

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

PRINTED: 06/20/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  06/06/2013
NAME OF PROVIDER OR SUPPLIER  HOMESTEAD NURSING CENTER, NEW CASTLE, KENTUCKY			STREET ADDRESS, CITY, STATE, ZIP CODE 50 ADAMS STREET NEW CASTLE, KY 40050		
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F 000	INITIAL COMMENTS  A standard health survey was conducted 06/04/13 through 06/06/13. A Life Safety Code Survey was conducted on 06/06/13. Deficiencies were cited with the highest scope and severity of a "F" for the Health and Life Safety Code with the facility having the opportunity to correct before remedies would be recommended.	F 000	Submission of this plan of correction does not constitute admission of agreement with conclusions set forth in the statement of deficiencies. However, in an effort to enhance the care furnished to our residents, we have augmented some of our existing policies and protocols. We acknowledge that federal and state regulations require a plan of correction, and we are therefore submitting this plan.		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE  A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.  The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to have survey results readily accessible for all residents to review. The survey book had been placed in the medication room behind the nurses' station, where residents did not have access.  The findings include:  During the Group Resident Council meeting, on 06/04/13 at 2:00 PM, with the surveyor, all residents in attendance (5) stated they did not know where the survey result book was kept. The	F 167	1. On 6/7/2013 the " Public Information" binder containing the survey results was placed back in the front lobby. On 6/11/2013, Denise Needham, Social Services Director informed the residents council that the survey results would be available for examination and posted in the front lobby in the binder titled " Public Information Binder."  2. The Administrator wrote a column in the July 2013 newsletter that is delivered to all residents and responsible parties, explaining that survey results would be available for examination and posted in the front lobby in the binder titled " Public Information Binder."  3. Residents will be informed monthly in the resident council meetings that the survey results are available for examination and posted in the front lobby of the facility in a binder titled " Public Information Binder."  4. The Quality Assurance Nurse has developed an audit to ensure the Public Information Binder with the survey results is located in the front lobby and available for review without request. The Administrator starting 6/7/2013 will conduct this audit weekly times 4 weeks, then monthly times four months. Then, the Quality Assurance Committee will determine the need for continuation.  5. The Administrator is responsible for compliance.	6/14/13	

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

TITLE

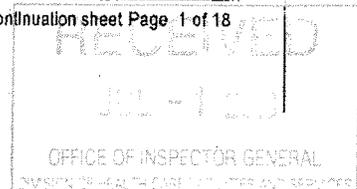
(X6) DATE

*Julene Stiles, RN*

*Administrator*

*6/28/2013*

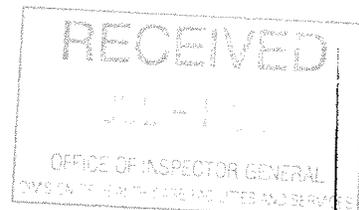
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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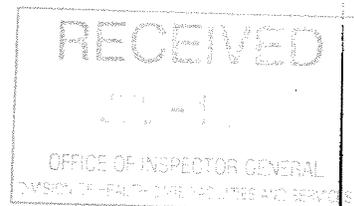
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F 167	Continued From page 1 residents did know they were allowed to examine the results.  Observation of the front lobby, on 06/04/13 at 2:40 PM, revealed the nurses' station (facility only had one), and other areas of the facility observed had no survey results available for review. Observation revealed a sign posted on the wall beside the nurses' station that informed the reader the survey results were available upon request.  Interview with the Administrator, on 06/04/13 at 2:45 PM, revealed the survey result binder was kept on a table in the front lobby. However, observation revealed the binder was not there. The Administrator questioned the staff and a nurse brought the survey binder out of the medication room behind the nurses' station. The Administrator stated she did not know why the survey binder had been placed in the medication room. It was supposed to be in the front lobby for all residents to review. She asked the staff available at the time of the observation and nobody knew who had placed the survey binder in the medication room.	F 167			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329			



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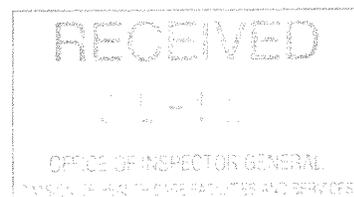
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F 329	Continued From page 2  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure two (2) of fourteen (14) sampled residents were free from unnecessary drugs. The facility failed to attempt a Gradual Dose Reduction (GDR) for Resident #4 and #10 who were receiving antipsychotic medications nor documented why it would be clinically contraindicated to reduce. Resident #4 had been on an antipsychotic medication since 03/23/11 without a GDR attempted. In addition, Resident #10 received Depakote without adequate monitoring.  The findings include:  The facility provided a two-page document (page 111-112) titled Medication Monitoring and Management as their policy. No date was	F 329	1. On 6/6/13, the facility psychiatrist saw Resident # 4 and Resident #10. The facility psychiatrist noted on 6/6/13 on Resident #4 that a trial dose reduction is contraindicated due to exacerbation of psychotic features and mood dysregulation. The psychiatrist noted on 6/6/13 on Resident #10 that a trial dose reduction is contraindicated related to anxiety, behavior disturbance, and mood dysregulation. On 6/21/13, the facility's Antipsychotic Reduction Committee requested dose reductions and review of dosages of Risperdal on Resident #4 and Resident #10. The psychiatrist decreased Resident #4 and 10's Risperdal dosages at that time. On 6/10/13, a STAT Depakote level was obtained for Resident #10. Resident #10's lab level was 31, which is considered a low level. This resident was not affected.  2. On 6/6/13, an audit was conducted by the Quality Assurance nurse to identify any resident on an antipsychotic medication. Any resident found to not have received a dose reduction within the last year was presented at the facility's Antipsychotic Reduction Committee conducted on 6/26/13. Request for antipsychotic dose reductions were sent to the psychiatrist for review of appropriate diagnosis and reduction. On 6/11/13, the Director of Nursing conducted an audit of all lab orders of all residents on Depakote for behaviors. Any residents found to have not received Depakote levels every 6 months as recommended by the psychiatrist had a STAT valproic acid level obtained. No resident was found to have an elevated valproic acid level. Therefore, no further residents were affected.  3. The Gradual Dose Reduction of Psychotropic Medications Assessment Form used during the facility's Antipsychotic Reduction Committee was modified to incorporate a physician's rationale for contraindication of dose reduction. All written orders for psychotic medications will be reviewed Monday through Friday in the morning Standards of Care		



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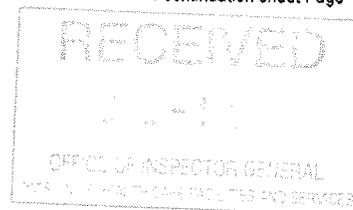
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F 329	Continued From page 3 included. The facility could not provide a policy for monitoring of drug levels. Review of the two-page document revealed on page 111 the policy read when a resident's clinical condition had improved or stabilized, and behavioral interventions had been effective in reducing the symptoms, the resident would be evaluated for the appropriateness of a taper or GDR of the medication. Antipsychotics: if the facility initiated antipsychotic therapy, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts) within the first year, unless clinically contraindicated. A GDR would be considered clinically contraindicated if targeted symptoms returned or worsened after the most recent attempt at a GDR and the physician documented the clinical rationale for why an additional attempted dose reduction would likely impair the resident's function, increase distressed behaviors, or cause psychiatric instability.  In addition, the document stated the continued use was in accordance with relevant current standard of practice and the physician would document the clinical rationale for why any additional attempted dose reduction would likely impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.  1. Review of Resident #4's clinical record revealed the facility admitted the resident on 02/15/11 with diagnoses of Dementia, Hypertension, and Anemia. On 02/18/11, the resident expressed sadness to the nurse. The resident's primary physician ordered an	F 329	meetings. All residents with new orders for Depakote for behaviors will be reviewed in the standards of care meetings to ensure an appropriate lab order has been obtained. The Staff Development Coordinator will in-service the facility's Antipsychotic Reduction Committee on the Medication Monitoring and Management of Antipsychotics policy by 6/26/13. In-servicing will be provided by the Staff Development Coordinator to all licensed nurses on obtaining appropriate physician ordered labs when Depakote for behaviors is ordered, and documentation of resident behaviors by 7/12/13. Certified Nursing Assistants will be in-serviced by the Staff Development Coordinator on documentation of resident behaviors by 7/12/13.  4. The Quality Assurance nurse will audit all residents on antipsychotic medications to ensure a dose reduction has been attempted per policy monthly times 3 months, then every two months times 3 months, then the Quality Assurance Committee will determine the need for continuation. The Quality Assurance nurse will audit all residents on Depakote for behaviors to ensure lab levels are ordered monthly times 3 months, then the Quality Assurance Committee will determine the need for continuation.  5. The Director of Nursing is responsible for compliance.	7/12/13	



