

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

PRINTED: 07/31/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185325	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/17/2014
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NAME OF PROVIDER OR SUPPLIER  CAL TURNER REHAB AND SPECIALTY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 466 BURNLEY RD. SCOTTSVILLE, KY 42164
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>A Recertification Survey was conducted on 07/15/14 through 07/17/14 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of an "E".</p>	F 000	<p>This plan of correction is offered as an attempt to provide the highest level of quality services possible to our residents and is not an admission that the deficiencies cited are correct.</p>	
F 164 SS=E	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p>	F 164	<p>1. Resident #1, Resident #2, and Resident #6 were assessed on 7/16/2014 by the Unit Supervisor and found to have no adverse effect related to the skin/ assessment/treatment /personal care process. RN #1, LPN #1, LPN #3, and CNA #1 were counseled on 7/17/14 by the Unit Supervisor to emphasize the importance of the resident's privacy when providing skin assessment/treatment/ personal care in accordance with our Rights and Responsibilities of Residents policy.</p> <p>2. The Unit Supervisors monitored the other 22 residents receiving skin assessments for privacy in accordance with the Rights and Responsibilities of Residents policy. No other residents were found to be affected.</p> <p>3. The Unit Supervisors provided education on the Rights and Responsibilities of Residents Policy to all nursing care staff to ensure their understanding and compliance; completed on 8/7/2014.</p>	8/8/2014

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

*Jacqueline H. Woodward*

TITLE

*Administrator*

(X6) DATE

*8/8/14*

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

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NAME OF PROVIDER OR SUPPLIER  <b>CAL TURNER REHAB AND SPECIALTY CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>466 BURNLEY RD. SCOTTSVILLE, KY 42164</b>
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F 164 Continued From page 1  
This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review, and review of the Resident's Rights policy/procedure, the facility failed to ensure privacy was provided for three (3) residents (Residents #1, #2, and #6), in the selected sample of twenty-two (22) residents, related to the failure to pull the privacy curtain or close the door when care was provided.

Findings include:

Review of the facility's policy/procedure entitled, "Rights and Responsibilities of Residents", revised 06/06, revealed the staff of the facility respects the basic rights of residents. These rights include the resident's independence of expression, decision, and action. Concern for the residents personal dignity and human relationship is always of great importance to our staff. The recognition of the rights and concerns has led to the adoption of the following statements of the residents rights and responsibilities. Residents should be assured of at least visual privacy in multi-bed rooms and in tub, shower and toilet rooms. Each resident shall be treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his/her personal needs.

1. Record review revealed the facility admitted Resident #1 on 11/05/05 with diagnoses which included Multiple Sclerosis, Alzheimer's Disease, Depressive Disorder, Dysphagia Unspecified, and Personal History of Urinary Tract Infection (UTI). Review of the Quarterly Minimum Data Set (MDS), dated 07/09/14, revealed Resident #1 was assessed to be severely impaired with a

F 164 4. Beginning on 8/7/2014, the Unit Supervisors will conduct a minimum of 10 nursing staff observations of treatment/skin assessments/personal care monthly to ensure quality resident care and staff compliance with Rights and Responsibilities of Resident Policy. Results of the Monthly Observations will be submitted to the DON for a period of four consecutive months to ensure Performance Improvement.

5. Completion date for the deficiency **8/8/2014**

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NAME OF PROVIDER OR SUPPLIER  <b>CAL TURNER REHAB AND SPECIALTY CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>456 BURNLEY RD. SCOTTSVILLE, KY 42164</b>		
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F 164	<p>Continued From page 2</p> <p>Brief Interview Mental Status (BIMs) score of three (3), and required extensive assistance with activities of daily living (ADLs).</p> <p>Observation during a skin assessment/treatment, on 07/16/14 at 9:20 AM, revealed Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #3 left the resident's privacy curtain open, while another staff (LPN #1) entered from the hallway into the room during Resident #1's assessment/treatment.</p> <p>2. Record review revealed the facility admitted Resident #6 on 08/18/13 with diagnoses which included Dementia CCE with Behavioral Disturbances, Anemia of Other Chronic Disease, Difficulty in Walking, Unspecified Episodic Mood Disorder, Unqualified Visual Loss-Both Eyes, Muscular Wasting, and Disuse Atrophy. Review of the Quarterly MDS, dated 06/19/14, revealed Resident #6 was assessed to be severely impaired with a BIMS score of three (3), and required extensive assistance with ADLs.</p> <p>Observation during a skin assessment, on 07/16/14 at 1:45 PM, revealed RN #1 exited Resident #6's room and left the hallway door open. The privacy curtain was not pulled while another nurse (LPN #3) continued to complete the skin assessment.</p> <p>Interview with RN #1, on 07/17/14 at 3:20 PM, revealed when providing care, always close the door, pull the window blinds and privacy curtain to provide privacy for any resident.</p> <p>Interview with LPN #1, on 07/16/14 at 2:48 PM, revealed her expectation was for staff to completely close the privacy curtains during</p>	F 164			

