heater rooms in the facility monthly x6 months. Any concerns identified will be addressed at that time. A summary of findings will be submitted to The Safety Committee and the Performance Committee monthly x6 months by the Maintenance Director for further review and recommendation.</li> </ol>	3/11/13

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K 070 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, all residents, staff and visitors. The facility is certified for One-Hundred Forty-Five (145) beds with a census of One-Hundred Thirty-Seven (137) on the day of the survey. The facility failed to ensure three (3) electric fireplaces were not in the facility.</p> <p>The findings include:</p> <p>Observation, on 01/23/13 at 2:56 PM with the Maintenance Supervisor, revealed electric fireplaces in the sitting areas of a-wing, a-wing, and c-wing.</p> <p>Interview, on 01/23/13 at 2:56 PM with the Maintenance Supervisor, revealed he was not aware the fireplaces were not allowed in a healthcare occupancy.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating</p>	K 070	<ol style="list-style-type: none"> <li>The heating elements in the facility decorative fireplaces have been permanently disabled by Maintenance staff on 2/18/13.</li> <li>The Maintenance Director completed and documented rounds of the center to determine that no portable space heating devices are present in the center on 2/18/13. No other concerns identified.</li> <li>The Maintenance Director was re-educated to the NFPA standard regarding the prohibition of portable space heating devices in the center by the Regional Property Manager on 2/15/13. Maintenance staff will inspect the decorative fireplaces monthly to assure that they remain in safe operating condition. If an unsafe condition is identified, it will be corrected immediately or the fireplace will be removed.</li> <li>The Maintenance Director will complete and document rounds of the facility to determine that portable space heating devices are not in use in the center weekly x4 weeks and then monthly x5 months. Any concerns identified will be addressed at that time. A summary of findings will be submitted by the Maintenance Director to The Safety Committee and the Performance Committee monthly x6 months for further review and recommendation.</li> </ol>	3/11/13

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K 070	Continued From page 25 devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).	K 070		
K 076 SS=D	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  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, thirty-two (32) residents, staff and visitors. The facility is certified for One-Hundred Forty-Five (145) beds with a census of One-Hundred Thirty-Seven (137) on the day of the survey. The facility failed to ensure oxygen storage over 300	K 076	1. The cabinets in the oxygen storage room made of combustible materials will be replaced with metal cabinets by 3/10/13 by Maintenance and Supply staff. The oxygen storage room was rearranged to provide at least 5 feet of space between the cabinets and any oxygen tanks by Maintenance staff on 2/18/13. The electrical outlets in the oxygen storage room located below 5 feet off the floor will be removed and the wiring capped by 2/22/13 by Maintenance staff and solid covers place on the outlet boxes. The light switches in the oxygen storage room will be bypassed with solid covers placed on the electrical boxes and only the switches on the wall light fixtures will be used by 2/22/13 by Maintenance staff.  2. The Maintenance Director will complete an inspection of the oxygen storage room to determine that this storage area is protected in accordance with NFPA standards including the presence of ignition sources not located over 5 feet from the floor or combustible items stored within 5 feet on 2/22/13.	3/11/13

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K 076	<p>Continued From page 26</p> <p>cu ft. was stored 5 feet away from any combustibles and ignition sources located five (5) feet from the floor.</p> <p>The findings include:</p> <p>Observation, on 01/24/13 at 9:30 AM with the Maintenance Supervisor, revealed nineteen (19) oxygen tanks in the oxygen storage room. The oxygen tanks were being stored within five (5) feet of combustible items and ignition sources were not located over five (5) feet from the floor.</p> <p>Interview, on 01/24/13 at 9:30 AM with the Maintenance Supervisor, revealed he was unaware oxygen tanks could not be stored within five (5) feet of combustible materials once the storage equals over 300 cubic feet in a smoke compartment.</p> <p>Reference: NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire</p>	K 076	<p>3. The Maintenance Director was re-educated by the Regional Property Manager on 2/15/13 regarding the NFPA standard regarding oxygen storage including that oxygen tanks cannot be stored within five feet of combustible materials and ignition sources are not located over 5 feet from the floor. Nursing, therapy, housekeeping, and administrative staff will be re-educated regarding proper storage of oxygen and respiratory supplies by the Administrator and completed by 3/10/13. Education will also be provided to representative(s) of our respiratory supply vendor related to the requirements of oxygen storage in accordance with NFPA standards by the Assistant Director of Nursing on 2/20/13.</p> <p>4. The Maintenance Director will inspect and document the oxygen storage area to determine that combustible items are stored at greater than 5 feet from the oxygen tanks and that ignition sources are not located over 5 feet from the floor 5 x per week x 4 weeks and then weekly 20 weeks. Any concerns identified will be addressed at that time. The Maintenance Director will submit a summary of findings to the facility Safety Committee and Performance Improvement Committee monthly x6 months for further review and recommendation.</p>	
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NAME OF PROVIDER OR SUPPLIER  OWENSBORO PLACE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD. OWENSBORO, KY 42303		
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K 076	Continued From page 27 storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.	K 076			
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144			