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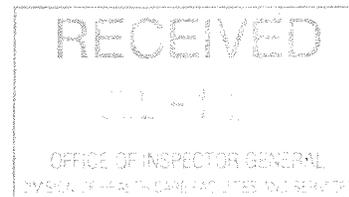
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F 329	Continued From page 4 antidepressant medication. On 02/25/11, the nurses' notes stated the resident had increased anxiety, Ativan 0.25mg was given as ordered. On 03/16/11, the Ativan 0.25mg was changed to be given every morning. The record revealed a condition change form was completed by a nurse for a status change on 03/23/11. The record revealed the facility called the psychiatric service that provided care for the residents in this nursing home. The psychiatrist ordered the Ativan to be discontinued and ordered Risperdal 0.5mg to be given at 4:00 PM daily. This was an antipsychotic medication. However, the record revealed the psychiatrist had not seen the resident yet. The psychiatrist's initial visit with the resident was on 04/11/11. A diagnosis of Parkinson was added. The psychiatrist's documentation revealed the resident was not exhibiting any hallucinations at that time; however, the psychiatrist documented the resident was paranoid per staff. Review of the most recent psychiatric follow-up evaluation revealed diagnoses of Depressive Affective Disorder, recurrent episode, severe degree with psychotic behavior, and Bereavement Disorder had been added.  Continued review of the clinical record revealed on 03/30/11, Resident #4 made negative statements like, "I want to get out of this jail." " Will someone give me bail money?" The resident voiced he/she was more confused. Later that day the nurse documented the resident was having episodes of hallucinations of seeing his/her father in a cage beside the resident's bed. The resident was re-admitted to the facility on 04/15/11 after hospitalization. The Risperdal 0.5mg (1) was reordered to be given at bedtime. Extensive review of the clinical record from May 2011 to	F 329			



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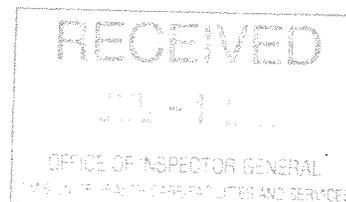
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F 329	<p>Continued From page 5</p> <p>June 2013 revealed no documented evidence of any hallucinations, delusions, or paranoid behaviors. It was well documented the resident becomes tearful at times and different antidepressants had been tried. The resident experienced a loss of their spouse and was given a diagnosis of Bereavement Disorder.</p> <p>Review of the facility's mood and behavior monitoring sheets from May 2012 through June 2013 revealed Resident #4 exhibited no psychotic behaviors, no hallucinations, no delusions or any type of behaviors. The only mood documented was on April 17, 2013 when the resident stated life was not worth living. However, review of the nurses' notes for that date revealed no documented mood or behaviors except occasional tearfulness.</p> <p>Review of the Psychiatric service evaluation forms revealed a standardized form with multiple choice to check for why a GDR would not be attempted. Review of completed forms dated 11/01/12 through 06/06/13 revealed the psychiatrist always checked Mood Dysregulation or Psychotic Features. However, the psychiatrist also checked the resident had no symptoms of psychotic features, no hallucinations, and no delusions. The last evaluation occurred during the survey on 06/06/13. The psychiatrist's assessment revealed the resident was in no acute distress, had no recent tearfulness, no psychotic episodes, and no hallucinations. Although, the resident had not exhibited any symptoms of psychotic features, the psychiatrist documented a GDR would not be attempted.</p> <p>Interview with the Psychiatrist, on 06/06/13 at</p>	F 329			



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F 329	Continued From page 6 11:00 AM, revealed the resident had a history of Major Depression with Psychotic Features and these types of patients required long term medication treatment. However, the psychiatrist did not know if the resident had ever had an inpatient stay at a Psych hospital or if the resident had been treated for depression prior to admission to this nursing facility. The psychiatrist stated the resident was in a really bad state of depression when the resident was first admitted to the nursing facility and she was afraid if a GDR of the Risperdal was attempted, the resident would deteriorate. She stated she would never attempt a GDR because the resident was still exhibiting symptoms of Depression. However, she revealed there was a GDR of the antidepressant medication ( Remeron) that failed and she was afraid to touch the Risperdal. She stated she had to add another medication Nyedexta 20mg (1) daily for tearfulness. This medication was added March 2012. When asked if she reviewed the facility's mood/behavior monitoring forms, she stated she did not but her liaison would read the nurses' notes and question staff on the resident's behaviors. She stated she was familiar with the federal regulations regarding GDR. She again stated she would not attempt a GDR for Resident #4 even though there were no documented episodes of psychotic behaviors.  Interview with the Administrator, on 06/06/13 at 3:30 PM, revealed the resident had been stable while on the drug Risperdal. She stated the resident had really bad hallucinations upon admission to the nursing facility (February 2011) and she was afraid if a GDR was attempted, the hallucinations may return. She stated the resident was doing so good, they did not want to mess	F 329			



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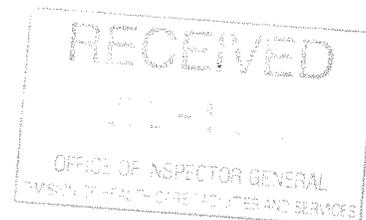
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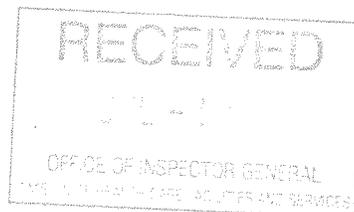
F 329	<p>Continued From page 7</p> <p>with the resident's medication. She reviewed the mood/behavior monitoring sheets and acknowledged no behaviors had been documented. She stated staff knew the resident well and did not always document behaviors in the record. She verified a GDR had not been attempted for the Risperdal.</p> <p>Interview with the Director of Nursing, on 06/06/13 at 4:20 PM, revealed the GDR committee was started last fall, 2012. She stated it was an intra-discipline team that consisted of herself, Administrator, Pharmacist, Social Worker, and the Psychiatrist upon her monthly visits. She stated they follow the quarterly assessment schedule and reviewed those residents receiving antipsychotic medications to determine if a GDR could be attempted. She continued to state the team would review nurses' notes, social services notes, mood/behavior monitoring forms, and the Psychiatric services evaluation forms to make their determination if a GDR should be attempted. The documentation from these meetings are shared with the psychiatrist's liaison before the psychiatrist's monthly scheduled visit. She stated a GDR was attempted for the antidepressant drug Remeron and the resident was noted to be tearful. She said no GDR had been attempted for the antipsychotic medication, Risperdal.</p> <p>Review of the GDR assessment form dated 11/07/12 revealed a GDR was indicated; however, it stated to continue the Risperdal due to history of visual hallucinations. On 02/19/13, the assessment revealed the antidepressant drug Remeron was discontinued on 11/07/12, was reordered on 11/19/12 due to resident's</p>	F 329		
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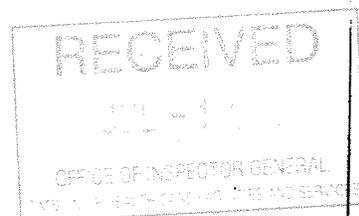
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F 329	Continued From page 8 tearfulness. On 04/16/13, the assessment revealed no GDR indicated, however it did not address the Risperdal.  Observation of Resident #4, on 06/04/13 at 12:25 PM, revealed the resident eating lunch in the main dining room. Observation, on 06/05/13 at 10:00 AM, revealed the resident dressed, sitting in a wheelchair, reading a Bible. Interview with the resident revealed the resident became tearful when speaking about his/her deceased spouse. However, the resident then smiled at the surveyor and talked of pleasant things that he/she enjoyed.  2. Review of Resident #10's medical record revealed diagnoses included Depressive Disorder, Psychosis, Affective Personality Disorder/Borderline Personality Disorder, and Generalized Anxiety. Review of the Significant Change Minimum Data Set (MDS) Assessment dated 05/14/13 revealed the facility assessed the resident to as having a Brief Interview for Mental Status (BIMS) score of twelve (12) indicating the resident was moderately impaired in cognitive skills for decision making. Further review revealed the facility assessed the resident as having verbal behavioral symptoms directed toward others.  Review of the Physician's Orders dated 06/13, revealed orders for Depakote 200 milligrams's (mg's) twice a day related to Bipolar Disorder. Further review revealed the medication was increased from 125 mg's twice a day to 250 mg twice a day on 08/02/13.	F 329			



