

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

PRINTED: 12/17/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185409	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/05/2013
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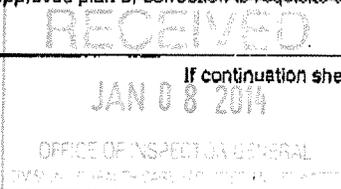
NAME OF PROVIDER OR SUPPLIER  CRESTVIEW CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065
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<p>F 000</p> <p>F 248 SS=D</p>	<p>INITIAL COMMENTS</p> <p>A standard recertification survey was conducted 12/03/13 through 12/05/13 and a Life Safety Code survey was conducted on 12/03/13. Deficiencies were cited with the highest scope and severity of an "F".</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy Activity Assessment and Documentation, it was determined the facility failed to provide activities based on the comprehensive assessment and interest of one (1) of fifteen (15) sampled residents (Resident #1).</p> <p>The findings include: Review of the facility's policy regarding Activity Assessment and Documentation, dated April 2010, revealed each resident would be assessed for physical, mental, spiritual, psychosocial, and leisure interests, as well as preferences for engagement in activities based on past and present patterns and interests.</p> <p>The facility did not provide a policy as to how it would meet the assessed activity needs and</p>	<p>F 000</p> <p>F 248</p>	<p><b>Plan of Correction</b> <b>Disclaimer for</b> <b>Crestview Center</b> Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because of State and Federal requirement.</p> <p>F248 (1) A list was composed by the Activity Director on 12/20/13 of the current resident activity preferences based on the resident's most recent Activity assessment and was posted at each nurses station. Resident #1 was reassessed by the Activity Director on 12/19/13 and added to the Activity list to communicate to staff the Activity preferences, including Bible study and other spiritual services/programs and assist to activities by nursing and/or activity staff. (2) Current resident's activity preferences were reviewed on 12/26/13 by the Activity Director to determine preferred activities. A resident activity preference list was posted at each nurses' station</p>	<p>1/6/14</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X8) DATE: 12/27/13

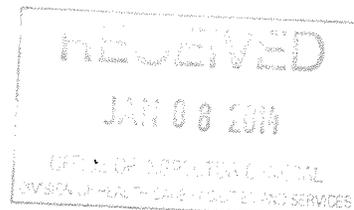
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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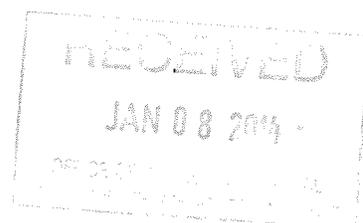
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F 248	<p>Continued From page 1 preferences.</p> <p>Review of the medical record for Resident #1 revealed the facility admitted the resident on 01/23/13. The facility assessed the resident utilizing the Minimum Data Set (MDS), on 09/16/13, as having a Brief Interview for Mental Status (BIMS) score of 3 which indicated severe cognitive impairment. Review of the Activity/Recreation Assessment, dated 09/19/13, revealed Resident #1 preferred to be involved in spiritual services/programs. Review of the comprehensive plan of care revealed the resident would be assisted and encouraged to listen to gospel music.</p> <p>Observation of Resident #1, on 12/04/13 at 10:07 AM, revealed Resident #1 was sitting in a wheelchair, parked in the 100 living room with head down and staring at the floor. The resident occasionally looked up at television. Christmas carols and trumpet music could be heard coming from the Bible study activity in the main dining room. The resident looked up and around when singing started, then again looked back down at the floor.</p> <p>Observations of Resident #1, on 12/04/13 at 10:24 AM, 10:48 AM, 11:00 AM, 11:30 AM, 1:02 PM, and 3:05 PM, reveal the resident was still sitting in the living room, not engaged in any activity.</p> <p>Interview with Resident #1's family member, on 12/05/13 at 11:01 AM, revealed the resident was very active in the church and often provided food for the church pot lucks. The family member stated the resident attended church regularly and appeared to still enjoy church services. The</p>	F 248	<p>on 12/26/13 by the Activity Director to communicate to nursing staff the residents' activity preferences for activity participation and assistance of resident to activities.</p> <p>(3) The Activity Director will identify residents based on their most recent activity assessment /preferences for each activity provided and those residents will be offered to attend the particular activity. The Activity Director will maintain a list of residents who have a preference for each activity in order for staff to encourage/assist residents to the activity. The Activity Director was re-educated on 12/19/13 by the Administrator regarding the facility activity policy and included that a list of residents activity preferences will be posted and maintained at each nursing unit and updated with changes by the Activity Director. The Director of Nursing will re-educated licensed nurses, nursing assistants and activity staff by 1/6/14 to the facility activities program and the posting of the list of resident activity preferences, the need to assist residents to those activities as indicated on the list and staff responsibilities during activities.</p>	



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F 248	<p>Continued From page 2</p> <p>family member relayed he/she used to see the resident in Bible studies, but noted as of late, the resident was not in attendance and did not know why the facility did not take the resident to participate in the activity.</p> <p>Review of the Residents Program Participation Record revealed the resident did not attend any religious activities in the month of November or December 2013.</p> <p>Interview with Certified Nursing Assistant (CNA) #6, on 12/05/13 at 12:50 PM, revealed they were not given a list as to which residents should attend which activity. The CNA revealed staff pretty much knew who to take to certain activities. The CNA revealed she did not transport the resident to the Bible study because she thought the resident was busy doing something else.</p> <p>Interview with the Activities Director, on 12/05/13 at 12:55 PM, revealed the resident liked to read, work puzzles, and did actively listen to anyone reading in a group activity. The Activities Director stated the living room was to be a quiet area and activities were no longer held in the space. The Activities Director indicated about a month ago the facility started to hold all group activities in the dining room to ensure the living room was kept a quiet space. However, the Activities Director felt this change had made it very difficult and felt a lot of residents were being left out and she had noticed a decline in attendance from residents who were cognitively impaired. The Activities Director further stated cognitively impaired residents tend to be in the Living Room area, so when activities were held in there, they were automatically included and could participate. The Activities Director felt it was out of habit that the</p>	F 248	<p>(4) The Activity Director will submit the activity attendance roster and the resident activity preference list to the Administrator weekly for twelve weeks, then monthly for three months. The administrator will review the activity attendance record and the activity preference list to determine residents are attending preferred activities. Any concerns identified will be corrected at this time. A summary of the findings will be submitted to the PI Committee by the Activity Director monthly for six months for further review and recommendations.</p> <p>(5) Date of Compliance: 1/06/14</p>	



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F 248	Continued From page 3 residents were placed in the living room and not brought down to the dining room. The Activities Director also indicated she did not provide the nursing staff with a list of residents or verbally tell the staff which residents to bring over to activities.	F 248		
F 279 SS=D	Interview with the Administrator, on 12/05/13 at 1:47 PM, revealed the purpose of activities was to provide stimulation, provide something for residents to do, and enhance the residents quality of life. The administrator stated small group activities at the facility are not as stimulating and had been held in the living room. The Administrator further stated he did observe activities, but was not aware of a decline in activity attendance since moving them to the dining room.  483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279	F279  (1) A Care Plan conference was held by Social Services Director on 12/11/13 with resident #2 and family to discuss alternate care regarding an electric wheelchair. The resident and family voiced satisfaction with the plan of care.  (2) The Social Services Director, Director of Nursing and Unit Manager completed an audit of Care Plan meeting notes to determine that residents were given an opportunity to participate in care plan decisions on 12/26/13. Any issues identified were addressed at that time.	1/6/14