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K 144	<p>Continued From page 28</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the emergency generator was maintained in accordance with NFPA standards. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, all residents, staff and visitors. The facility is certified for One-Hundred Forty-Five (145) beds with a census of One-Hundred Thirty-Seven (137) on the day of the survey. The facility failed to ensure the generator battery charger was not hooked directly to the battery.</p> <p>The findings include:</p> <p>Observation, on 01/23/13 at 2:27 PM with the Maintenance Supervisor, revealed the generator's battery charger was hooked directly to the generator battery.</p> <p>Interview, on 01/23/13 at 2:27 PM with the Maintenance Supervisor, revealed he was not aware that the battery charger could not be hooked directly to the battery.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers' recommendations and accepted engineering practices.</p>	K 144	<ol style="list-style-type: none"> <li>1. The charger was replaced on 1/24/13 by the Wayne Supply technician and is not connected directly to the battery.</li> <li>2. The Maintenance Director further inspected and documented the emergency generator to determine that it is maintained in accordance with NFPA standards on 1/28/13. No other concerns identified.</li> <li>3. The Maintenance Director was re-educated by the Regional Property Manager on 2/15/13 regarding the Maintenance of emergency generators in accordance with NFPA standards including that the generator battery charger can not be hooked directly to the battery. Generator inspections will be done weekly ongoing. Any issues with proper operation will be addressed at that time.</li> <li>4. The Maintenance Director will complete and document an inspection of the emergency generator weekly to determine that emergency generators are maintained in accordance with NFPA standards including the proper use of the batter charger. Any concerns identified will be addressed at that time. The Maintenance Director will submit a summary of findings to The Safety Committee and the Performance Committee monthly x6 months for further review and recommendation.</li> </ol>	3/11/13

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K 144	Continued From page 29 Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.	K 144		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, all residents, staff and visitors. The facility is certified for One-Hundred Forty-Five (145) beds with a census of One-Hundred Thirty-Seven (137) on the day of the survey. The facility failed to ensure electrical panels maintained three (3) feet of clearance around them.  The findings include:  Observations, on 01/23/13 at 2:42 PM with the Maintenance Supervisor, revealed the electrical panel in the dry storage area of the kitchen and the d-wing utility room had storage within 3 feet of the electrical panels.  Interview, on 01/23/13 at 2:42 PM with the Maintenance Supervisor, revealed he was aware there could not be storage within 3 feet of electrical panels but was unaware the items were being stored improperly.	K 147	1. The items placed in front of the electrical panel in the dry storage area of the kitchen were removed on 1/23/13 by kitchen staff. The items in the D-wing utility room were removed by Maintenance staff on 2/12/13.  2. The Maintenance Director completed and documented and inspection on 2/14/13 of the center electrical wiring panels to determine that it was maintained in accordance to NFPA standards including that electrical panels must not have storage within 3 feet of clearance around them. No other concerns were identified.  3. The nursing, dietary, therapy, housekeeping, and administrative staff will be re-educated to the NFPA standard of maintaining electrical wiring including the requirement that storage must not be within 3 feet of clearance of the electric panels with a completion date by 3/10/13 by the Administrator.  4. The Maintenance staff and the Housekeeping Supervisor will inspect all areas where electrical panels are located each week for 3 months and then monthly x3 months. Any concerns identified will be addressed at that time. A summary of findings will be submitted by the Maintenance Director to the Safety Committee and the Performance Committee monthly x6 months for further review and recommendation.	3/10/13