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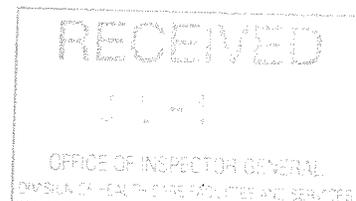
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 9</p> <p>Continued review revealed no Physician's Orders to obtain Valproic Acid levels, even though the resident was receiving Depakote 200 mg's twice a day. Review of the Laboratory data revealed the last Valproic Acid level was obtained on 08/07/12 with a level of 36 Low (reference 50-100 ug/ml).</p> <p>Review of the Psychiatric Follow up Evaluations completed by the Psychiatrist for 01/10/13, 02/07/13, 03/07/13, 04/11/13, and 05/02/13 revealed the latest Valproic Acid level was obtained on 08/07/12 with a level of 36 Low.</p> <p>Interview, on 06/06/13 at 11:10 AM, with the Psychiatrist revealed the Depakote was ordered for Bipolar Disorder and was a mood stabilizer for this resident. Further interview revealed Valproic Acid levels should be drawn at least every six (6) months while the resident was receiving Depakote and the Psychiatrist indicated she was unaware the level had not been obtained since 08/12.</p> <p>Interview, on 06/06/13 at 11:20 AM, with the Consulting Pharmacist revealed he completed monthly Drug Regimen Reviews at the facility. He stated during the reviews he checked for duplicate therapy, high doses of medication, pertinent diagnoses, blood pressure checks, duration of medications, and monitoring blood levels of medications; however, he had "missed" that the Valproic Acid level was not being monitored. He further stated there did not have to be a therapeutic level of Valproic Acid if using the Depakote for behaviors; however, the levels would need to be checked routinely to ensure the blood levels were not toxic.</p>	F 329			



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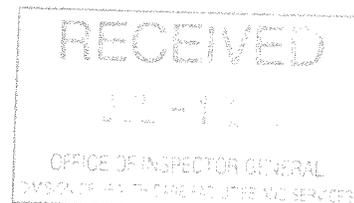
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F 329	Continued From page 10  Interview, on 06/06/13 at 4:20 PM, with the Director of Nursing (DON) revealed normally the Psychiatrist would write orders for labs for behavior medications which required blood levels to be monitored. She stated the Unit Manager was pulled off the floor once a week to audit and monitor medications which required blood levels to be drawn.  Interview with the Unit Manager, on 06/06/13 at 4:30 PM, revealed she depended on the Physician/Psychiatrist to order labs for behavior medications which required monitoring of blood levels such as Valproic Acid because it was up to the Physician's discretion. Further review revealed she also reviewed the pharmacist's Drug Regimen Reviews when doing the audits of the medications.	F 329			
F 371 SS=F	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to serve food under sanitary conditions.	F 371	1. On 6/21/13, an audit was performed by the Director of Nursing Services on all charts of residents residing in the facility from 6/4/13 through 6/11/13 for signs and symptoms of food borne illness. No residents were found to exhibit any signs and symptoms of food borne illness, therefore no residents were affected.  2. Since the alleged deficient practice was found during tray line service on 6/4/13, all residents in the facility during that time had the potential to be affected. An audit was conducted on 6/21/13 by the Director of Nursing Services on all residents in the facility from 6/4/13 through 6/11/13 for signs and symptoms of food borne illness. No residents were affected.  3. On 6/6/13, the Dietary Manager in-serviced all dietary staff on the hand washing policy and procedure. A new policy and procedure regarding tray line was implemented on 6/6/13 by the		



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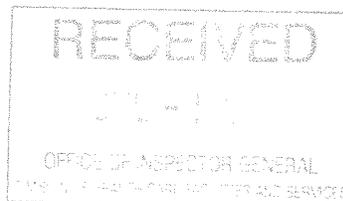
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F 371	<p>Continued From page 11</p> <p>The dietary worker left the tray line and went throughout the kitchen numerous times and returned to the tray line to serve food without washing hands.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Employee Sanitary Practices (no-date) revealed employees were to follow the hand washing policy and procedure.</p> <p>Review of the hand washing procedure (no date) revealed hands were to be washed after handling soiled dishes.</p> <p>Observation of the tray line service, for 06/04/13 at 11:00 AM, revealed the dietary worker left the tray line numerous times and went to obtain food from the stove, dropped tongs and ladles onto the floor and into the steam table water, obtained temperatures of foods, removed pans from the steam table and placed back into oven, and obtained bowls and plates without washing hands prior to returning to the tray line service.</p> <p>Interview with the Dietary Worker, on 06/04/13 at 12:00 PM, revealed hands should have been washed upon return to the food tray line after handling soiled dishes and touching other equipment in the kitchen. The Dietary worker said she usually washed her hands; however, was nervous during the tray line observation.</p> <p>Interview with the Dietary Manager, on 06/06/13 at 2:00 PM, revealed the dietary worker should not have left the tray line to obtain items needed. The kitchen had a staff assigned to be a "runner"</p>	F 371	<p>Dietary Manager. This policy and procedure ensures that the tray line staff remain on the tray line and another dietary staff member will have the job assignment to obtain food or supplies needed, ensuring no unclean items are handled by tray line staff. The Dietary Manager in-serviced all dietary staff on the tray line policy and procedures on 6/6/13.</p> <p>4. The Dietary Manager will observe dietary employees on the tray line to ensure tray line and hand washing policy and procedures are being followed twice a week times four weeks, once a week times four weeks, then once a week every other week times four weeks. At that time, the Quality Assurance Committee will determine the need for continuation.</p> <p>5. The Dietary Manager is responsible for compliance.</p>	7/4/13	



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F 371	Continued From page 12 to get items the tray line server may have needed. According to the Dietary Manager, if the dietary worker left the tray line and touched other areas in the kitchen with her hands, she should have washed her hands prior to returning to the tray line.	F 371			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the contract pharmacy reported any irregularities to the attending physician and the Director of Nursing in regard to recommendation of a Gradual Dose Reduction (GDR) for two (2) of fourteen (14) sampled residents. Residents #4 and # 10. In addition, Resident #10 received Depakote without monitoring levels and the Pharmacist failed to recommend monitoring of the Depakote levels. (Refer to F329)  The findings include:	F 428	1. On 6/6/13, the facility psychiatrist saw Resident #4 and Resident #10. The facility psychiatrist noted on 6/6/13 on Resident #4 that a trial dose reduction is contraindicated due to exacerbation of psychotic features and mood dysregulation. The psychiatrist noted on 6/6/13 on Resident #10 that a trial dose reduction is contraindicated related to anxiety, behavior disturbance, and mood dysregulations. On 6/21/13, the facility's Antipsychotic Reduction Committee requested dose reductions and review of dosage of Risperdal on Resident #4 and #10's Risperdal dosages at that time. On 6/10/13, a STAT Depakote level was obtained for Resident #10. Resident #10's lab level was 31, which is considered a low level. This resident was not affected.  2. On 6/6/13, an audit was conducted by the Quality Assurance nurse to identify any resident on an antipsychotic medication. Any resident found to not have received a dose reduction within the last year was presented at the facility's Antipsychotic Reduction Committee conducted on June 26, 2013. Requests for antipsychotic dose reductions were sent to the psychiatrist for review of appropriate diagnosis and reductions. On 6/11/13, The Director of Nursing conducted an audit on all lab orders of all residents on Depakote for behaviors. Any residents found to have not received Depakote levels every 6 months as recommended by the psychiatrist had a STAT valporic acid level obtained. No resident was found to have an elevated valporic acid level. Therefore, no further residents were affected.		