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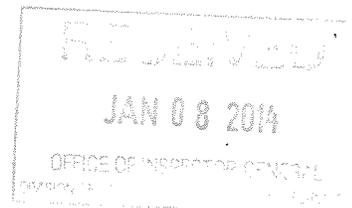
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F 279	<p>Continued From page 4 §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure an opportunity to explore and participate in alternative care was provided during the care plan conference of one (1) of fifteen (15) sampled residents. The facility removed Resident #2's electric wheelchair (w/c) from use.</p> <p>The findings include:</p> <p>Review of the facility's policy, Care Plan, revised 12/15/10, revealed the purpose was to guide therapeutic interventions to meet the resident's needs and achieve expected outcomes. The facility would promote participation of the resident in planning care. The standards of practice were to ensure the resident's care plan were updated, if unable to attend, and document in the resident's progress notes.</p> <p>Review of the facility's Admission Packet, page 13, Rights Related to Your Care, revealed the resident had the right to be fully informed in advance about care and treatment, and about any changes in treatment that may affect the well-being; and the right to participate in the care and treatment plan.</p> <p>Review of Resident #2's clinical record revealed the facility re-admitted the resident on 10/21/13 after an acute hospital stay, with a diagnosis of a right Below the Knee Amputation (BKA) in 2007. The record revealed the resident used an electric</p>	F 279	<p>(3) The Interdisciplinary Team to include Nurse Practice Educator, Social Services Director, Activity Director, Director of Food and Nutrition and the MDS Nurse were re-educated on 12/26/13 by the Director of Nursing including giving the resident the opportunity to explore and participate in alternative care during the care plan conference.</p> <p>(4) The Administrator will audit social services and care plan notes for 3 residents with care plan conferences held weekly for twelve weeks, then monthly for three months to determine changes in the residents care are communicated to the resident and the residents' responsible party and that the resident is given the opportunity to participate in the plan of care. Any concerns identified will be addressed at that time. A summary of the audits will be submitted to the PI Committee monthly for six months by the Administrator for further review and recommendations.</p> <p>(5) Date of Compliance: 1/06/14</p>	
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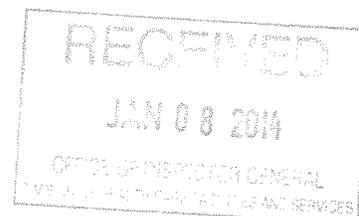
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F 279	<p>Continued From page 5 wheelchair for locomotion. The facility utilized, the Minimum Data Set (MDS) on 10/28/13, to assess the resident's Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident was cognitively intact. Review of the Mood and Behavior section of the MDS revealed the resident had no Mood or Behaviors. The facility assessed the resident's functional status as independent with locomotion on and off the unit. Review of the resident care plan conference notes revealed the resident was in attendance. Further review of the care conference notes dated 02/02/13, 08/07/13 and 09/27/13 revealed no evidence the facility was concerned with the resident's use of the electric wheelchair, safety or the resident's behavior. Review of the care conference note, dated 11/04/13 revealed the facility had made an administrative decision based on Resident #2 and Resident #6's safety, to discontinue the use of the motorized w/c. Review of the resident's event reports, dated 01/09/13 thru 11/04/13, revealed on 03/01/13 the resident fell from the electric w/c. The facility assessed the root cause as intrinsic due to a syncopal episode. Continued review of the resident's event report revealed, on 07/08/13, the resident was assessed with a skin tear when the resident's foot slid off the foot rest of the electric w/c, the facility determined no contributing factors with the intervention of a Velcro strap implemented to hold the resident's foot in place. Further review of the event reports for Resident #2, from 01/09/13-11/04/13, revealed the facility had no investigative reports of the resident's electric w/c safety concerns. The record revealed the resident was involved in activities, resident council and independent with the use of the electric w/c throughout the facility.</p>	F 279		
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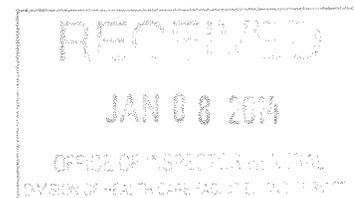
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F 279	<p>Continued From page 6</p> <p>Interview with Resident #2, on 11/03/13 at 9:45 AM, revealed the resident had been in the electric w/c since admission. The resident said the electric w/c was the only means to maintain his/her independent mobility. The resident indicated being involved in many activities throughout the facility and the resident was involved in his/her care plan conferences. The resident stated the facility hadn't discussed safety or possible discontinuation of the electric w/c during any care plan conferences. The conference held on 11/04/13 informed him/her the electric w/c would be discontinued. The resident indicated the facility would have the hallway cluttered at times which made it difficult to navigate the electric w/c. The resident relayed the facility would not discuss opportunities to afford him/her the ability to remain independent with the electric w/c. The resident felt depressed and would leave this facility for another facility if he/she could.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 11/03/13 at 3:40 PM, revealed Resident #2 was active and independent in the electric w/c. She revealed no concerns with the resident's safe use of the electric w/c.</p> <p>Review of an Occupational Therapy (OT) Evaluation, dated 10/17/21-10/21/13, revealed the resident was independent with the electric w/c. Review of the OT progress notes, dated 10/22/13-11/4/13, revealed the resident was assessed as being independent with the electric w/c. Further review of the record revealed OT cancelled the electric w/c assessment due to an administrative decision to discontinue the resident's use of it. The record revealed that OT</p>	F 279		
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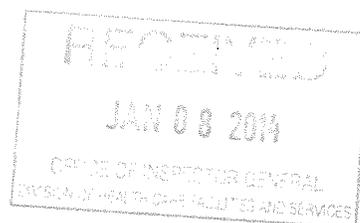
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F 279	<p>Continued From page 7</p> <p>felt the consequences to discontinuing the electric w/c was a decrease in overall quality of life and risk of a functional decline.</p> <p>Interview with the Occupational Therapist (OT), on 11/04/13 at 4:20 PM, revealed the resident was evaluated for generalized weakness after a recent hospitalization. She revealed the goal was the resident would operate the electric w/c with safe technique. She revealed the electric w/c evaluation was cancelled due to the facility's decision related to safety. The OT revealed the resident would be able to maneuver the manual w/c for short distance and the loss of the electric w/c would have a negative affect on the resident's quality of life.</p> <p>Interview with the Social Worker (SW), on 12/04/13 at 4:40 PM, revealed the resident regularly attended care plan conference. The SW the resident's safety, behavior or use of the electric w/c were not care planned because the facility had not identified it as a concern. She further stated the facility had not involved the resident in the removal of the electric w/c, because the electric w/c was not identified as a concern.</p>	F 279		
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</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>	F 323	<p>F323</p> <p>(1) The incident involving resident's #2 and #6 was investigated on 12/19/13 and a root cause was determined by the Director of Nursing and the care plan was updated.</p>	1/7/14



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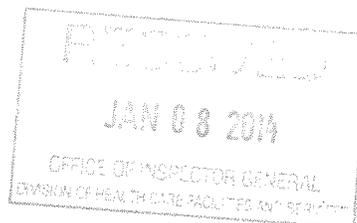
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F 323	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, and review of the facility's policy, it was determined the facility failed to investigate the root cause of a resident to resident incident for two (2) of fifteen (15) sampled residents to prevent accidents/incidents (Residents #2 and #6). On 10/30/13, Resident #2 was in an electric wheelchair (w/c) and Resident #6 was in the hallway when the Resident #6's right (rt) foot was injured.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Accidents, Incidents, and Adverse Events, revised 0/01/13, revealed the facility would review, report and investigate all resident to resident accident/incidents. The incident could involve an observation of a situation that posed a threat to safety. The policy continued to reveal a patient to patient incident would require the investigation be initiated immediately by the Administrator, Director of Nursing, Charge Nurse or Supervisor.</p> <p>Review of Resident #6's clinical record revealed the facility admitted the resident on 12/27/10, with diagnoses of Alzheimer Disease and Dementia. The facility utilized, The Minimum Data Set (MDS) on 11/15/13, to assess the resident's Brief Interview for Mental Status (BIMS) score of three (3) which indicated the resident had a severe cognitive impairment. Review of the MDS functional section revealed the resident required total care with the activities of daily living (ADL). Review of the nurse's note dated, 10/30/13 at 10:30 AM, revealed the resident's right foot was</p>	F 323	<p>(2) The Director of Nursing and the Nurse Practice Educator reviewed the 24 hour report book on 12/20/13 for the past 60 days for incidents and compared with Event reports to determine if any other incidents had not been investigated. No other residents were identified.</p> <p>(3) The Director of Nursing and the Nurse Practice Educator were re-educated on 12/27/13 by the Manager of Clinical Operations to facility Incident/Accident policy and documentation/investigation required when an incident occurs. Nursing staff will be re-educated by the Nurse Practice Educator on Incident/Accident reporting and the documentation and investigation required when an event occurs by 1/6/14.</p> <p>(4) The Director of Nursing and/or the Nurse Practice Educator will complete an audit of the 24 hour report book and the incident/accident reports weekly for twelve weeks, then monthly for three months to determine incidents/accidents are investigated. Any concerns will be addressed at that time. A summary of the findings will be</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185409	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/05/2013
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NAME OF PROVIDER OR SUPPLIER  CRESTVIEW CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 323	<p>Continued From page 9</p> <p>injured by Resident #2's electric w/c. The nurse's note revealed the incident was reported to the Director of Nursing (DON), that the resident's right toes (digit 1, 2, and 3) were injured.</p> <p>Interview with Registered Nurse (RN) #2, on 12/03/13 at 2:20 PM, revealed she was the nurse who cared for both residents' the day of the incident. She had not witnessed the resident to resident incident, but did hear Resident #6 yell out. She stated Resident #2 had at times exhibited verbal behaviors toward other residents. Continued interview revealed the DON was notified of the incident. She stated the DON was responsible for accident/incident investigation.</p> <p>Interview in the Social Worker's office with the Assistant Director of Nursing (ADON), on 12/04/13 at 4:30 PM, revealed any accident/incident that occurred to a resident outside of the normal care and services should be investigated. She stated the interdisciplinary Team (IDT), Unit Manager or DON were responsible for the investigation. The UM stated the root cause of the incident was determined by Resident #2's history of reckless use of the electric w/c and behaviors. She revealed the facility had not assessed, care planned or had any evidence of the resident's careless use of the electric w/c. She revealed the IDT was not involved in the investigation.</p> <p>Interview in the Social Worker's office with the Social Worker, on 12/4/13 at 4:40 PM, in the presence of the ADON revealed she was unaware of Resident #2's careless use of the electric w/c or verbal behavior to other residents until the resident to resident incident occurred.</p>	F 323	<p>submitted to the PI Committee by the Director of Nursing for six months for further review and recommendations.</p> <p>(5) Date of Compliance: 1/07/14</p>	
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F 323	<p>Continued From page 10</p> <p>Review of the Event Reports for Resident #2, dated 01/09/13 thru 11/04/13, revealed on 03/01/13 the resident fell from electric w/c, the facility assessed the root cause as intrinsic due to a syncopal episode. Review of the event report, dated 07/08/13, revealed the resident was assessed with a skin tear when the resident's foot slid off the foot rest of the electric w/c, the facility assessed no contributing factors and added an intervention of a Velcro strap to hold the resident's foot. The facility had no evidence an investigation was completed regarding the resident to resident incident that occurred on 10/30/13.</p> <p>Interview with the DON, on 12/04/13 at 5:30 PM, revealed a resident to resident incident was anything that occurred out of the normal care and services. She had knowledge of the accident/incident, but did not initiate an investigation. The DON stated an accident/incident investigation was not initiated because Resident #2 had no injury. She continued to state the root cause was assumed to be Resident #2's careless use of the electric w/c. She indicated the purpose of an accident/incident investigation was to establish the root cause and implement interventions to prevent further incidents. The DON had no evidence that established Resident #2's careless use of the electric w/c was the root cause of the accident/incident.</p> <p>Interview with Administrator, on 12/04/13 at 5:50 PM, revealed he was aware of the incident between Resident #2 and Resident #6. He stated the IDT determined through the investigation the root cause of the incident was Resident #2's inattentiveness to surroundings while operating</p>	F 323		
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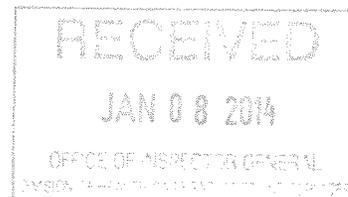
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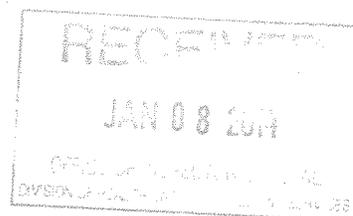
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F 323	Continued From page 11 the electric w/c. The administrator was unaware the incident had not been investigated to determine the root cause.	F 323		
F 363 SS=E	<p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED</p> <p>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to ensure the correct scoops were utilized to measure the servings for six (6) of ten (10) therapeutic diets served.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Menu Standards, revision date 10/06/13, revealed the policy was to ensure nutritional adequacy, regulatory compliance, operational efficiencies and resident quality of life.</p> <p>Review of the Menu Guide Report for 12/03/13 revealed the Dysphagia advanced marinated vegetable salad was to be dispensed at 1/2 cup and the Dysphagia pureed zesty cucumber salad was to be dispensed at 1/2 cup. The Dysphagia pureed zesty cucumber salad specified a #10 scoop.</p>	F 363	<p>F363</p> <ol style="list-style-type: none"> <li>(1) The cook immediately changed to the appropriate scoop on 12/03/13 and continued serving with the appropriate size scoop sizes.</li> <li>(2) An audit was completed on 12/27/13 by the Unit Mgr. to determine if any resident had gastrointestinal concerns associated with food quantity consumed. No resident was identified.</li> <li>(3) Dietary staff will be re-educated on using proper scoop sizes by the Registered Dietitian by 1/05/14.</li> <li>(4) The Registered Dietitian will monitor proper scoop size usage two times weekly for two weeks, weekly times six weeks then monthly for four months. Audit results will be submitted by the Registered Dietitian to the PI committee monthly for six months for further review and recommendations.</li> <li>(5) Date of Compliance: 1/06/14</li> </ol>	1/6/14