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F 164	<p>Continued From page 3 catheter care.</p> <p>3. Observation of Resident #2's catheter care, on 07/16/14 at 2:00 PM, revealed Certified Nurse Aide (CNA) #1 did not fully close the privacy curtain in the resident's room, which was a multi-bedroom. Further observation revealed CNA #1 uncovered Resident #2 leaving his/her genitalia exposed and exited the room to retrieve a trash bag.</p> <p>Interview with Resident #2, on 07/16/14 at 2:45 PM, revealed it was bothersome to be uncovered and stated, "you never know who may walk in."</p> <p>Interview with CNA #1, on 07/16/14 at 2:44 PM, revealed he should have covered the resident's genitalia when he left the room.</p> <p>Interview with CNA #2, on 07/17/14 at 10:20 AM, revealed when providing care to residents, the door and the privacy curtain should be closed to keep residents from being exposed.</p> <p>Interview with LPN #2, on 07/17/14 at 8:37 AM, revealed when providing care for residents the door should be closed, blinds pulled, and privacy curtain pulled to ensure dignity and privacy for the resident.</p> <p>Interview with the Director of Nursing (DON), on 07/17/14 at 12:28 PM, revealed when providing care for the residents, the staff should always close the door and pull the privacy curtain around the resident.</p>	F 164	<p>1. Resident #1 was assessed by the Unit Supervisor on 7/16/2014 and found to have no adverse effect from the Indwelling Urinary Catheter care.</p>	8/8/2014
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

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NAME OF PROVIDER OR SUPPLIER  CAL TURNER REHAB AND SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 466 BURNLEY RD. SCOTTSVILLE, KY 42164		
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F 315	<p>Continued From page 4</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure residents received appropriate treatment and service related to catheter care for one (1) resident (Resident #1), in the selected sample of twenty-two (22) residents. Registered Nurse (RN) #1 did not change her gloves or wash her hands after provision of peri-care, and then provided catheter care.</p> <p>Findings include:</p> <p>Review of the facility's policy/procedure, "Indwelling Urinary Catheters", revised 08/12, revealed catheter care was to be completed every shift by staff. Review of the facility's policy/procedure, "Rights and Responsibilities of Residents", revised 06/06, revealed the staff of the facility respects the basic rights of residents. These rights include the resident's independence of expression, decision, and action. Concern for the resident's personal dignity and human relationship is always of great importance to our staff. The recognition of the rights and concerns</p>	F 315	<p>RN #1 was counseled on 7/17/2014 by the Unit Supervisor to emphasize the importance of catheter care in accordance with our Indwelling Urinary Catheter Policy.</p> <p>2. The Unit Supervisor assessed all residents with an Indwelling Urinary Catheter to ensure no other issues with care and maintenance of catheters and found no other instances.</p> <p>3. The Unit Supervisors provided education on the Indwelling Urinary Catheter Policy to all nursing staff to ensure their understanding and compliance; completed on 8/7/2014.</p> <p>4. Beginning 8/7/2014, the Unit Supervisors will conduct a minimum of 10 nursing staff observations of performing Indwelling Catheter Care monthly to ensure quality resident care and staff compliance with the Indwelling Catheter Policy. Results of the Monthly Observations will be submitted to the DON for a period of four consecutive months to ensure Performance Improvement.</p> <p>5. Completion date for the deficiency 8/8/2014</p>		

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F 315	<p>Continued From page 5</p> <p>has led to the adoption of the following statements of the residents' rights and responsibilities. Residents have the right to be suitably dressed at all times and given assistance when needed in maintaining body hygiene and good grooming.</p> <p>Record review revealed the facility admitted Resident #1 on 11/05/2005 with diagnoses which included Multiple Sclerosis, Alzheimer's Disease, Depressive Disorder, Dysphagia Unspecified, and Personal History of Urinary Tract Infection (UTI). Review of the quarterly Minimum Data Set (MDS), dated 07/09/14, revealed Resident #1 was assessed to be severely impaired with a Brief Interview Mental Status (BIMs) score of three (3), and required extensive assistance with activities of daily living (ADLs).</p> <p>Observation, on 07/16/14 at 9:20 AM, revealed RN #1 and Licensed Practical Nurse (LPN) #3 assessed Resident #1's skin and provided peri/catheter care. RN #1 cleaned the resident's anal area with a washcloth, and did not change her gloves. She obtained another wash cloth and provided catheter care without washing her hands or changing gloves.</p> <p>Interview with RN #1, on 07/17/14 at 3:30 PM, revealed she did not change her gloves during Resident #1's care, and she only touched the washcloth with her gloves during the peri/catheter care.</p> <p>Interview with the Director of Nursing (DON), on 07/17/14 at 12:28 PM, revealed the staff should always change their gloves before cleaning around the catheter.</p>	F 315			