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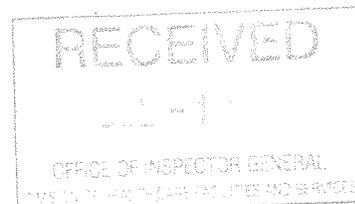
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F 428	Continued From page 13 The facility provided a two-page documentation for medication monitoring and management as their policy. No date was included. The facility could not provide a policy for monitoring of drug levels. Review of the two-page documentation revealed if a medication seemed unnecessary or harmful to the resident, the Director of Nursing (DON) or consultant Pharmacist would request the prescriber to evaluate the resident for continued need for the medication or consider tapering the medication. In addition, the document indicated a Gradual Dose Reduction (GDR) would be initiated for residents on antipsychotic medication unless clinically contraindicated.  1. Review of Resident #4's clinical record revealed the facility admitted the resident on 02/15/11 with diagnoses of Dementia, Hypertension, and Anemia. The clinical record revealed on 02/18/11, the resident expressed sadness to the nurse. The resident's physician started the resident on an antidepressant. On 02/25/11, the nurses' notes stated the resident had increased anxiety, Ativan 0.25mg was given as ordered. On 03/16/11, the Ativan 0.25mg was changed to be given every morning. The record revealed the resident had a change in condition on 03/23/12. The facility called Psych Services and the Psychiatrist ordered the Ativan to be discontinued and start Risperdal 0.5mg at 4:00 PM daily. However, the record revealed the psychiatrist had not seen the resident yet. The initial psychiatric evaluation was conducted on 04/11/11 and a diagnosis of Parkinson was added. The documentation revealed the resident was not exhibiting any hallucinations at that time; however, the Psychiatrist documented the	F 428	3. The Gradual Dose Reduction of Psychotropic Medications Assessment Form used during the facility's Antipsychotic Reduction Committee was modified to incorporate a physician's rationale for contraindication of dose reduction. All written orders for psychotic medications will be reviewed Monday through Friday in the morning standards of care meetings. All residents with new orders for Depakote for behaviors will be reviewed in the Standards of Care meetings to ensure an appropriate lab order has been obtained. The Staff Development Coordinator will in-service the Antipsychotic Reduction Committee, including the contracted pharmacist, on the medication moderating and Management of Antipsychotics policy by 6/26/13. In-servicing will be provided by the Staff Development Coordinator to all licensed nurses on obtaining appropriate physician ordered labs when Depakote for behaviors is ordered, and documentation of resident behaviors by 7/12/13. Certified Nursing Assistants will be in-serviced by the Staff Development Coordinator on documentation of resident behaviors by 7/12/13.  4. The Quality Assurance nurse will audit all residents on antipsychotic medications to ensure a dose reduction has been recommended by the contracted pharmacist and attempted per policy monthly times 3 months, every two months times 3 months, then the Quality Assurance Committee will determine the need for continuation. The Quality Assurance nurse will audit all residents on Depakote for behaviors to ensure lab levels are recommended by the consultant pharmacist and ordered monthly times 3 months, then Quality Assurance Committee will determine the need for continuation.  5. The Administrator is responsible for compliance. 7/12/13		



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F 428	<p>Continued From page 14</p> <p>resident was paranoid per staff. Review of the on-going monthly psych evaluations revealed diagnoses of Depressive Affective Disorder, recurrent episode, severe degree with psychotic behavior, and Bereavement Disorder was added at some point.</p> <p>Review of the consultant pharmacist medication regimen review for 03/24/13 revealed he requested a diagnosis for the use of Risperdal. The record revealed the diagnosis of Non-Alzheimer's Dementia with Psychotic Disorder was given.</p> <p>Continued review of the pharmacy review revealed on 06/03/11, the pharmacist documented GDR Risperdal 1st (-) Y. On 09/22/11, the pharmacist documented checked Risperdal, Psych note, no changes. The Risperdal was not mentioned from 09/22/11 through 05/30/13.</p> <p>Interview with the Consultant Pharmacist, on 06/05/13 at 11:15 AM, revealed he conducted monthly medication regimen reviews for all residents at this nursing facility. He stated he had reviewed Resident #4's medications, including Risperdal, each month. In regard to GDR, he said whenever the psychiatrist noted on her evaluation form a trial dose reduction would be contraindicated secondary to risk for exacerbation of mood dysregulations or psychotic features, he would not recommend a GDR. He stated he knew the federal regulations and had recommended GDR before but not for the Risperdal. He assumed the resident was still exhibiting behaviors and required the medication. He revealed he was on the newly formed GDR</p>	F 428			



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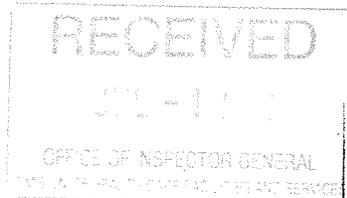
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NAME OF PROVIDER OR SUPPLIER  HOMESTEAD NURSING CENTER, NEW CASTLE, KENTUCKY	STREET ADDRESS, CITY, STATE, ZIP CODE 60 ADAMS STREET NEW CASTLE, KY 40050
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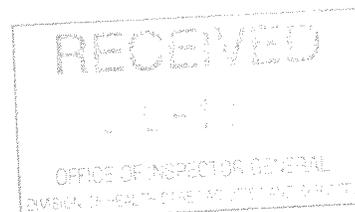
F 428	<p>Continued From page 15</p> <p>committee and the committee would review residents on antipsychotic medication quarterly. He again confirmed he had not recommended a GDR for the drug Risperdal.</p> <p>Interview with the Director of Nursing, on 06/06/13 at 4:20 PM, revealed the pharmacist did attend the GDR Committee monthly meetings and did recommend GDR for some medications. However, since the Psychiatrist checked she did not want to attempt a GDR on the Risperdal, they did not request a GDR. She revealed the Administrator and DON reviewed the pharmacy reports.</p> <p>2. Review of Resident #10's clinical record revealed diagnoses which included Depressive Disorder, Psychosis, Affective Personality Disorder/Borderline Personality Disorder, and Generalized Anxiety. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 05/14/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of twelve (12) indicating the resident was moderately impaired in cognitive skills.</p> <p>Review of the Mood and Behavior Log for 05/12 revealed the resident was short tempered, and continued to have verbal and physical behaviors, and continued to reject care. Further review revealed the 06/13 Mood and Behavior Log revealed the resident continued to have verbal behaviors and rejection of care.</p> <p>Review of the Physician's Orders, dated 06/13, revealed orders for Depakote 200 mg's (Bipolar Disorder mood stabilizer) twice a day related to</p>	F 428		
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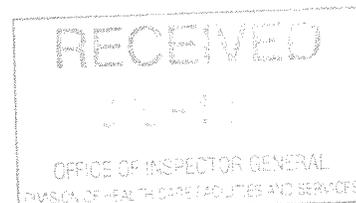
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F 428	<p>Continued From page 16 Bipolar Disorder.</p> <p>Continued review, revealed the Depakote was increased 08/02/12 from 125 mg twice a day to 250 mg's twice a day. Review of the laboratory data revealed the last Valproic Acid level to monitor the Depakote medication was obtained on 08/07/12 with a level of 36 Low (reference 50-100 ug/ml).</p> <p>Review of the Psychiatric Follow up Evaluations completed by the Psychiatrist for 01/10/13, 02/07/13, 03/07/13, 04/11/13, and 05/02/13 revealed a trial dose reduction of the psychiatric medications was contraindicated secondary to the risk of either mood dysregulation, or anxiety with a description of the resident's current mood and behaviors including an assessment and clinical review of the resident's current condition since the last visit. Each of the Evaluations indicated the last Valproic Acid was obtained on 08/07/12 and there was no recommendations noted to check a subsequent Valproic Acid level.</p> <p>Further review of the medical record revealed there was no documented evidence the Consulting Pharmacist had recommended checking the Valproic Acid level in order to ensure adequate monitoring of the Depakote.</p> <p>Interview, on 06/06/13 at 11:10 AM, with the Psychiatrist revealed the resident had Bipolar Disorder and the Depakote was needed for a mood stabilizer and she would not decrease the dosage unless there was adverse side effects such as drowsiness. Continued interview revealed the Valproic Acid levels should be drawn at least every six (6) months while the resident</p>	F 428			



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F 428	<p>Continued From page 17</p> <p>was receiving Depakote and she indicated she was unaware the level had not been obtained since 08/12.</p> <p>Interview, on 06/06/13 at 11:20 AM, with the Consulting Pharmacist revealed he had "missed" that the Valproic Acid level was not being monitored during his drug regimen reviews. He further stated there did not have to be a therapeutic level of Valproic Acid if using the Depakote for behaviors; however, the the levels would need to be checked routinely to prevent toxicity.</p> <p>Interview, on 06/06/13 at 4:20 PM, with the Director of Nursing (DON) revealed normally the Psychiatrist would write orders for labs for behavior medications which required blood levels to be monitored and the Unit Manager was to audit and monitor medications that required monitoring of blood levels.</p> <p>Interview with the Unit Manager, on 06/06/13 at 4:30 PM, revealed she depended on the Physician/Psychiatrist to order labs for behavior medications which required monitoring such as Valproic Acid and this was up to the Physician's discretion. She stated she also reviewed the pharmacist's drug regimen review for recommendations when doing her medication audit.</p>	F 428			