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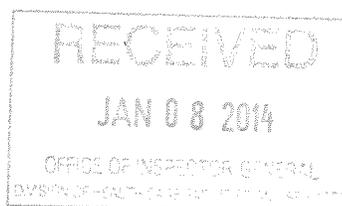
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F 363	Continued From page 12 Review of Food and Nutrition Services Scoop Sizes revealed a #10 scoop measured 3/8 cup with a three (3) ounce volume and was to be used for meat patties. The #12 scoop measured 1/3 cup with a volume of 2-3/4 ounces to be used with salads. The #6 scoop measured 2/3 cup and was to be used with lunch-type salads. The #8 scoop measured 1/2 cup with a four (4) ounce volume to be used with casseroles, potatoes, vegetables, pudding, etc.  Observation during the supper tray line, on 12/03/13 at 5:55 PM, revealed four (4) servings of the dysphagia advanced marinated vegetable salad and two (2) servings of the dysphagia pureed zesty cucumber were served with ladles that were not designated as a scoop and not labeled as to the size, ounces or volume being dispensed.  Interview with Dietary Staff #1, on 12/03/13 at 5:55 PM, revealed the ladle used did not match the menu guide. She reported the guide was used to ensure the correct amount was served to the residents. She reported the ladle size should have been checked with the menu guide to ensure the correct ladle was used during meal service. She stated she was to ensure the residents received the correct serving sizes.	F 363			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431	F431 (1) Registered Nurse #4 was re-educated by Director of Nursing on 12/26/13 on the facility policy regarding Storage and Expiration of Medication, Biologicals, Syringes and Needles to include only authorized facility	1/7/14	



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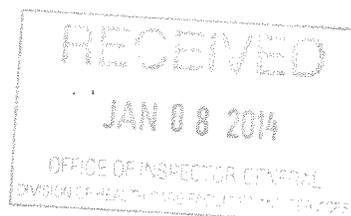
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F 431	<p>Continued From page 13</p> <p>controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to ensure one (1) of two (2) medications rooms were accessed by authorized staff only. The authorized staff allowed housekeeping staff access to the medication room unattended.</p> <p>The findings include:</p>	F 431	<p>staff have possession of opened medication storage areas. A review of the medication room was conducted by the Unit Mgr. on 12/03/13 and no missing medications or biologicals were identified.</p> <p>(2) An audit was completed by The Director of Nursing, Nurse Practice Educator and the Unit Mgr. on 12/26/13 of current residents' Medication Administration Record and medication supply to determine that medications and biological are accounted for. No concerns were identified.</p> <p>(3) The Licensed Nurses and Housekeeping staff will be re-educated by the Nurse Practice Educator to ensure that the medication room is to remain locked and not left unattended including while being cleaned by unauthorized staff by 01/06/14.</p> <p>(4) The Director of Nursing will audit the cleaning of the medication rooms weekly for four weeks, every two weeks for one month then monthly for four months to determine that the medication rooms are accessed by authorized personnel only and not left unattended when unauthorized staff are present. Results from the</p>	



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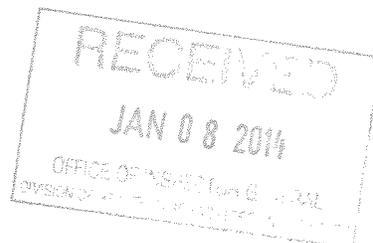
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F 431	<p>Continued From page 14</p> <p>Review of the facility's policy regarding Storage and Expiration of Medications, Biologicals, Syringes and Needles, dated 05/01/10, revealed the facility should ensure only authorized facility staff have possession of open medication storage areas.</p> <p>Observation of the Front Hall medication room, on 12/04/13 at 9:50 AM, revealed the Intravenous (IV) E (Emergency) Kit was unlocked and contained IV fluids and IV medications.</p> <p>Observation of the Front Hall medication room, while standing in front of the nurses station near the 100 Hall, on 12/04/13 at 1:25 PM, revealed the medication room door was propped open with a staff member moving items on the floor and cleaning the floor.</p> <p>Interview with Registered Nurse (RN) #1, on 12/04/13 at 1:25 PM, identified the staff member as a housekeeping staff cleaning the medication room. She reported she did not provide access to the medication room for the housekeeping staff.</p> <p>Observation and interview of RN #4, upon return to the nurses station, on 12/04/13 at 1:40 PM, revealed she provided access to the medication room for housekeeping to clean the medication room. She stated, the medications were locked up and there was not any medications accessible in the room. Upon review of the IV E-box, she stated there was IV fluids with the medication, Potassium Chloride in the fluids. She reported the box did contain medications.</p> <p>Interview with the Director of Nursing, on 12/05/13 at 2:39 PM, revealed the medication</p>	F 431	<p>Medication Room audit will be submitted to the PI Committee by the Director of Nursing for six months for further review and recommendation.</p> <p>(5) Date of Compliance: 1/07/14</p>	



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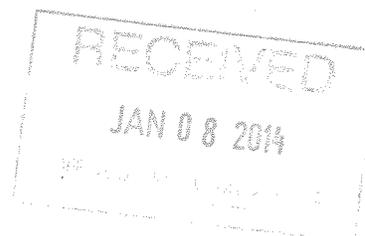
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F 431	Continued From page 15 room should not be left unlocked, and unattended with housekeeping in the medication room. She reported the nurses had the keys and should remain in the room for supervision of the area.	F 431		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to provide an emergency call light system in one (1) of one (1) unlocked bathrooms, identified as the visitor bathroom. The visitor bathroom located on the resident unit remained unlocked and resident accessible.  The findings include:  Review of the facility's policy, identified as 2.1 Call Lights, revised 10/01/12, revealed all residents would have a call light device within their reach at all times when unattended to ensure safety and communication between staff and residents.  Observation of the bathroom, identified as the visitor bathroom, on 12/03/13 at 8:50 AM and 12/04/13 at 10:49 AM revealed the bathroom door ajar and accessible. The bathroom did not have an emergency call light.	F 463	F463 (1) An emergency call light was immediately placed in the visitor bathroom across from the front reception office by the Maintenance Director on 12/5/13. (2) The Maintenance Director visually checked all visitor/resident bathrooms on 12/05/13 to determine there was an emergency call light in place. No resident bathrooms were identified as missing emergency call lights. (3) The Maintenance Director was re-educated by the Administrator to the resident call light system including from toilet and bathroom facilities on 12/20/13. (4) The Maintenance Director will complete an audit of the resident call light system to determine that resident and visitor bathrooms are equipped with an emergency call light monthly for six months. A summary of the findings will be submitted to the PI Committee by the Maintenance Director monthly for six months for further review and recommendations. (5) Date of Compliance: 1/06/14	1/6/14



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F 463	Continued From page 16 Observation, on 12/05/13 at 9:10 AM, revealed Unsamped Resident A was observed to exit the visitors bathroom across from the reception area. Resident A was using a walker as he/she came out of the bathroom. Resident A stated, " I did not know which bathroom to go to."  Interview with the Administrator, on 12/05/13 at 11:20 AM, revealed the bathroom remained unlocked after the slide locks were removed from the doors as the result of a previous survey. He stated the staff kept an eye on the bathroom for residents who attempt to use this bathroom. He reported there had only been one (1) male resident that had attempted to use the bathroom in the past and the staff re-directed him when he attempted to use that bathroom.	F 463		