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F 333	Continued From page 6	F 333	1. A physician's order was obtained for resident #14 on 7/16/2014 by the Unit Supervisor to reflect the accurate dosage and frequency. Resident #14 was observed by the lead Nurse and the Unit Supervisor on 7/16/2014 immediately and throughout the remainder of the day with no adverse effect. CMT #1 was counseled on 7/16/2014 by the Unit Supervisor to emphasis the importance of administering accurate medication to the residents in accordance with the Administration of Medication Policy.	8/8/2014	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure residents are free of any significant medication errors for one resident (Resident #14), in the selected sample of twenty-two (22) residents.  Findings include:  Review of the facility's "Administration of Medication" policy/procedure, revised 02/14, revealed to check the Medication Administration Record (MAR) for medications to be given. The MAR and the label affixed to the container should have corresponding information, including dosage instructions.  Observation, on 07/16/14 at 7:47 AM, revealed Certified Medication Technician (CMT) #1 administered one Coreg 25 milligrams (mg) tablet to Resident #14.  Record review revealed the facility admitted Resident #14 on 06/03/14 with diagnoses which included Atrial Fibrillation, Congestive Heart Failure, and a Cardiac Pacemaker. Review of the Physician's Orders, dated 06/03/14, and the MAR, dated July 2014, revealed an order for	F 333 F 333	2. All residents who were administered medications on 7/16/2014 by CMT #1 were identified by the Unit Supervisor with no other residents were determined to be affected.  3. The Unit Supervisors provided education on the Administration of Medication Policy to all licensed nurses and CMT's to ensure their understanding and compliance; completed on 8/7/2014.  4. Effective 7/16/2014, any nurse or CMT who identifies a variance from the medication administration policy will report it to the DON or Unit Supervisors and a medication error report will be initiated. Rates and variances will be monitored ongoing by the Performance		

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F 333	<p>Continued From page 7</p> <p>Coreg 25 mg, give 50 mg once a dey. Further review of the MAR revealed CMT #1 initialed the medication as given twelve (12) days from 07/01/14 to 07/16/14.</p> <p>Interview with CMT #1, on 07/16/14 at 8:30 AM, revealed she had been giving Resident #14 one 25 mg Coreg tablet as the box indicated to give one pill. She revealed she should follow the MAR; however, the instruction to give 50 mg was missed.</p> <p>Interview with the Pharmacist, on 07/17/14 at 10:10 AM, revealed if Coreg was given at the inappropriate dosage, it may not have been as effective and the resident could have rebound tachycardia.</p> <p>Interview with the interim Director of Nursing (DON), on 07/17/14 at 11:40 AM, revealed she expected staff to read and give medications according to the MAR.</p>	F 333	<p>Improvement committee for necessary remedies to ensure a medication error rate of less than 5% is maintained. The Unit Supervisors will complete observations of the medication pass on a random basis of 10 staff monthly to monitor the accuracy of medication orders and accuracy of the dosage to ensure the facility maintains a medication error rate of less than 5%. Results of the monthly observations will be submitted to the DON for a period of four consecutive months to ensure Performance Improvement.</p> <p>5. Completion date for the deficiency <b>8/8/2014</b></p>		

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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  BUILDING: 01.  PLAN APPROVAL: 1992.  SURVEY UNDER: 2000 Existing.  FACILITY TYPE: SNF/NF.  TYPE OF STRUCTURE: One (1) story, Type III (211).  SMOKE COMPARTMENTS: Six (6) smoke compartments.  FIRE ALARM: Complete fire alarm system installed in 1992 with 21 smoke detectors and 5 heat detectors.  SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1992.  GENERATOR: Type II generator installed in 1992. Fuel source is Diesel.  A standard Life Safety Code Survey was conducted on 07/16/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred ten (110) beds with a census of one-hundred seven (107) on the day of the survey.  The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from	K 000	This plan of correction is offered as an attempt to provide the highest level of quality services possible to our residents and is not an admission that the deficiencies cited are correct.  	