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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: 1971</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Four (4) 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 natural gas.</p> <p>A standard Life Safety Code survey was conducted on 06/6/13. Homestead Nursing Center was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty (60) beds with a census of fifty five (55) 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>Submission of this plan of correction does not constitute admission of agreement with conclusions set forth in the statement of deficiencies. However, in an effort to enhance the care furnished to our residents, we have augmented some of our existing policies and protocols. We acknowledge that federal and state regulations require a plan of corrections, and we are therefore submitting this plan.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Green Haller, RN* TITLE: *Administrator* (X6) DATE: *7/16/2013*

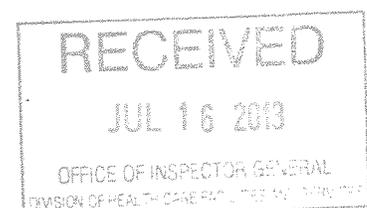
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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If continuation sheet Page 1 of 35

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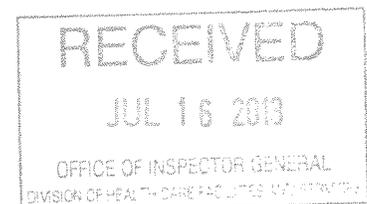
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185362	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HOMESTEAD NURSING CENTER  B. WING _____	(X3) DATE SURVEY COMPLETED  06/06/2013
NAME OF PROVIDER OR SUPPLIER  HOMESTEAD NURSING CENTER, NEW CASTLE, KENTUCKY			STREET ADDRESS, CITY, STATE, ZIP CODE 60 ADAMS STREET NEW CASTLE, KY 40050	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		
K 025 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for sixty (60) beds, with a census of fifty five (55) on the day of the survey. The facility failed to ensure smoke partitions were accessible.</p> <p>The findings include:</p> <p>Observation, on 06/06/13 at 9:33 AM, with the Maintenance Director revealed the smoke</p>	K 025	<p>1. All firewalls currently in place will have larger fire rated door openings installed by 7/18/13. All walkways through access panels will be reinforced with non-rotting/crumbling 3/4 inch plywood by 7/18/13. Wiring near walkways and firewalls will be gathered and secured to ensure an unobstructed passage for navigation 7/18/13.</p> <p>2. On 6/28/13, the Maintenance Director completed an audit of all access panels to ensure smoke partitions were easily visualized and assessable. All smoke partitions found to be not easily visualized or assessable through the access panels will be corrected to prevent others from being affected.</p> <p>3. All firewalls currently in place will have larger fire rated door openings installed by 7/18/13. All walkways through access panels will be reinforced with non-rotting/crumbling 3/4 inch plywood by 7/18/13. Wiring near walkways and firewalls will be gathered and secured to ensure an unobstructed passage for navigation by 7/18/13. Audits will be performed to ensure smoke partitions are easily visualized and assessable starting 7/19/13.</p> <p>4. Upon completion of work the President of the company will visually audit to ensure work is completed as stated. A Quality Assurance audit form has been created to ensure ease of access and visualization of smoke partitions from access panels. This audit will be performed by the Maintenance Director and/or assistant once monthly starting 7/19/13. Results will be reported to the Quality Assurance Committee monthly.</p> <p>5. The Director of Maintenance is responsible for compliance.</p>	7/21/13



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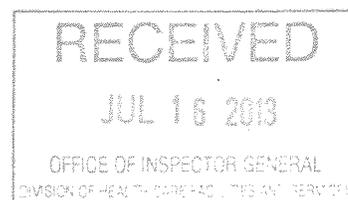
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K 025	<p>Continued From page 2</p> <p>partitions extending above the ceiling located throughout the facility were not easily accessible for survey or routine maintenance. The access panels are located far enough away that climbing and crawling, over obstacles is required.</p> <p>Interview, on 06/06/13 at 9:33 AM, with the Maintenance Director revealed he was aware the smoke partition were difficult to access; however, the ceiling was made of asbestos and that's why he had not installed the new accesses to the smoke partitions.</p> <p>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. Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as</p>	K 025		



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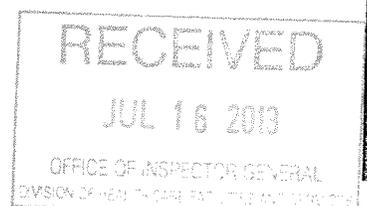
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K 025	Continued From page 3 follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.  19.3.7.4 Not less than 30 net ft <sup>2</sup> (2.8 net m <sup>2</sup> ) per patient in a hospital or nursing home, or not less than 15 net ft <sup>2</sup> (1.4 net m <sup>2</sup> ) per resident in a limited care facility, shall be provided within the aggregate area of corridors, patient rooms, treatment rooms, lounge or dining areas, and other low hazard areas on each side of the smoke barrier. On stories not housing bed or litterborne patients, not less than 6 net ft <sup>2</sup> (0.56 net m <sup>2</sup> ) per occupant shall be provided on each side of the smoke barrier for the total number of occupants in adjoining compartments. 19.3.7.5 Openings in smoke barriers shall be protected by fire-rated glazing; by wired glass panels and steel frames; by substantial doors, such as 13/4-in.	K 025			



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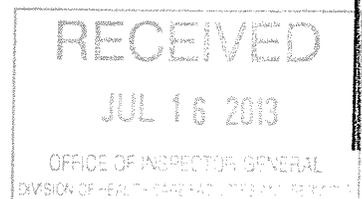
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K 025	Continued From page 4 (4.4-cm) thick, solid-bonded wood core doors; or by construction that resists fire for not less than 20 minutes. Nonrated factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door shall be permitted. Exception: Doors shall be permitted to have fixed fire window assemblies in accordance with 8.2.3.2.2.	K 025			
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-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: 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 four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty five (55) on the day of the survey. The facility failed to ensure doors located in a smoke barrier would resist the passage of smoke.	K 027	1. On 6/25/13, the Maintenance Director ordered cross-coordinating devices for the three smoke barrier doors. These devices will be installed by 7/21/13.  2. On 6/24/13, the Maintenance Director completed an audit of all cross-corridor doors. No other doors were noted with gaps or openings greater than 1/8 inch.  3. The Maintenance Director will attempt to correct the deficient practice through the purchase and installation of cross-coordinating devices for the three smoke barrier doors by 7/2/2013. If additional assistance is needed, the Maintenance Director will contact contractors to request consultation on repair of the doors.  4. A quality assurance audit form has been developed to inspect all facility smoke barrier doors for gaps and openings greater than 1/8 inch. The Maintenance Director and/or assistant once monthly will conduct this audit starting 7/18/13. Results will be reported to the Quality Assurance Committee monthly.  5. The Director of Maintenance is responsible for compliance.	7/19/2013	



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K 027	Continued From page 5  The findings include:  Observation, on 06/06/13 between 9:30 AM and 2:30 PM, with the Maintenance Director revealed the cross corridor doors in the smoke barriers located throughout the facility had a gap greater than 1/8th of an inch and would not resist the passage of smoke.  Interview, on 06/06/13 between 9:30 AM and 2:30 PM, with the Maintenance Director revealed he was not aware the doors had a gap too large, but would have them adjusted to meet the requirement.  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.  Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.	K 027		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	1. On 6/7/2013, typed delayed egress signage in black lettering on white background with letters 1 inch high and greater than 1/8 inch in stroke width were placed on the Dining Room and South Hall Exit Doors. The incorrect signage was removed at this time. Custom signage was ordered 6/12/13 by the Maintenance Director.	



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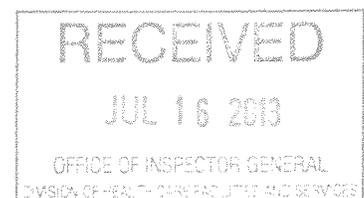
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K 038	Continued From page 6  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty five (55) on the day of the survey. The facility failed to maintain signage for doors equipped with delayed egress locks.  The findings include:  Observation, on 06/06/13 between 9:30 AM and 2:30 PM, with the Maintenance Director revealed the delayed egress doors located in the Dining Room and the South Hall Exit were not equipped with proper signage. The delayed egress signage did not have a contrasting background.  Interview, on 06/06/13 between 9:30 AM and 2:30 PM, with the Maintenance Director revealed he was unaware the delayed egress signage was required to have a contrasting background.	K 038	2. The Maintenance Director on 6/7/2013 completed an audit of delayed egress signage on all doors in the facility equipped with delayed egress locks. No other doors equipped with delayed egress locks had incorrect signage.  3. On 6/20/13, the assistant Maintenance Director replaced the typed egress signage with the custom ordered signs with red lettering on a white background on the Dining Room and South Hall Exit Doors.  4. A quality assurance audit form has been developed to inspect delayed egress signage on all doors in the facility equipped with delayed egress locks. The Maintenance Director and/or assistant once monthly will conduct this audit starting 6/21/13. Results will be reported to the Quality Assurance Meeting monthly.  5. The Maintenance Director is responsible for compliance.	6/21/13	