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NAME OF PROVIDER OR SUPPLIER  CRESTVIEW CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065
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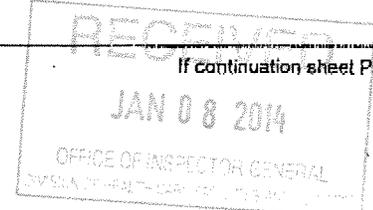
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1964, 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V Unprotected</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system</p> <p>GENERATOR: Type II generator, fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 12/03/13. Crestview Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for fifty eight (58) beds with a census of fifty six (56) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p><b>Plan of Correction</b></p> <p><b>Disclaimer for Crestview Center</b></p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because of State and Federal requirement.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

*[Signature]* x Administrator x 12/27/13

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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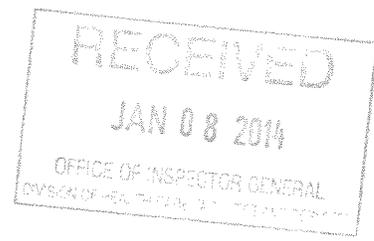
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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185409</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING	(X3) DATE SURVEY COMPLETED  <b>12/03/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CRESTVIEW CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1871 MIDLAND TRAIL SHELBYVILLE, KY 40065</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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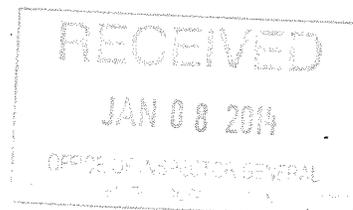
K 000	Continued From page 1  Deficiencies were cited with the highest deficiency identified at "F" level.  K 025 SS=E NFFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers in accordance with NFPA standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, forty two (42) residents, staff and visitors. The facility is certified for fifty eight (58) beds with a census of fifty six (56) on the day of the survey.  The findings include:  Observation, on 12/03/13 at 9:30 AM, with the Maintenance Director revealed the smoke barrier located in the attic of the 100 Hall was not protected with drywall on both sides of the smoke barrier leaving the bare wood framing studs exposed on one side of the smoke barrier.	K 000  K 025	K025 (1) The identified smoke barrier in 100 hall and 300 hall will be repaired by the Maintenance Director by 1/09/14. (2) A walkthrough of the facility and further review of the attic on 12/3/13 by the Maintenance Director revealed no other areas found to be affected. (3) The Maintenance Director was re-educated on 12/20/13 by the Administrator on NFPA 101 standards for smoke barriers including checking all areas in the facility where smoke barriers are required and making repairs as indicated. Re-education included adding checking of smoke barriers to the monthly Preventative Maintenance task list. (4) The Maintenance Director will complete a monthly audit of the integrity of smoke barriers and any issues identified will be addressed at that time. A summary of the audits will be submitted to the PI Committee by the Maintenance Director monthly for six months for further review and recommendation. (5) Date of Compliance: 1/10/14	1/10/14
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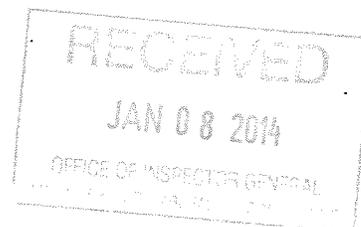
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K 025	Continued From page 2  Interview, on 12/03/13 at 9:30 AM, with the Maintenance Director revealed he was not aware the smoke barriers only had drywall on one side of the framing.  Observation, on 12/03/13 at 9:45 AM, with the Maintenance Director revealed the smoke barrier located in the attic of the 300 Hall was not continuous to the roof sheathing. The brick and concrete block wall was not completely to the roof sheathing leaving gaps that would not resist the passage of smoke between smoke compartments.  Interview, on 12/03/13 at 9:45 AM, with the Maintenance Director revealed he was not aware of the gaps and that the wall was to be continuous to the roof sheathing.  Reference: NFPA 101 (2000 edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. 8.3 SMOKE BARRIERS	K 025		



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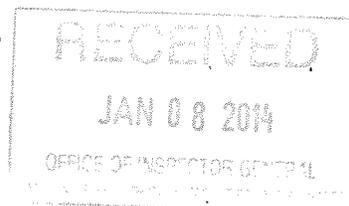
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K 025	Continued From page 3 8.3.1* General. Where required by Chapters 12 through 42, smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.	K 025		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/4-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 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  This STANDARD is not met as evidenced by:	K 027	K027  (1) The Maintenance Director installed a door coordinator on the 200 hallway door on 12/10/13. (2) A walk through of the facility and observation of cross corridor doors to determine that they can resist the passage of smoke in accordance with NFPA standards on 12/3/13 by the Maintenance Director revealed no other doors affected. (3) The Maintenance Director was re-educated on 12/20/13 by the Administrator to NFPA standards	1/6/14



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K 027	<p>Continued From page 4</p> <p>Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, thirty four (34) residents, staff and visitors. The facility has fifty eight (58) certified beds with a census of fifty six (56) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 12/03/12 at 2:07 PM, with the Maintenance Director revealed the cross-corridor doors located in the 200 Hall would not close completely when tested. This was due to the doors not having a coordinating device to ensure the door without the astragal would close first after the initial close.</p> <p>Interview, on 12/03/12 at 2:07 PM, with the Maintenance Director revealed he was unaware the doors needed a coordinator to ensure the doors would close properly in the event of an emergency.</p> <p>NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.</p> <p>Reference: NFPA 80 (1999 Edition)</p> <p>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</p>	K 027	<p>regarding smoke barriers being able to resist the passage of smoke, including to ensure cross-corridor doors have a coordinating device if they are unable to close properly. Education also included adding the checking of cross-corridor doors to the Preventative Maintenance task list.</p> <p>(4) The Maintenance Director will complete an audit for cross-corridor doors to determine they will resist the passage of smoke in accordance of NFPA standards monthly for six months. The findings from audits will be submitted to the PI Committee by the Maintenance Director monthly for six months for further review and recommendation.</p> <p>(5) Date of Compliance: 1/06/14</p>



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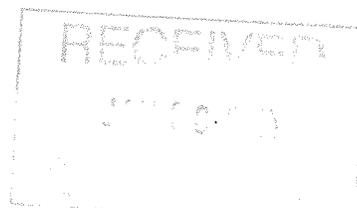
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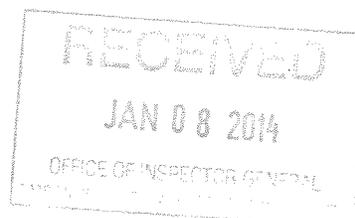
K 027	Continued From page 5 device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.  Reference: NFPA 101 (2000 edition)  8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. NFPA 101 LIFE SAFETY CODE STANDARD	K 027		
K 038 SS=D	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, five (5) residents, staff and visitors. The facility is certified for fifty eight (58) beds with a census of fifty six (56) on the day of the survey. The facility failed to maintain signage for doors equipped with delayed egress locks, and projections from the wall.	K 038	K038 (1) The delayed egress signage was placed on the Main Lobby door by the Maintenance Director on 12/3/13; the shelf located at the receptionist windows in the Main Lobby was cut down on 12/27/13 by the Maintenance Director per standard. (2) A walk through on 12/3/13 by the Maintenance Director was completed to determine that exits are readily accessible and appropriate signage in place in accordance with NFPA standards. No other concerns were identified. (3) The Maintenance Director was re-educated by the Administrator on 12/20/13 regarding access accessibility and exit door signage requirements in accordance with NFPA standards. Education	1/6/14



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K 038	<p>Continued From page 6</p> <p>The findings include:</p> <p>1. Observation, on 12/03/13 at 1:32 PM, with the Maintenance Director revealed the exit located in the Main Lobby was equipped with a delayed egress lock and a keypad override. However, the code for the keypad was not posted and the door was not equipped with delayed egress signage.</p> <p>Interview, on 12/03/13 at 1:32 PM, with the Maintenance Director revealed he was not aware the delayed egress signage was not on the exit located in the Main Lobby.</p> <p>2. Observation, on 12/03/13 at 1:34 PM, with the Maintenance Director revealed a shelf located at the receptionist window in the Main Lobby that projected eleven (11) inches out from the wall.</p> <p>Interview, on 12/03/13 at 1:34 PM, with the Maintenance Director revealed he was not aware of the egress requirements.</p> <p>Reference:</p> <p>NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks, Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in</p>	K 038	<p>included adding inspection of egress doors monthly as part of the Preventative Maintenance task list.</p> <p>(4) The Maintenance Director will audit egress doors monthly for appropriate signage and to determine that exits are readily accessible at all times in accordance NFPA standards. A summary of findings from the monthly checks will be submitted to the PI Committee by the Maintenance Director for six months for further review and recommendations.</p> <p>(5) Date of Compliance: 1/06/14</p>	



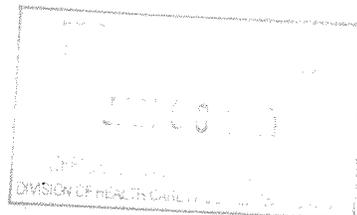
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K 038	<p>Continued From page 7</p> <ul style="list-style-type: none"> <li>• accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</li> <li>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</li> <li>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</li> <li>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</li> </ul>	K 038		



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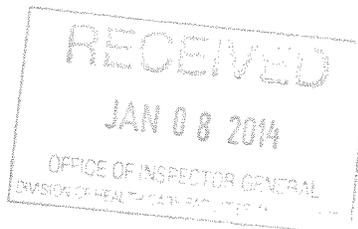
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K 038	<p>Continued From page 8</p> <p>(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.</p> <p>7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m)</p>	K 038		
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K 038	<p>Continued From page 9</p> <p>in width.</p> <p>(c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.</p> <p>7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way.</p> <p>Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2.</p> <p>Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6.</p> <p>Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23.</p> <p>Reference: CMS S&amp;C letter 5-38</p> <p>7.3.2* Measurement of Means of Egress.</p>	K 038	