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

*Jacqueline H. Woodward*

TITLE

*Administrator*

(X6) DATE

*8/8/14*

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

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K 000 Continued From page 1  
Fire).

K 000,

Deficiencies were cited with the highest deficiency identified at "E" level.

K 038 NFPA 101 LIFE SAFETY CODE STANDARD

K 038 The facility ensures the exits are maintained in accordance with NFPA 101 7.1. 19.2.1

8/16/14

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 the exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred ten (110) beds and at the time of the survey, the census was one-hundred seven (107).

The findings include:

Observation, on 07/16/14 at 10:22 AM with the Maintenance Director, revealed the building 3 switch gear room does not have a 4' wide durable surface to a public way from the side exit.

Interview, on 07/16/14 at 10:23 AM with the Maintenance Director, revealed he was unaware the exit was not properly equipped with a

1. On 07/16/14, The Manager Facility Operations surveyed the exit doors of the buildings 3 switch gear room and determined this was not a required exit path for residents. No residents were identified to be affected.

2. On 07/16/14, The Manager Facility Operations surveyed all other exit doors for buildings 3 thru 5 to ensure that appropriate durable surfaces are in place to the public way. All inspections were completed by 5:00 p.m. on 07/16/14. No other residents were identified to be affected.

3. On 08/01/14, The Manager of Facilities Operations hired a local contractor to install a 4' wide concrete sidewalk from the exit door of building 3 switchgear room to the public way. This sidewalk will be completed no later than 5:00 p.m. August 15, 2014.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186326	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  07/16/2014
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NAME OF PROVIDER OR SUPPLIER  CAL TURNER REHAB AND SPECIALTY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 466 BURNLEY RD. SCOTTSVILLE, KY 42164
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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 038	<p>Continued From page 2 sidewalk.</p> <p>The census of one-hundred seven (107) was verified by the Administrator on 07/16/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 07/16/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 edition) 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>	K 038	<p>4. Starting 8/1/14, the Facility manager or designee will check all exits for proper walkways to ensure exiting to a public way as a part of quarterly life safety inspection with additional manager from Facilities Manager team. This will be done for the next 6 months and findings of the inspections will be reported by Facility Manager to the Sub-Safety Committee quarterly.</p> <p>5. All corrective actions will be completed by 5:00 p.m. on 8/15/14.</p>	
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NAME OF PROVIDER OR SUPPLIER  CAL TURNER REHAB AND SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 458 BURNLEY RD. SCOTTSVILLE, KY 42164	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 3	K 038	The facility ensures that building has a complete sprinkler system in accordance with NFPA Standards. 1. On 07/16/14, the Manager of Facility Operations surveyed the shower rooms on building 4 and 5 and determined no other areas were identified to be affected. On 8/1/14, the Manager of Facility Operations contracted with a local fire sprinkler company to add an additional sprinkler head in the shower room in building 5 and building 4 for the center stall of each of these shower rooms. The sprinklers were added and project was completed on 8/5/14.2.  2. On 07/16/14, the Manager of Facility Operations surveyed all other smoke compartments of the facility to ensure that there are no other areas that lack sprinkler coverage. No other areas or residents were identified to be affected.  3. Beginning 8/20/14, the Facility Manager will conduct monthly Life Safety walk through inspections with the DON or designee for the next 6 months.  4. Beginning 8/20/14, the Facility Manager will report quarterly to the Sub-Safety committee any deficient practices for the next 6 months.  5. All corrective actions were completed on 8/06/14.	8/06/14
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 building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice has the potential to affect two (2) of six (6) smoke compartments, all residents, staff and visitors. The facility has the capacity for one-hundred ten (110) beds and at the time of the survey, the census was one-hundred seven (107). According to CMS S&C 13-55-LSC the enforcement implication would be a fully sprinklered facility with minor problems  The findings include:			