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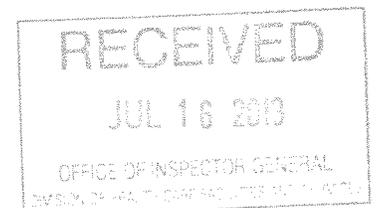
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K 038	Continued From page 7  Reference:  NFPA 101 (2000 edition)  7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.  (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.  (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.  (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release	K 038			



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K 038	<p>Continued From page 8</p> <p>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.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</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>	K 038			



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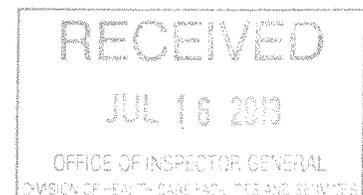
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K 038	Continued From page 9  7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.  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. 7.5.1.1 Exits shall be located and exit access shall be arranged	K 038			

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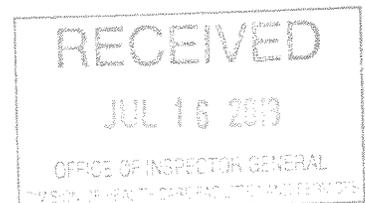
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 038	Continued From page 10 so that exits are readily accessible at all times. 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. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23.	K 038			
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty five (55)	K 045	1. The Maintenance Director replaced the breezeway exit light fixture with a new light fixture that provides required illumination on 6/21/13.  2. The Maintenance Director completed an audit of all exits to ensure proper functioning of fixtures and lighting on 6/10/13. No further exit lighting was noted to be nonfunctional.  3. The Maintenance Director corrected the deficiency on 6/12/13 with the installation of the exit light fixture outside the breezeway off the dietary department. The Maintenance Director will audit all exit lighting to ensure proper functioning and compliance.  4. A quality assurance form has been developed to monitor for the proper functioning of all exit lighting fixtures. This audit will be conducted by the Maintenance Director and/or assistant weekly times three months, then monthly		



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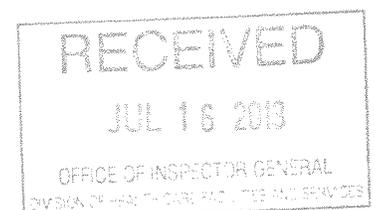
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K 045	<p>Continued From page 11 on the day of the survey. The facility failed to provide required illumination outside an exit for discharge.</p> <p>The findings include:</p> <p>Observation, on 06/06/13 between 9:30 AM and 2:30 PM, with the Maintenance Director revealed the breezeway exit located off the Kitchen did not have a light installed outside to provide the required illumination for exit discharge. The exit was equipped with a light fixture which was equipped for one bulb; however the bulb was not installed. The exit also had a battery light connected to the exit sign inside; however the light did not function when tested.</p> <p>Interview, on 06/06/13 between 9:30 AM and 2:30 PM, with the Maintenance Director revealed he was not aware the exits did not have the required illumination for egress lighting.</p> <p>Reference NFPA 101 (2000 edition)</p> <p>18.2.7 Discharge from Exits. Discharge from exits shall be arranged in accordance with Section 7.7.</p> <p>18.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8.</p>	K 045	<p>times three months. These results will be reported to the Quality Assurance Committee monthly. After six months, the Quality Assurance Committee will determine the need for continuation.</p> <p>5. The Director of Maintenance is responsible for compliance.</p>	6/12/2013



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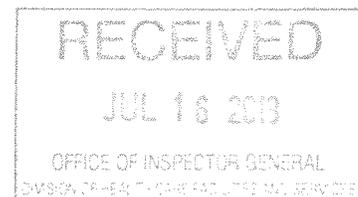
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K 045	Continued From page 12  7.7 DISCHARGE FROM EXITS 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23. 7.7.2 Not more than 50 percent of the required number of exits, and not more than 50 percent of the required egress capacity, shall be permitted to discharge through areas on the level of exit discharge, provided that the criteria of 7.7.2(1) through (3) are met: (1) Such discharge shall lead to a free and unobstructed way to the exterior of the building, and such way is readily visible and identifiable from the point of discharge from the exit. (2) The level of discharge shall be protected throughout by an approved, automatic sprinkler system in accordance with Section 9.7, or the portion of the level of discharge used for this purpose shall be protected by an approved, automatic sprinkler system in accordance with Section 9.7 and shall be separated from the nonsprinklered portion of the floor by a fire resistance rating meeting the requirements for	K 045			



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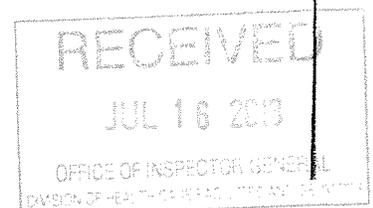
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K 045	Continued From page 13 the enclosure of exits (see 7.1.3.2.1). Exception: The requirement of 7.7.2(2) shall not apply where the discharge area is a vestibule or foyer meeting all of the following: (a) The depth from the exterior of the building shall not be more than 10 ft (3 m) and the length shall not be more than 30 ft (9.1 m). (b) The foyer shall be separated from the remainder of the level of discharge by construction providing protection not less than the equivalent of wired glass in steel frames. (c) The foyer shall serve only as means of egress and shall include an exit directly to the outside. (3) The entire area on the level of discharge shall be separated from areas below by construction having a fire resistance rating not less than that required for the exit enclosure. Exception No. 1: Levels below the level of discharge shall be permitted to be open to the level of discharge in an atrium in accordance with 8.2.5.6. Exception No. 2: One hundred percent of the exits shall be permitted to discharge through areas on the level of exit discharge as provided in Chapters 22 and 23. Exception No. 3: In existing buildings, the 50 percent limit on egress capacity shall not apply if the 50 percent limit on the required number of exits is met. 7.7.3 The exit discharge shall be arranged and marked to make clear the direction of egress to a public way. Stairs shall be arranged so as to make clear the direction of egress to a public way. Stairs that continue more than one-half story beyond the level of exit discharge shall be interrupted at the level of exit discharge by partitions, doors, or	K 045		



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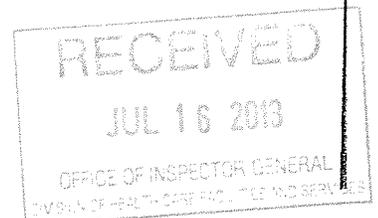
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K 045	Continued From page 14 other effective means. 7.7.4 Doors, stairs, ramps, corridors, exit passageways, bridges, balconies, escalators, moving walks, and other components of an exit discharge shall comply with the detailed requirements of this chapter for such components. 7.7.5 Signs. (See 7.2.2.5.4 and 7.2.2.5.5.) 7.7.6 Where approved by the authority having jurisdiction, exits shall be permitted to discharge to roofs or other sections of the building or an adjoining building where the following criteria are met: (1) The roof construction has a fire resistance rating not less than that required for the exit enclosure. (2) There is a continuous and safe means of egress from the roof.  7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be	K 045			



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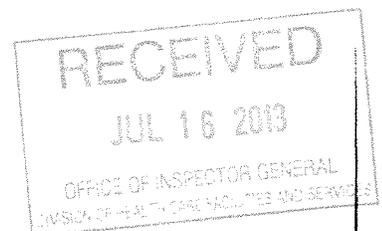
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K 045	Continued From page 15 continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.  Reference: NFPA 101 (2000 Edition)  19.2.8 Illumination of Means of Egress.	K 045		