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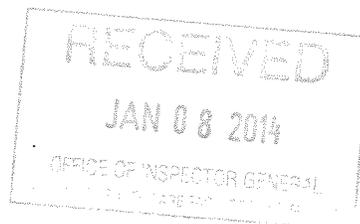
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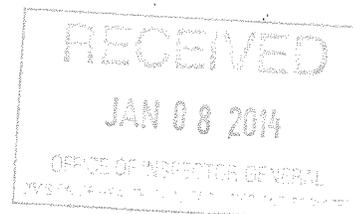
K 038	Continued From page 10 The width of means of egress shall be measured in the clear at the narrowest point of the exit component under consideration. Exception: Projections not more than 3 1/2 in. (8.9 cm) on each side shall be permitted at 38 in. (96 cm) and below.  Reference: S&C-12-21-LSC NFPA 101 LIFE SAFETY CODE STANDARD	K 038		
K 046 SS=F	Emergency lighting of at least 1 1/2 hour duration is provided in accordance with 7.9. 19.2.9.1.  This STANDARD is not met as evidenced by: Based on battery light testing record review, and interview, it was determined the facility failed to test emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, fifty eight (58) residents, staff and visitors. The facility is certified for fifty eight (58) beds with a census of fifty six (56) on the day of the survey. The facility failed to test emergency battery lighting for thirty (30) seconds monthly and ninety (90) minutes annually.  The findings include:  Battery light testing record review, on 12/03/13 at 9:45 AM, with the Maintenance Director revealed the facility did not have documentation for the thirty (30) second monthly test, or the ninety (90) minute annual testing of emergency battery lighting located in the transfer switch room.  Interview, on 12/03/13 at 9:45 AM, with the	K 046	K046 (1) The 30 second battery light testing and the 90 minute testing of emergency battery lighting in the transfer room was completed and documented in the Preventative Maintenance log on 12/23/13 by the Maintenance Director. No other concerns were identified. (2) The 30 second battery light testing and the 90 minute testing of emergency battery lighting in the transfer room was completed and documented in the Preventative Maintenance log on 12/23/13 by the Maintenance Director. No other concerns were identified. (3) The Maintenance Director was re-educated by the Administrator on 12/20/13 regarding battery light testing and emergency battery lighting testing requirements in accordance with NFPA standards including documentation for testing the emergency battery lighting in the Preventative Maintenance log.	1/6/14



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NAME OF PROVIDER OR SUPPLIER  CRESTVIEW CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065	
(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 046	<p>Continued From page 11</p> <p>Maintenance Director revealed he was not aware documentation was to be kept for emergency battery light testing.</p> <p>Reference: NFPA 101 (2000 edition) 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 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</p>	K 046	<p>(4) The Maintenance Director will complete the 30 second battery lighting testing monthly and the 90 minute emergency battery lighting tests annually and submit the Preventative Maintenance log documentation to the Administrator monthly to determine that test is completed and documented. A summary of findings will be submitted to the PI Committee by the Administrator monthly for twelve months for further review and recommendation.</p> <p>(5) Date of Compliance: 1/06/14</p>



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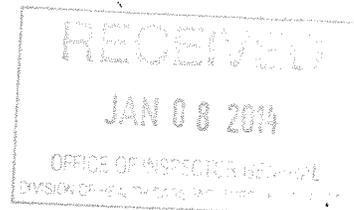
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NAME OF PROVIDER OR SUPPLIER  CRESTVIEW CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065
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<p>K 046</p> <p>K 047 SS=D</p>	<p>Continued From page 12</p> <p>Inspection is performed at 30-day intervals.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, five (5) residents, visitors, and staff. The facility is certified for fifty eight (58) beds with a census of fifty six (56) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 12/03/13 at 2:00 PM, with the Maintenance Director, revealed the Kitchen did not have proper exit signage to make the path of egress clearly recognizable.</p> <p>Interview, on 12/03/13 at 2:00 PM, with the Maintenance Director revealed he was not aware the Kitchen did not have proper exit signage.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>18.2 MEANS OF EGRESS REQUIREMENTS 18.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance</p>	<p>K 046</p> <p>K 047</p>	<p>K047</p> <p>(1) The emergency lighting above the kitchen door was installed by the Advanced Mechanical on 12/23/13 to provide proper exit signage to make the path of egress clearly recognizable.</p> <p>(2) An audit of facility exits was completed to determine that exit signs are maintained in accordance with NFPA standards on 12/3/13 by the Maintenance Director. No other doors were identified to be without proper exit signage to make the path of egress clearly recognizable.</p> <p>(3) The Maintenance Director was re-educated on 12/20/13 by the Administrator on Preventative Maintenance rounds to NFPA standards regarding the monitoring of exit signage to determine that proper exit signage is in place to make the path of egress clearly recognizable.</p> <p>(4) The Maintenance Director will complete an audit of the exit signs monthly for six months to determine that signs are displayed with continuous illumination also served by the emergency lighting system. The Administrator will submit a summary of findings to</p>	
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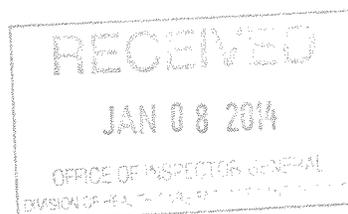
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NAME OF PROVIDER OR SUPPLIER  CRESTVIEW CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065
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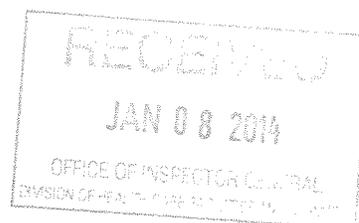
K 047	<p>Continued From page 13 with Chapter 7. Exception: As modified by 18.2.2 through 18.2.11.</p> <p>18.2.10 Marking of Means of Egress. 18.2.10.1 Means of egress shall have signs in accordance with Section 7.10.</p> <p>7.10 MARKING OF MEANS OF EGRESS 7.10.1 General. 7.10.1.1 Where Required. Means of egress shall be marked in accordance with Section 7.10 where required in Chapters 11 through 42. 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. 7.10.1.3 Exit Stair Door Tactile Signage. Tactile signage shall be located at each door into an exit stair enclosure, and such signage shall read as follows: EXIT Signage shall comply with CABO/ANSI A117.1, American National Standard for Accessible and Usable Buildings and Facilities, and shall be installed adjacent to the latch side of the door 60 in. (152 cm) above the finished floor to the centerline of the sign. Exception: This requirement shall not apply to existing buildings, provided that the occupancy classification does not change. 7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no</p>	K 047	<p>The PI Committee monthly for six months for further review and recommendation. (5) Date of Compliance: 1/06/14</p>	
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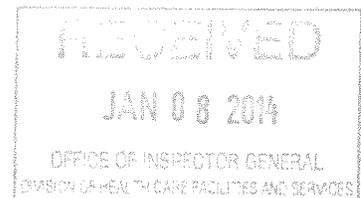
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K 047	<p>Continued From page 14</p> <p>point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs.</p> <p>Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements.</p> <p>7.10.1.5* Floor Proximity Exit Signs.</p> <p>Where floor proximity exit signs are required in Chapters 11 through 42, signs shall be placed near the floor level in addition to those signs required for doors or corridors. These signs shall be illuminated in accordance with 7.10.5.</p> <p>Externally illuminated signs shall be sized in accordance with 7.10.6.1. The bottom of the sign shall be not less than 6 in. (15.2 cm) but not more than 8 in. (20.3 cm) above the floor. For exit doors, the sign shall be mounted on the door or adjacent to the door with the nearest edge of the sign within 4 in. (10.2 cm) of the door frame.</p> <p>7.10.1.6* Floor Proximity Egress Path Marking.</p> <p>Where floor proximity egress path marking is required in Chapters 11 through 42, a listed and approved floor proximity egress path marking system that is internally illuminated shall be installed within 8 in. (20.3 cm) of the floor. The system shall provide a visible delineation of the path of travel along the designated exit access and shall be essentially continuous, except as interrupted by doorways, hallways, corridors, or other such architectural features. The system shall operate continuously or at any time the building fire alarm system is activated. The activation, duration, and continuity of operation of the system shall be in accordance with 7.9.2.</p> <p>7.10.1.7* Visibility.</p> <p>Every sign required in Section 7.10 shall be located and of such size, distinctive color, and design that it is readily visible and shall provide</p>	K 047	



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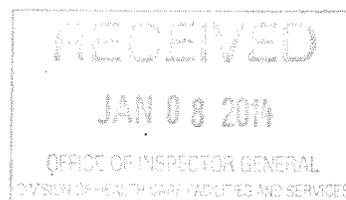
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K 047	<p>Continued From page 15</p> <p>contrast with decorations, interior finish, or other signs. No decorations, furnishings, or equipment that impairs visibility of a sign shall be permitted. No brightly illuminated sign (for other than exit purposes), display, or object in or near the line of vision of the required exit sign that could detract attention from the exit sign shall be permitted.</p> <p>7.10.2* Directional Signs. A sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent.</p> <p>7.10.3* Sign Legend. Signs required by 7.10.1 and 7.10.2 shall have the word EXIT or other appropriate wording in plainly legible letters.</p> <p>7.10.4* Power Source. Where emergency lighting facilities are required by the applicable provisions of Chapters 11 through 42 for individual occupancies, the signs, other than approved self-luminous signs, shall be illuminated by the emergency lighting facilities. The level of illumination of the signs shall be in accordance with 7.10.6.3 or 7.10.7 for the required emergency lighting duration as specified in 7.9.2.1. However, the level of illumination shall be permitted to decline to 60 percent at the end of the emergency lighting duration.</p> <p>7.10.5 Illumination of Signs. 7.10.5.1* General. Every sign required by 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode.</p> <p>7.10.5.2* Continuous Illumination. Every sign required to be illuminated by 7.10.6.3 and 7.10.7 shall be continuously illuminated as</p>	K 047		