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NAME OF PROVIDER OR SUPPLIER  CAL TURNER REHAB AND SPECIALTY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 456 BURNLEY RD. SCOTTSVILLE, KY 42164
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K 056	<p>Continued From page 4</p> <p>Observation, on 07/16/14 at 1:35 PM with the Maintenance Director, revealed the shower room in building 5 did not have proper sprinkler protection for the center stall of the room.</p> <p>Interview, on 07/16/14 at 1:36 PM with the Maintenance Director, revealed he was unaware the center shower in the shower room was not properly sprinkler protected.</p> <p>Observation, on 07/16/14 at 2:15 PM with the Maintenance Director, revealed the shower room in building 4 did not have proper sprinkler protection for the center stall of the room.</p> <p>Interview, on 07/16/14 at 2:16 PM with the Maintenance Director, revealed he was unaware the center shower in the shower room was not properly sprinkler protected.</p> <p>The census of one-hundred seven (107) was verified by the Administrator on 07/16/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 07/16/14.</p> <p>Actual NFPA Standard:</p> <p>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.</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>	K 056		
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NAME OF PROVIDER OR SUPPLIER  <b>CAL TURNER REHAB AND SPECIALTY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>466 BURNLEY RD. SCOTTSVILLE, KY 42184</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 056	<p>Continued From page 5</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> <ul style="list-style-type: none"> <li>(1) Sprinklers installed throughout the premises</li> <li>(2) Sprinklers located so as not to exceed maximum protection area per sprinkler</li> <li>(3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</li> </ul> <p>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:</p> <ul style="list-style-type: none"> <li>(1) Wet pipe system</li> <li>(2) Light hazard or ordinary hazard occupancy</li> <li>(3) 20-ft (6.1-m) maximum ceiling height</li> </ul> <p>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</p>	K 056		

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NAME OF PROVIDER OR SUPPLIER  <b>CAL TURNER REHAB AND SPECIALTY CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>466 BURNLEY RD. SCOTTSVILLE, KY 42164</b>
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K 056	Continued From page 6 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.	K 056	The facility ensures that all wiring and equipment are in accordance with NFPA 70, NEC 9.1.2.	
K 147 SS=E	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, fifty-eight (58) residents, staff and visitors. The facility has the capacity for one-hundred ten (110) beds and at the time of the survey, the census was one-hundred seven (107).</p> <p>The findings include:</p> <p>Observations, on 07/16/14 at 7:45 AM with the Maintenance Director, revealed open electrical junction box located above resident room# B18.</p> <p>Interview, on 07/16/14 at 7:46 AM with the Maintenance Director, revealed he was unaware of the open electrical box located in the etic.</p>	K 147	<p>1. On 07/16/14 the Facility Manager assigned work orders to Engineering staff to install cover plates on open junction boxes for smoke compartments and residents identified to be affected, one located in building B above ceiling of room B18 and 2 boxes in building 4 above ceiling of nurses station; one box in building C above ceiling of room C19 and one box above ceiling in room C22. The work orders were completed on 7/16/14.</p> <p>2. On 7/16/14, the Facility Manager and Engineering staff inspected all smoke compartments for the potential to affect residents, staff, and visitors. On 07/16/14, Engineering staff was assigned to look and ensure all electrical junction boxes had cover plates on them. All inspections were completed by 5:00 p.m. on 08/1/14. No other smoke compartments and residents were identified as having the potential to be affected.</p>	08/02/14

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NAME OF PROVIDER OR SUPPLIER  <b>CAL TURNER REHAB AND SPECIALTY CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>466 BURNLEY RD. SCOTTSVILLE, KY 42164</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 147	<p>Continued From page 7</p> <p>Observations, on 07/16/14 at 8:05 AM with the Maintenance Director, revealed two (2) open electrical junction boxes located above the nurses' station in building 4.</p> <p>Interview, on 07/16/14 at 8:06 AM with the Maintenance Director, revealed he was unaware of the open electrical boxes located in the attic.</p> <p>Observations, on 07/16/14 at 8:28 AM with the Maintenance Director, revealed open electrical junction box located above resident room# C19.</p> <p>Interview, on 07/16/14 at 8:29 AM with the Maintenance Director, revealed he was unaware of the open electrical box located in the attic.</p> <p>Observations, on 07/16/14 at 8:25 AM with the Maintenance Director, revealed open electrical junction box located above resident room# C22.</p> <p>Interview, on 07/16/14 at 8:26 AM with the Maintenance Director, revealed he was unaware of the open electrical box located in the attic.</p> <p>The census of one-hundred seven (107) was verified by the Administrator on 07/16/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 07/16/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 70 (1999 edition) 370.28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of</p>	K 147	<p>3. Beginning 8/20/14, the Facility Manager will conduct monthly Life Safety inspections with DON or designee which will include electrical system inspections. These inspections will continue for 6 months. Beginning 8/20/14, the Facility's Manager will also conduct quarterly Life Safety inspections with another Manager from Facilities Management team.</p> <p>4. Beginning 8/1/14, the Facility's Manager will monitor monthly completion of preventive maintenance room inspections to include electrical safety inspections. Beginning 8/19/14, the Facility Manager will report quarterly to the Sub-Safety committee any deficient practices for the next 6 months.</p> <p>5. All corrective actions were completed by 5:00 p.m. on 08/02/14.</p>	

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K 147	Continued From page 8 use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147		