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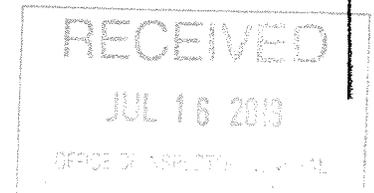
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K 045	Continued From page 16	K 045		
K 046 SS=F	Means of egress shall be illuminated in accordance with Section 7.8.  NFPA 101 LIFE SAFETY CODE STANDARD  Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.  This STANDARD is not met as evidenced by: Based on observation, and interview it was determined the facility failed to test emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty five (55) on the day of the survey. The facility failed to test emergency battery lighting for 90 minutes annually.  The findings include:  Observation, on 06/06/13 at 10:52 AM, with the Maintenance Director revealed the facility did not have documentation for the annual testing of emergency battery lighting located in the facility.  Interview, on 06/06/13 at 10:52 AM, with the Maintenance Director revealed he was not aware documentation was to be kept for emergency battery light testing.  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	K 046  1. On 6/7/13 all battery powered emergency light fixtures were tested by the Maintenance Director for 90 minutes and recorded on a log documenting that the annual test was completed. All battery powered emergency light fixtures were operational and working properly during the 90-minute test.  2. On 6/7/13, all battery powered emergency light fixtures were tested by the Maintenance Director for 90 minutes. All battery powered emergency light fixtures were operational and working properly during the 90-minute test. Therefore, no residents were affected.  3. The Maintenance Director and assistant were inserviced by the Administrator on 6/7/13 on the regulation of emergency lighting monthly and yearly testing requirements as defined in K 046. On 6/7/13, a log was created to ensure documentation of monthly testing of battery powered emergency lighting for 30 seconds or greater, and annual testing of battery powered emergency lighting for 90 minutes. The Maintenance Director added the log as part of the monthly inspections to be completed in the Maintenance Department. The Maintenance Director and/or assistant will audit to ensure testing and completion of log.  4. The Administrator will audit this log monthly times one year to ensure monthly and annual testing and completion of the log by the Maintenance Department. These results will be reported to the monthly Quality Assurance meetings.  5. The Director of Maintenance is responsible for compliance.	6/14/13	



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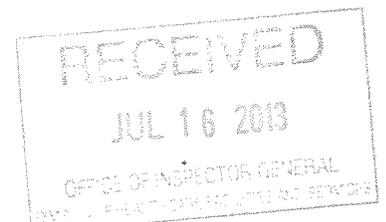
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K 046	Continued From page 17 that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not 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.  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 inspection is performed at 30-day intervals.	K 046		
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	K 050	1. On 6/7/13, the Maintenance Director and Administrator developed an annual schedule of fire drills to ensure that all future fire drills are held at unexpected times.  2. There have been no fire situations within the last year. Although all residents had the potential to be affected, no residents were affected.	



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K 050	<p>Continued From page 18</p> <p>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</p> <p>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 four (4) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty five (55) on the day of the survey. The facility failed to ensure the fire drills were conducted quarterly and at unexpected times on third shift.</p> <p>The findings include:</p> <p>Fire Drill review, on 06/06/13 at 10:11 AM, with Maintenance Director revealed the facility failed to conduct fire drills at unexpected times on third (3rd) shift.</p> <p>Interview, on 06/06/13 at 10:11 AM, with the Maintenance Director revealed he was not aware the fire drills were not being conducted as required.</p> <p>Reference: NFPA Standard NFPA 101 19.7.1.2.</p>	K 050	<p>3. On 6/7/13, the Administrator inserviced the Maintenance Director and Assistant on the regulation regarding performance of fire drills at unexpected times. On 6/7/13, the Maintenance Director and Administrator developed a schedule of when fire drills will occur throughout the remainder of 2013, to ensure the drills are conducted quarterly on each shift at unexpected times under varied conditions on all shifts. The Maintenance Director and/or assistant or designee will utilize the Record of Drills and Fire Drill Statement Report to record the events and the attendance of each drill conducted in the facility. The Administrator will in-service the Maintenance Director, assistant, and designees on how to utilize the Record of Drills and Fire Drill Statement Report by 7/19/13.</p> <p>4. The Maintenance Director will inform the Administrator that the fire drill will occur by utilization of the set fire drill schedule. Both the Administrator and Maintenance Director, assistant, or designee will sign the Fire Drill Statement Report to indicate that the drill occurred as scheduled. The Fire Drill Statement Report and Record of Drills will be presented to the Quality Assurance Committee monthly times three months for review of compliance. After three months, the Quality of Assurance Committee will determine the need for continuation.</p> <p>5. The Maintenance Director is responsible for compliance.</p>	7/19/13	



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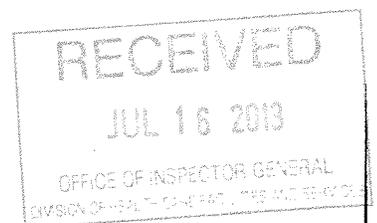
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K 050	Continued From page 19 Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.  Reference: NFPA 101 Life Safety Code (2000 Edition). 19.7* OPERATING FEATURES 19.7.1 Evacuation 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 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	K 050			

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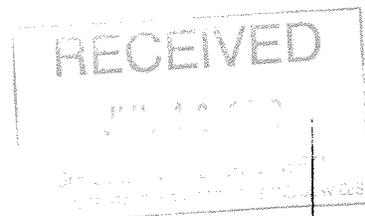
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185362	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HOMESTEAD NURSING CENTER  B. WING _____	(X3) DATE SURVEY COMPLETED  06/06/2013
NAME OF PROVIDER OR SUPPLIER  HOMESTEAD NURSING CENTER, NEW CASTLE, KENTUCKY			STREET ADDRESS, CITY, STATE, ZIP CODE 50 ADAMS STREET NEW CASTLE, KY 40050	
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K 050  K 056 SS=D	Continued From page 20 areas or to the exterior of the building. 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 installed, in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty five (55) on the day of the survey. The facility failed to ensure the facility sprinkler heads were not blocked by light fixtures.  The findings include:  Observation, on 06/06/13 between 9:30 AM and 2:30 PM, with the Maintenance Director revealed	K 050  K 056	1. On 6/25/13, the Maintenance Director relocated the light fixture in the bathroom of room #129 greater than 12 inches from the sprinkler head. On 6/18/13, Brown and Sprinkler Corporation assessed and provided any repairs needed to the sprinkler head located in room # 122.  2. An audit conducted on 6/14/13 by the Maintenance Director of all sprinkler heads throughout the facility noted no further light fixtures blocking the sprinkler heads and all sprinkler heads had fluid inside their glass chambers. Therefore, there is no further potential for residents to be affected.  3. On 6/24/13, the Administrator inserviced the Maintenance Director and assistant on the regulations regarding blockage of sprinkler heads and the fluid inside the glass chambers of the sprinkler heads. On 6/25/13, the Maintenance Director moved the light fixture in the bathroom of room #129 at least 12 inches from the sprinkler head. On 6/18/13, Brown Sprinkler Corporation assessed and provided any repairs needed to the sprinkler head located in room # 122.  4. The quality assurance nurse developed an audit to check all sprinkler heads in the facility to ensure nothing including light fixtures are blocking the sprinkler head, and that the sprinklers have fluid in their glass chambers. This audit will be conducted monthly by the Maintenance Director and/or assistant. The results will be reviewed in the monthly Quality Assurance meetings.  5. The Director of Maintenance is responsible for compliance.	6/28/13



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K 056	<p>Continued From page 21</p> <p>a light fixture installed within twelve (12) inches of a sprinkler head located in the bathroom of room #129. Further observation revealed the fluid inside the glass of the sprinkler head located in room #122 had leaked out and potentially no longer functional.</p> <p>Interview, on 06/06/13 between 9:30 PM and 2:30 PM, with the Maintenance Director revealed he had just become aware of the sprinkler head requirement. Further interview revealed he had not noticed the fluid filled in the glass of the sprinkler head had leaked out.</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>	K 056			



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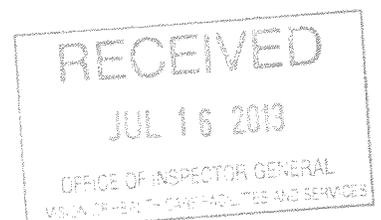
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K 056	<p>Continued From page 22</p> <p>(1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="0"> <thead> <tr> <th>Distance from Sprinklers to above Bottom of Side of Obstruction (A)</th> <th>Maximum Allowable Distance of Deflector Obstruction (in.) (B)</th> </tr> </thead> <tbody> <tr><td>Less than 1 ft</td><td>0</td></tr> <tr><td>1 ft to less than 1 ft 6 in.</td><td>2 1/2</td></tr> <tr><td>1 ft 6 in. to less than 2 ft</td><td>3 1/2</td></tr> <tr><td>2 ft to less than 2 ft 6 in.</td><td>5 1/2</td></tr> <tr><td>2 ft 6 in. to less than 3 ft</td><td>7 1/2</td></tr> <tr><td>3 ft to less than 3 ft 6 in.</td><td>9 1/2</td></tr> <tr><td>3 ft 6 in. to less than 4 ft</td><td>12</td></tr> <tr><td>4 ft to less than 4 ft 6 in.</td><td>14</td></tr> <tr><td>4 ft 6 in. to less than 5 ft</td><td>16 1/2</td></tr> <tr><td>5 ft and greater</td><td>18</td></tr> </tbody> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m.</p>	Distance from Sprinklers to above Bottom of Side of Obstruction (A)	Maximum Allowable Distance of Deflector Obstruction (in.) (B)	Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	16 1/2	5 ft and greater	18	K 056		
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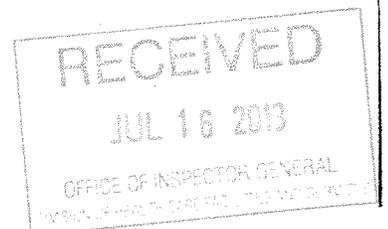
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K 056	Continued From page 23 Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.  Reference: NFPA 13 (1999 Edition)  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: (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.	K 056		