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K 047	Continued From page 16 required under the provisions of Section 7.8. Exception*: Illumination for signs shall be permitted to flash on and off upon activation of the fire alarm system. 7.10.6 Externally Illuminated Signs. 7.10.6.1* Size of Signs. Externally illuminated signs required by 7.10.1 and 7.10.2, other than approved existing signs, shall have the word EXIT or other appropriate wording in plainly legible letters not less than 6 in. (15.2 cm) high with the principal strokes of letters not less than 3/4 in. (1.9 cm) wide. The word EXIT shall have letters of a width not less than 2 in. (5 cm), except the letter I, and the minimum spacing between letters shall be not less than 3/8 in. (1 cm). Signs larger than the minimum established in this paragraph shall have letter widths, strokes, and spacing in proportion to their height. Exception No. 1: This requirement shall not apply to existing signs having the required wording in plainly legible letters not less than 4 in. (10.2 cm) high. Exception No. 2: This requirement shall not apply to marking required by 7.10.1.3 and 7.10.1.5. 7.10.6.2* Size and Location of Directional Indicator. The directional indicator shall be located outside of the EXIT legend, not less than 3/8 in. (1 cm) from any letter. The directional indicator shall be of a chevron type, as shown in Figure 7.10.6.2. The directional indicator shall be identifiable as a directional indicator at a distance of 40 ft (12.2 m). A directional indicator larger than the minimum established in this paragraph shall be proportionately increased in height, width and stroke. The directional indicator shall be located at the end of the sign for the direction indicated. Exception: This requirement shall not apply to	K 047		



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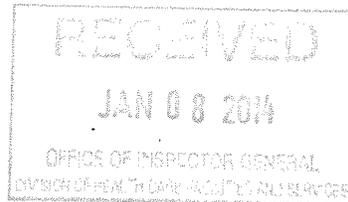
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K 047	<p>Continued From page 17 approved existing signs. Figure 7.10.6.2 Chevron-type Indicator.</p> <p>7.10.6.3* Level of Illumination. Externally illuminated signs shall be illuminated by not less than 5 ft-candles (54 lux) at the illuminated surface and shall have a contrast ratio of not less than 0.5.</p> <p>7.10.7 Internally Illuminated Signs. 7.10.7.1 Listing. Internally illuminated signs, other than approved existing signs, or existing signs having the required wording in legible letters not less than 4 in. (10.2 cm) high, shall be listed in accordance with UL 924, Standard for Safety Emergency Lighting and Power Equipment. Exception: This requirement shall not apply to signs that are in accordance with 7.10.1.3 and 7.10.1.5.</p> <p>7.10.7.2* Photoluminescent Signs. The face of a photoluminescent sign shall be continually illuminated while the building is occupied. The illumination levels on the face of the photoluminescent sign shall be in accordance with its listing. The charging illumination shall be a reliable light source as determined by the authority having jurisdiction. The charging light source shall be of a type specified in the product markings.</p> <p>7.10.8 Special Signs. 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: <b>NO EXIT</b> Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm)</p>	K 047		
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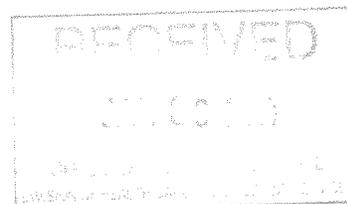
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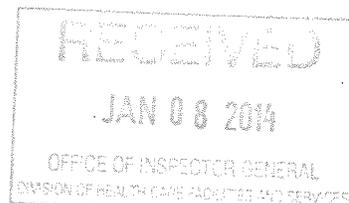
K 047	<p>Continued From page 18 and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. Exception: This requirement shall not apply to approved existing signs. 7.10.8.2 Elevator Signs. Elevators that are a part of a means of egress (see 7.2.13.1) shall have the following signs, with minimum letter height of 5/8 in. (1.6 cm), in every elevator lobby: (1) * Signs that indicate that the elevator can be used for egress, including any restrictions on use (2) * Signs that indicate the operational status of elevators 7.10.9 Testing and Maintenance. 7.10.9.1 Inspection. Exit signs shall be visually inspected for operation of the illumination sources at intervals not to exceed 30 days. 7.10.9.2 Testing. Exit signs connected to or provided with a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3.  7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. Reference: NFPA 96 (1998 edition) 7-5.1 A readily accessible means for manual activation shall be located between 42 in. and 60 in. (1067 mm and 1524 mm) above the floor, located in a path of exit or egress, and clearly identify the hazard protected. The automatic and manual means of system activation external to the control head or releasing device shall be</p>	K 047		
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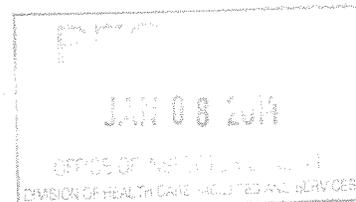
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K 047	Continued From page 19 separate and independent of each other so that failure of one will not impair the operation of the other. Exception No. 1: The manual means of system activation shall be permitted to be common with the automatic means if the manual activation device is located between the control head or releasing device and the first fusible link. Exception No. 2: An automatic sprinkler system.	K 047		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, fifty eight (58) residents, staff and visitors. The facility is certified for fifty eight (58) beds with a census of fifty six (56) on the day of the survey. The facility failed to ensure the fire drills were conducted quarterly at unexpected times.	K 050	K050 (1) The Maintenance Director conducted fire drills on the 1 <sup>st</sup> shift on 1/9/13 at 1:30 pm, 3/28/13 at 12:35 pm, 7/2/13 at 10:15 am and 10/21/13 at 11:00 am; 2 <sup>nd</sup> shift on 2/13/13 at 6:00 pm, 5/9/13 at 4:20 pm, 8/12/13 at 9:50 pm and 11/21/13 at 7:01 pm; 3 <sup>rd</sup> shift on 3/7/13 at 5:50 am, 6/12/13 at 4:30 am, 9/13/13 at 5:45 am and 12/10/13 at 3:00 am. No other concerns were identified.  (2) The Maintenance Director conducted fire drills on the 1 <sup>st</sup> shift on 1/9/13 at 1:30 pm, 3/28/13 at 12:35 pm, 7/2/13 at 10:15 am and 10/21/13 at 11:00 am; 2 <sup>nd</sup> shift on 2/13/13 at 6:00 pm, 5/9/13 at 4:20 pm, 8/12/13 at 9:50 pm and 11/21/13 at 7:01 pm; 3 <sup>rd</sup> shift on 3/7/13 at 5:50 am, 6/12/13 at 4:30 am, 9/13/13 at 5:45 am and 12/10/13 at 3:00 am. No other concerns were identified.	1/6/14



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>485409</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING	(X3) DATE SURVEY COMPLETED  <b>12/03/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CRESTVIEW CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1871 MIDLAND TRAIL SHELBYVILLE, KY 40065</b>	
(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 050	<p>Continued From page 20</p> <p>The findings include:</p> <p>Fire Drill record review, on 12/03/13 at 10:24 AM, with Maintenance Director revealed the facility failed to conduct a fire drill in the second (2nd) quarter of 2013 on first (1st) shift. Further fire drill record review revealed the fire drills on third (3rd) shift were not conducted at unexpected times under varied conditions. The fire drills for 3rd shift were conducted as follows;</p> <p>3rd quarter 09/13/13 @ 5:45 AM 2nd quarter 06/12/13 @ 4:30 AM 1st quarter 03/07/13 @ 5:30 AM 4th quarter 12/06/12 @ 5:00 AM</p> <p>Interview, on 12/03/13 at 10:24 AM, with the Maintenance Director revealed he was not aware the fire drill was missed in the 2nd quarter of 2013. Further interview revealed he was not aware the fire drills on 3rd shift were not conducted in accordance with NFPA standards.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.</p> <p>Reference: NFPA 101 Life Safety Code (2000 Edition). 19.7* OPERATING FEATURES 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of</p>	K 050	<p>(3) The Maintenance Director was re-educated by the Administrator on 12/20/13 regarding both the quarterly requirement for fire drills on each shift and the requirement for unexpected and varied times in accordance with NFPA standards.</p> <p>(4) The Maintenance Director will submit documentation for monthly fire drills to the Administrator monthly for twelve months for review to determine that fire drills are held on each shift and at unexpected and varied times in accordance with NFPA standards. Any concerns will be identified at that time. A summary of finding will be submitted to the PI Committee monthly by the Administrator for twelve months for further review and recommendation.</p> <p>(5) Date of Compliance: 1/06/14</p>



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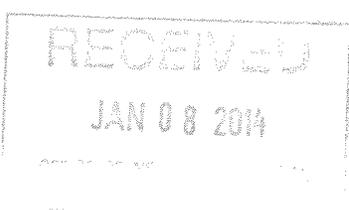
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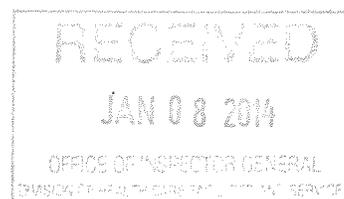
K 050	Continued From page 21 fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator ' s position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, Interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050		
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of	K 051	K051 (1) The identified manual fire pull station will be relocated within five feet of the exit door and clear of furniture or other obstacles by Koorsen in accordance with NFPA standards by 1/3/14. (2) The Maintenance Director audited the facility fire pull stations on 12/3/13 to identify any other manual pull stations were no greater than five feet away from	1/7/14