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K 147	<p>Continued From page 30</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>110-26. Spaces</p> <p>10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> <p>(A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code.</p> <p>(1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.</p> <p>Table 110.26(A)(1) Working Spaces</p> <table border="1"> <thead> <tr> <th>Nominal Voltage to Ground</th> <th colspan="3">Minimum Clear Distance</th> </tr> <tr> <th>Condition 1</th> <th>Condition 2</th> <th colspan="2">Condition 3</th> </tr> </thead> <tbody> <tr> <td>0-150</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> </tr> <tr> <td>151-600</td> <td>900 mm (3 ft)</td> <td colspan="2">1 m (3½ ft)</td> </tr> <tr> <td></td> <td></td> <td colspan="2">1.2 m (4 ft)</td> </tr> </tbody> </table> <p>Note: Where the conditions are as follows: Condition 1 - Exposed live parts on one side and</p>	Nominal Voltage to Ground	Minimum Clear Distance			Condition 1	Condition 2	Condition 3		0-150	900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	151-600	900 mm (3 ft)	1 m (3½ ft)				1.2 m (4 ft)		K 147		
Nominal Voltage to Ground	Minimum Clear Distance																							
Condition 1	Condition 2	Condition 3																						
0-150	900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)																					
151-600	900 mm (3 ft)	1 m (3½ ft)																						
		1.2 m (4 ft)																						

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NAME OF PROVIDER OR SUPPLIER  OWENSBORO PLACE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD, OWENSBORO, KY 42303	
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K 147	<p>Continued From page 31</p> <p>no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts.</p> <p>Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as grounded.</p> <p>Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between.</p> <p>(a) Dead-Front Assemblies. Working space shall not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other than the back or sides. Where rear access is required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided.</p> <p>(b) Low Voltage. By special permission, smaller working spaces shall be permitted where all uninsulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc.</p> <p>(c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service</p>	K 147		

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185236	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0101 B. WING _____	(X3) DATE SURVEY COMPLETED  01/24/2013
NAME OF PROVIDER OR SUPPLIER  OWENSBORO PLACE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD. OWENSBORO, KY 42363	
(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 147	Continued From page 32 the installation. (2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. (3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or platform to the height required by 110.26(E). Within the height requirements of this section, other equipment that is associated with the electrical installation and is located above or below the electrical equipment shall be permitted to extend not more than 150 mm (6 in.) beyond the front of the electrical equipment. (B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded. (C) Entrance to Working Space. (1) Minimum Required. At least one entrance of sufficient area shall be provided to give access to working space about electrical equipment. (2) Large Equipment. For equipment rated 1200 amperes or more and over 1.8 m (6 ft) wide that contains overcurrent devices, switching devices, or control devices, there shall be one entrance to the required working space not less than 610 mm (24 in.) wide and 2.0 m (6½ ft) high at each end of the working space. Where the entrance has a personnel door(s), the door(s) shall open in the direction of egress and be equipped with panic bars, pressure plates, or other devices that are normally latched but open under simple pressure. A single entrance to the required working space	K 147		

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NAME OF PROVIDER OR SUPPLIER  OWENSBORO PLACE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 LEITCHFIELD RD. OWENSBORO, KY 42303		
(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 147	Continued From page 33 shall be permitted where either of the conditions in 110.26(C)(2)(a) or (b) is met (a) Unobstructed Exit. Where the location permits a continuous and unobstructed way of exit travel, a single entrance to the working space shall be permitted. (b) Extra Working Space. Where the depth of the working space is twice that required by 110.26(A)(1), a single entrance shall be permitted. It shall be located so that the distance from the equipment to the nearest edge of the entrance is not less than the minimum clear distance specified in Table 110.26(A)(1) for equipment operating at that voltage and in that condition. (D) Illumination. Illumination shall be provided for all working spaces about service equipment, switchboards, panelboards, or motor control centers installed indoors. Additional lighting outlets shall not be required where the work space is illuminated by an adjacent light source or as permitted by 210.70(A)(1), Exception No. 1, for switched receptacles. In electrical equipment rooms, the illumination shall not be controlled by automatic means only.	K 147			