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K 056	Continued From page 24  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 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 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than	K 076		



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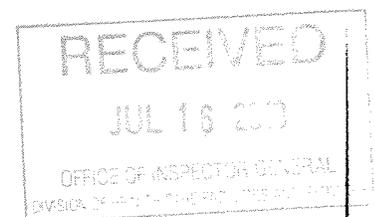
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K 076	Continued From page 25 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty five (55) on the day of the survey. The facility failed to ensure oxygen storage over 300 cu ft. was stored in a room with an ignition source not located below five (5) feet from the floor.  The findings include:  Observation, on 06/06/13 at 9:37 AM, with the Maintenance Director revealed oxygen tanks in excess of 300 ft3 located in the soiled linen room near the nurses' station had a light switch and two receptacles installed below five (5) feet from the floor.  Interview, on 06/06/13 at 9:37 AM, with the Maintenance Director revealed he was unaware the light switch and receptacles could not be below five feet from the floor if the oxygen storage was greater than 300 ft3.  Reference:	K 076	1. On 6/21/13, The nursing department moved all oxygen cylinders to a storage area where an ignition source is not below five feet from the floor . All combustible materials were removed from this room and stored in the facility supply room.  2. An audit conducted on 6/21/13, by the Assistant Director of Nursing revealed that no other oxygen tanks or combustibles were being stored in any other location within the facility. Therefore, no further residents had the potential to be affected.  3. On 6/21/13, the Assistant Director of Nursing relocated all oxygen cylinders and combustible materials in the facility to meet regulation. The "empty" tanks that were located in an area that did not meet regulation were moved to the oxygen room where "full" tanks are kept. The tanks were then separated by signage designating "empty" and "full". The oxygen room does not have an ignition source below five feet from the floor. All combustible items were removed from the oxygen room and stored in the facility supply room.  4. All licensed nurses, certified nursing assistants, and Respiratory therapist will be inserviced on the requirement to keep the oxygen cylinders in their new location in the oxygen room by the Staff Development Coordinator by 7/15/13. The Quality Assurance nurse will develop an audit that will be completed weekly times 2 months, then biweekly times two months, then monthly to ensure compliance starting 6/28/13. The results will be presented at the monthly Quality Assurance meetings.  5. The Director of Nursing is responsible for compliance.	7/15/13



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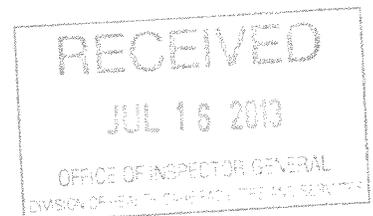
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K 076	Continued From page 26 NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m <sup>3</sup> (300 ft <sup>3</sup> ) but less than 85 m <sup>3</sup> (3000 ft <sup>3</sup> ) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating	K 076		



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K 076	Continued From page 27 elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.	K 076		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff, and visitors. The facility is certified for sixty (60) beds with a census of fifty five (55) on the day of the survey.  The findings include:  Observation, on 06/06/13 between 9:30 AM and 2:30 PM, with the Maintenance Director revealed the facility did not have documentation for the transfer times, on the monthly generator testing.	K 144	1. On 6/14/13, The Maintenance Director updated the facility generator- testing log to include transfer times when start-up is completed. On 6/6/13, the Maintenance Director disconnected the battery charger from the generator battery and reconnected to the generator starter.  2. The Maintenance Director on 6/14/13 completed a review of the current generator-testing log. The log was updated to meet regulation at the time. On 6/6/13, the Maintenance Director inspected the generator for any further connections that would not meet regulation. No further deficiencies were found. No residents were affected. As there have been no power outages when the generator did not operate correctly.  3. 6/14/13, the Maintenance Director and assistant were inserviced by the Administrator on the regulations regarding the generator and documentation required on weekly generator checks and monthly under load testing. At that time, the Maintenance Director updated the facility generator-testing log to include transfer times when start-up is completed. On 6/6/13, The Maintenance Director corrected the problem when the battery charger was disconnected from the generator battery and reconnected to the generator starter.  4. A quality assurance audit form was developed to ensure that weekly checks and monthly load testing is being performed on the generator. The audit form will also check to ensure that the generator battery charger is not connected directly	



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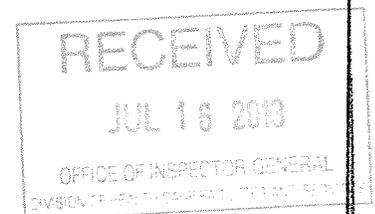
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K 144	<p>Continued From page 28</p> <p>Further observation revealed the generators battery charger was connected directly to the generator battery.</p> <p>Interview, on 06/06/13 between 9:30 AM and 2:30 PM, with the Maintenance Director revealed he was not aware the transfer times were to be documented. Further observation revealed he was not aware the battery charger could not be connected directly to the generator battery.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers' recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p>	K 144	<p>to the generator battery. The Quality Assurance nurse will complete this audit monthly starting 6/21/13. The results will be reviewed in the monthly Quality Assurance Committee meetings.</p> <p>5. The Director of Maintenance is responsible for compliance.</p>	6/29/13

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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
K 144	Continued From page 29 a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]  Reference: NFPA 110 (1999 Edition).  5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room	K 144		



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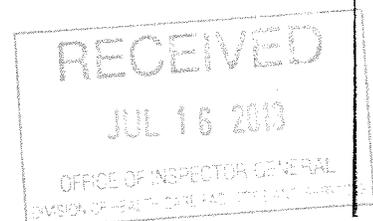
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K 144	Continued From page 30 lighting shall be supplied from the load side of the transfer switch.  Reference: NFPA 99 (1999 Edition)  Actual NFPA Standard: NFPA 99, 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1. (b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b). Actual Standard: NFPA 110, 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position. Actual Standard: NFPA 99, 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-	K 144			

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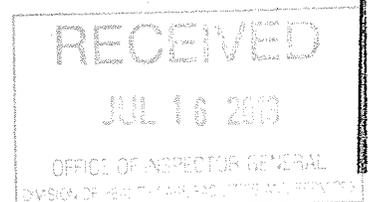
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K 144	Continued From page 31 4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. (b) Inspection and Testing. 1. Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. 2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads. 3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures. Actual Standard: NFPA 99, 3- 3-4.4.2. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.  6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's	K 144		



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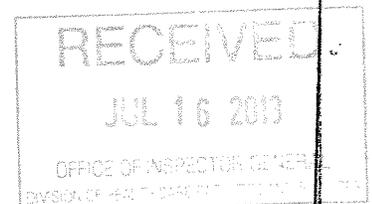
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K 144	Continued From page 32 recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction  6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established  6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.  6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.  Reference: NFPA 101 ( 2000 edition)  7.9.1.2 Where maintenance of illumination depends on changing from one energy source to another, a delay of not more than 10 seconds shall be permitted. Reference: NFPA 110 (1999 ed.) 5-7 Heating, Cooling, and Ventilating. 5-7.1* Consideration shall be given to properly sizing the ventilation or air-conditioning systems to remove all the heat rejected to the EPS equipment room by the	K 144		



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K 144	Continued From page 33 energy converter, uninsulated or insulated exhaust pipes, and other heat-producing equipment. 5-7.2 Adequate ventilation shall be provided to prevent temperatures or temperature rises in the EPS and related accessory equipment that exceed the recommendations of the manufacturer. 5-7.3 For the EPS equipment room, the ventilation or cooling equipment, or both, shall be sized so that the ambient temperature shall not exceed the EPS equipment manufacturer ' s criteria or allowable maximum temperatures.  Reference: NFPA 110 (1999 Edition)  5-2.1 The EPS shall be installed in a separate room for Level 1 installations. EPSS equipment shall be permitted to be installed in this room. The room shall have a minimum 2-hour fire rating or shall be located in an adequate enclosure located outside the building capable of resisting the entrance of snow or rain at a maximum wind velocity required by local building codes. No other equipment, including architectural appurtenances,	K 144			



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K 144	Continued From page 34 except those that serve this space, shall be permitted in this room.	K 144			