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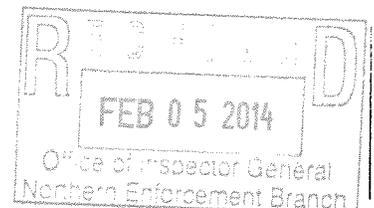
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K 051	<p>Continued From page 22</p> <p>tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building fire alarm system was installed as required by NFPA standards. The deficient practice has the potential to affect one (1) of five (5) smoke compartments, five (5) residents, staff, and visitors. The facility is certified for fifty eight (58) beds with a census of fifty six (56) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 12/03/13 at 1:37 PM, with the Maintenance Director revealed the manual fire pull station located in the Main Lobby was blocked by furniture and installed greater than five (5) feet from the exit door.</p> <p>Interview, on 12/03/13 at 1:37 PM, with the Maintenance Director revealed he was not aware</p>	K 051	<p>the exit door or blocked by furnishings. No other concerns were identified.</p> <p>(3) The Maintenance Director was re-educated on 12/20/13 by the Administrator to the NFPA standards that fire pull stations are not be located greater than five feet from the exit door and should never be blocked by furnishings.</p> <p>(4) The Maintenance Director will audit facility fire pull stations monthly for six months to determine that fire pull stations are located within five feet of the exit door and not blocked by furnishings. Any concerns identified will be addressed at that time. A summary of findings will be submitted by the Administrator to the PI Committee monthly for six months for further review and recommendation.</p> <p>(5) Date of Compliance: 1/07/14</p>	



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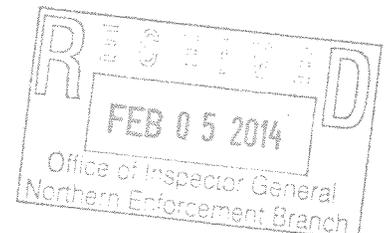
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K 051	Continued From page 23 the manual pull station for the fire alarm was to be located within five (5) feet of each exit door. Further interview revealed he was not aware the pull station was blocked by the furniture.  Reference: NFPA 72 (1999 Edition).  5.12 Manually Actuated Alarm-Initiating Devices. 5.12.1 Manual fire alarm boxes shall be used only for fire alarm-initiating purposes. 5.12.2 Combination manual fire alarm boxes and guard 's signaling stations shall be permitted. 5.12.3 Each manual fire alarm box shall be securely mounted. 5.12.4 The operable part of each manual fire alarm box shall be not less than 1.1 m (3½ ft) and not more than 1.37 m (4½ ft) above floor level. 5.12.5* Manual fire alarm boxes shall be located throughout the protected area so that they are conspicuous, unobstructed, and accessible. 5.12.6 Manual fire alarm boxes shall be located within 1.5 m (5 ft) of the exit doorway opening at each exit on each floor. 5.12.7 Manual fire alarm boxes shall be mounted on both sides of grouped openings over 12.2 m (40 ft) in width, and within 1.5 m (5 ft) of each side of the opening. 5.12.8* Additional manual fire alarm boxes shall be provided so that the travel distance to the nearest fire alarm box will not be in excess of 61 m (200 ft) measured horizontally on the same floor.	K 051		
K 056 SS=E	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	K 056	K056  (1) The Administrator and Property Manager are in the process of obtaining bids for a sprinkler system coverage of wardrobe	<i>12/29/13</i> <i>correct</i> <i>Amended</i> <i>2/20/14</i>



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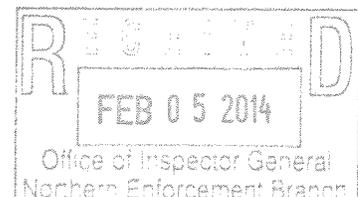
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K 056	<p>Continued From page 24</p> <p>building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, 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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system installed, in accordance with NFPA Standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, forty six (46) residents, staff and visitors. The facility is certified for fifty eight (58) beds with a census of fifty six (56) on the day of the survey. The facility failed to ensure complete sprinkler coverage for wardrobe type closets.</p> <p>The findings include:</p> <p>Observation, on 12/03/13 between 9:30 AM and 3:00 PM, with the Maintenance Director revealed wardrobe type closets located in rooms #100, 102, 104, 106, 201, 202, 203, 204, 205, 206, 207, 208, 209, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, and 314 did not have adequate sprinkler coverage. The rooms had one sprinkler head per room and were located on the far side of the room on the wall.</p> <p>Interview, on 12/03/13 between 9:30 AM and 3:00</p>	K 056	<p>type closets located in rooms 100, 102, 104, 106, 201, 203, 204, 205, 206, 207, 208, 209, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, and 314. Bids and selected contractor will be determined by 1/6/14.</p> <p>(2) An audit of the facility sprinkler system was completed on 12/3/13 by the Maintenance Director to determine that complete sprinkler coverage was present in accordance with NFPA standards including in resident rooms with wardrobe type closets. No other concerns were identified.</p> <p>(3) The Maintenance Director was re-educated on 12/20/13 by the Administrator to the NFPA standard related to the requirement that the facility maintain a complete sprinkler system including complete sprinkler coverage to rooms with wardrobe type closets. A waiver has been requested for a compliance date of 2/6/14 due to the holidays and the magnitude of the work involved. A bid has been received from Century Fire Protection but parts have to be ordered, which may take up to two weeks and then a week to install the sprinklers. We estimate the job to be completed by 2/5/14.</p>	



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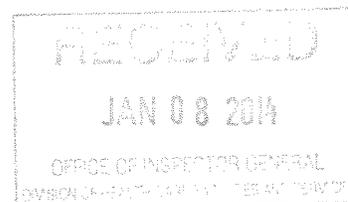
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K 056	<p>Continued From page 25</p> <p>PM, with the Maintenance Director revealed he was not aware of the requirements for proper sprinkler coverage.</p> <p>Reference: NFPA 13 (1999 Edition) 5-13 8.1</p> <p>Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.</p> <p>Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:</p> <p>(1) Sprinklers installed throughout the premises</p> <p>(2) Sprinklers located so as not to exceed maximum protection area per sprinkler</p> <p>(3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</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,</p>	K 056	<p>The sprinkler system still works and is monitored as required, so no residents or staff will be affected during this time. The Property Manager and the Administrator will oversee the project to completion. The Administrator will keep the Life Safety office appraised during this time via email.</p> <p>(4) The Administrator will submit a monthly progress summary related to the sprinkler system installation and function to the PI Committee monthly until work is completed. Once the work is completed, the Maintenance Director will complete a monthly audit for six months to determine that complete sprinkler coverage is in place as per NFPA standards. Any concerns identified will be reported to the Administrator and addressed at that time. A summary of this audit will be submitted by the Administrator to the PI Committee for six months for further review and recommendation.</p> <p>(5) Date of Compliance: 2/6/14</p>		



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K 051	Continued From page 23 the manual pull station for the fire alarm was to be located within five (5) feet of each exit door. Further interview revealed he was not aware the pull station was blocked by the furniture.  Reference: NFPA 72 (1999 Edition).  5.12 Manually Actuated Alarm-Initiating Devices. 5.12.1 Manual fire alarm boxes shall be used only for fire alarm-initiating purposes. 5.12.2 Combination manual fire alarm boxes and guard 's signaling stations shall be permitted. 5.12.3 Each manual fire alarm box shall be securely mounted. 5.12.4 The operable part of each manual fire alarm box shall be not less than 1.1 m (3½ ft) and not more than 1.37 m (4½ ft) above floor level. 5.12.5* Manual fire alarm boxes shall be located throughout the protected area so that they are conspicuous, unobstructed, and accessible. 5.12.6 Manual fire alarm boxes shall be located within 1.5 m (5 ft) of the exit doorway opening at each exit on each floor. 5.12.7 Manual fire alarm boxes shall be mounted on both sides of grouped openings over 12.2 m (40 ft) in width, and within 1.5 m (5 ft) of each side of the opening. 5.12.8* Additional manual fire alarm boxes shall be provided so that the travel distance to the nearest fire alarm box will not be in excess of 61 m (200 ft) measured horizontally on the same floor.	K 051		
K 056 SS=E	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	K 056	K056 (1) The Administrator and Property Manager are in the process of obtaining bids for a sprinkler system coverage of wardrobe	2/6/14



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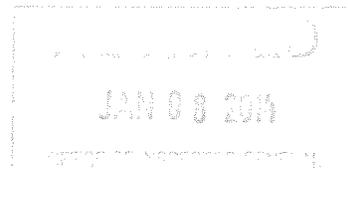
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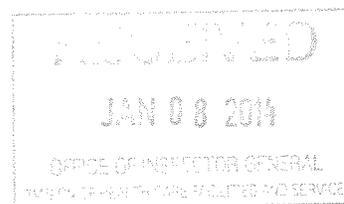
K 056	<p>Continued From page 24</p> <p>building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system installed, in accordance with NFPA Standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, forty six (46) residents, staff and visitors. The facility is certified for fifty eight (58) beds with a census of fifty six (56) on the day of the survey. The facility failed to ensure complete sprinkler coverage for wardrobe type closets.</p> <p>The findings include:</p> <p>Observation, on 12/03/13 between 9:30 AM and 3:00 PM, with the Maintenance Director revealed wardrobe type closets located in rooms #100, 102, 104, 106, 201, 202, 203, 204, 205, 206, 207, 208, 209, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, and 314 did not have adequate sprinkler coverage. The rooms had one sprinkler head per room and were located on the far side of the room on the wall.</p> <p>Interview, on 12/03/13 between 9:30 AM and 3:00</p>	K 058	<p>type closets located in rooms 100, 102, 104, 106, 201, 203, 204, 205, 206, 207, 208, 209, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, and 314. Bids and selected contractor will be determined by 1/6/14.</p> <p>(2) An audit of the facility sprinkler system was completed on 12/3/13 by the Maintenance Director to determine that complete sprinkler coverage was present in accordance with NFPA standards including in resident rooms with wardrobe type closets. No other concerns were identified.</p> <p>(3) The Maintenance Director was re-educated on 12/20/13 by the Administrator to the NFPA standard related to the requirement that the facility maintain a complete sprinkler system including complete sprinkler coverage to rooms with wardrobe type closets. A waiver has been requested for a compliance date of 2/6/14 due to the holidays and the magnitude of the work involved. A bid has been received from Century Fire Protection but parts have to be ordered, which may take up to two weeks and then a week to install the sprinklers. We estimate the job to be completed by 2/5/14</p>	
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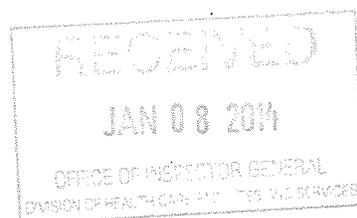
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185409	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2013
NAME OF PROVIDER OR SUPPLIER  CRESTVIEW CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065	
(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 056	Continued From page 25 PM, with the Maintenance Director revealed he was not aware of the requirements for proper sprinkler coverage.  Reference: NFPA 13 (1999 Edition) 5-13 8.1  Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.  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,	K 056	The sprinkler system still works and is monitored as required, so no residents or staff will be affected during this time. The Property Manager and the Administrator will oversee the project to completion. The Administrator will keep the Life Safety office appraised during this time via email.  (4) The Administrator will submit a monthly progress summary related to the sprinkler system installation and function to the PI Committee monthly until work is completed. Once the work is completed, the Maintenance Director will complete a monthly audit for six months to determine that complete sprinkler coverage is in place as per NFPA standards. Any concerns identified will be reported to the Administrator and addressed at that time. A summary of this audit will be submitted by the Administrator to the PI Committee for six months for further review and recommendation.  (5) Date of Compliance: 2/6/14	



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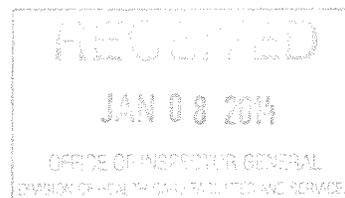
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K 056	Continued From page 26 pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)  Maximum Allowable Distance Distance from Sprinklers to of Deflector above Bottom of Side of Obstruction (A) 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  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). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall. Reference: NFPA 13 (1999 Edition) 7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied:	K 056		



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K 056	Continued From page 27 (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.  Reference: NFPA 101 (2000 edition) 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception:* Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes	K 056		



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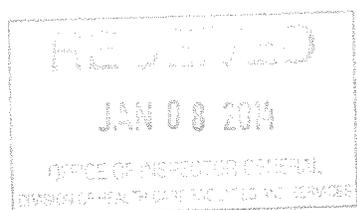
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K 056	Continued From page 28 not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.	K 056		
K 061 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure valves located in the facility sprinkler system were supervised by a tamper switch. The deficiency had the potential to affect five (5) of five (5) smoke compartments, fifty eight (58) residents, staff, and visitors. The facility is certified for fifty eight (58) beds with a census of fifty six (56) on the day of the survey. The facility failed to install a supervised tamper switch on the main shut off valve of the sprinkler system.</p> <p>The findings include:</p> <p>Observation on 12/03/13, at 1:47 PM, with the Maintenance Director revealed the main sprinkler shut off valve located in the 100 Hall Mechanical Room was not equipped with a supervised tamper switch to notify the facility if the valve was closed.</p>	K 061	<p>K061</p> <p>(1) The supervised tamper switch will be installed to the main sprinkler shut off valve located in 100 hall mechanical room on 1/03/14 by Koorsen.</p> <p>(2) An audit of the automatic sprinkler system valve in the facility was completed by the Maintenance Director on 12/3/13. Any concerns identified were addressed at that time.</p> <p>(3) The Maintenance Director was re-educated by the Administrator on 12/20/13 on NFPA standards related to required automatic sprinkler systems having valve supervised so that at least a local alarm will sound when the valve is closed. The Maintenance Director will complete an audit of the sprinkler system valve monthly for three months, then quarterly for two quarters to determine that a supervised tamper switch is in place in accordance with NFPA standards.</p>	1/7/14



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K 061	Continued From page 29  Interview, on 12/03/13 at 1:47 PM, with the Maintenance Director revealed he was not aware the main valve on the sprinkler system had to be supervised.  Reference: NFPA 101 (2000 Edition).  9.7.2.1* Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.	K 061	Any concerns identified will be addressed at that time. A summary of findings will be submitted to the PI Committee by the Administrator monthly for six months for further review and recommendation.  (4) Date of Compliance: 1/07/14	
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	K 068	K068 (1) The plywood in the 100 hall maintenance room was removed and the fresh air vent was cleared in accordance with NFPA standards by the Maintenance Director on 12/3/13.	1/6/14



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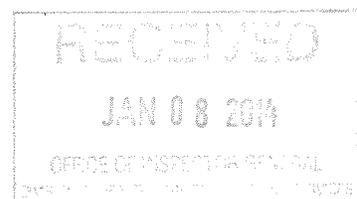
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K 068	<p>Continued From page 30</p> <p>determined the facility failed to ensure combustion air and ventilation for boilers, incinerators, fuel fired HVAC, and water heater rooms were installed in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, five (5) residents, staff and visitors. The facility is certified for fifty eight (58) beds with a census of fifty six (56) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 12/03/13 at 1:42 PM, with the Maintenance Director revealed the through the wall fresh air vent serving the gas fired water heater located in the 100 Hall Mechanical Room was blocked by a piece of plywood.</p> <p>Interview, on 12/03/13 at 1:42 PM, with the Maintenance Director revealed he was aware the vent had been blocked and this was to keep pipes in the room from freezing.</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition)</p> <p>Section 19.5 Building Services 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</p>	K 068	<p>(2) The Maintenance Supervisor completed an audit on 12/3/13 of the facility ventilation to determine that combustion air and ventilation for boilers, incinerators, fuel fired HVAC and heater rooms are installed and maintained in accordance with NFPA standards. No other concerns were identified.</p> <p>(3) The Maintenance Director was re-educated by the Administrator on 12/20/13 to the NFPA standards regarding the requirement that combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to outside air including not placing plywood or other item in front of the vents.</p> <p>(4) The Maintenance Director will complete an audit of the vents for combustion, boiler, incinerator and heater rooms to determine that NFPA standards are in place weekly for four weeks, then monthly for five months. Any concerns identified will be addressed at that time. The Administrator will submit a summary of findings to the PI Committee monthly for six months for further review and recommendation.</p> <p>(5) Date of Compliance: 1/06/14</p>	
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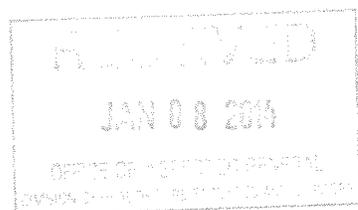
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K 068	Continued From page 31 of fuel and shut down the equipment in case of either excessive temperature or ignition failure.	K 068		
K 072 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, thirty (30), staff and visitors. The facility is certified for fifty eight (58) beds with a census of fifty six (56) on the day of the survey. The facility failed to ensure the means of egress was free of all obstructions or impediments.</p> <p>The findings include:</p> <p>Observations, on 12/03/13 between 9:30 AM and 3:00 PM, with the Maintenance Director revealed a linen cart, and a blood pressure machine plugged into the wall and charging in the 100 Short Hall. Further observation revealed two (2) lifts, a wheelchair, and a linen cart being stored in the 300 Hall.</p> <p>Interview, on 12/03/13 between 9:30 AM and 3:00 PM, with the Maintenance Director revealed the</p>	K 072	<p>K072</p> <p>(1) The identified blood pressure machine on the 100 short hall was relocated on 12/3/13 to the nurses' station, the two lifts were relocated to non-exit access area, the wheelchair was placed in a storage room and the linen cart was taken to the shower room from the 300 hall by Maintenance Director on 12/3/13.</p> <p>(2) The Maintenance Director made rounds of the facility to determine that means of egress were free of all obstructions or impediments in accordance with NFPA standards on 12/3/13. No other concerns identified.</p> <p>(3) Nursing staff will be re-educated by the Director of Nursing by 1/6/14 to the NFPA standard regarding the requirement that a means of egress remain free from obstructions and impediments including not to leave wheelchairs, lifts, linen carts, blood pressure machines or other items in the hallways or near exit doors when not in use so as not to create any obstruction. The Maintenance Director was re-</p>	1/7/14





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K 147	Continued From page 33 Interview, on 12/03/13 between 9:30 AM and 3:00 PM, with the Maintenance Director revealed he was not aware heat tape was a fire hazard.  Reference: NFPA 101 (2000 Edition)  9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.  Reference: NFPA 70 400-8  ( Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Reference: NFPA 99 (1999 edition)  3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	K147 (1) The heat tape was removed from the attic pipes above the Laundry room by Hamilton & Price on 12/27/13 and will be removed from the walk-in freezer drain line in the kitchen on 12/27/13 by Advanced Mechanical. (2) An audit of the facility water pipes and drains was completed on 12/3/13 by the Maintenance Director to determine that no other Heat Tape was in use. No concerns were identified. (3) The Maintenance Director was re-educated by the Administrator on 12/20/13 to the NFPA standards regarding the requirement that electrical wiring and equipment is in accordance with NFPA 70 and National Electric Code 9.1.2 including that Heat Tape is not to be used. (4) The Maintenance Director will complete an audit of the facility water and drain pipes to determine that no heat tape is in use and electrical wiring and equipment to determine that NFPA standards are in place monthly for six months. Any concerns identified will be addressed at that time. A summary of findings will be submitted to the PI Committee by the Administrator monthly for six months for further review and recommendation. (5) Date of Compliance: 1/06/14	1/6/14

