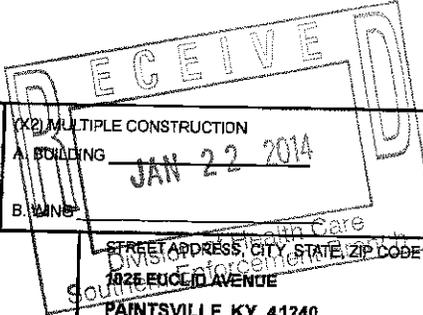


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/08/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/19/2013
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NAME OF PROVIDER OR SUPPLIER
MOUNTAIN MANOR OF PAINTSVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE
1022 EUGENE AVENUE
PAINTSVILLE, KY 41240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on 12/17-19/13. Deficient practice was identified at "D" level. An abbreviated standard survey (KY21018, KY21098) was also conducted at this time. Both complaints were unsubstantiated with no deficient practice identified.	F 000	Mountain Manor of Paintsville does not believe and does not admit that any deficiencies existed, either, before, during or after the survey. Mountain Manor of Paintsville reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is it meant to establish any standard of care, contract obligation or position, and Mountain Manor reserves the right to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance, or self-critical examination privileges which Mountain Manor of Paintsville does not waive, and reserves the right to assert in any administrative, civil, criminal claim, action or proceeding. Mountain Manor of Paintsville offers its responses, credible allegation of compliance, and plan of correction as part of its ongoing effort to provide quality care to its residents.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	F 225 483.13(c)(1)(ii)-(iii), (c)(2)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS It is the policy of this facility that all residents are protected from abuse, neglect and mistreatment. It is the policy of this facility that (1) all alleged violations involving mistreatment, neglect, or abuse including injuries of unknown source and misappropriation of resident property are	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *1-20-2014*

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

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F 225	<p>Continued From page 1</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policies and procedures, it was determined the facility failed to ensure an allegation of neglect was investigated and failed to report the alleged incident to the appropriate state agencies in accordance with facility policy for one of twenty-two sampled residents (Resident #22).. A review of documentation revealed physician's orders for Resident #22 to receive oxygen as needed by means of a BiPAP (bi-level positive airway pressure) machine (a breathing apparatus that helps the user get more air into the lungs) by mask at 4 liters per minute (LPM). However, documentation revealed on 12/06/13 at approximately 12:30 AM, facility staff observed Resident #22's BiPAP mask positioned on the side of his/her face instead of over the resident's nose/mouth, and the oxygen connected to the BiPAP mask was noted to be turned in the "O" position and was not providing oxygen to the resident. In addition, on 12/06/13 at approximately 8:00 AM, facility staff observed the oxygen administered to Resident #22 through the BiPAP mask was set at 10 LPM instead 4 LPM as ordered by the physician. However, based on interviews and a review of documentation, the</p>	F 225	<p>reported immediately to the administrator of the facility and to other officials in accordance with State law including the State Survey and Certification Agency; (2) all alleged violations are thoroughly investigated and (3) protective measures should be taken immediately if an allegation of abuse, mistreatment or neglect is reported. This is evidenced by the following:</p> <ol style="list-style-type: none"> 1) The facility was not aware of any allegations of abuse, mistreatment or neglect until informed by the state survey agency on 12-17-2013. An investigation was conducted by Anna Caldwell, ADON on 12-06-2013 regarding the incident. <p>Had the allegations been made to the facility we would have followed our policy and began a thorough investigation of the allegations and followed through with proper reporting procedures to all necessary state agencies. This facility will always work directly with all state agencies to investigate and resolve any and all allegations.</p> <p>Once the facility was made known of the allegation we worked in conducting our own investigation and assisting in the investigations of state survey agency.</p> <p>Resident #22 was assessed on 12-06-2013 by LPN Colby Shefflett after resident's oxygen was discovered to be turned off and BiPAP mask on the side of the face. Resident #22 continued to be monitored throughout the night and into the next day by</p>		

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F 225	<p>Continued From page 2</p> <p>facility failed to investigate the incidents to determine why staff had failed to ensure the oxygen delivered to Resident #22 on 12/06/13 at approximately 12:30 AM and 8:00 AM was not delivered at the rate prescribed by the resident's physician.</p> <p>The findings include:</p> <p>A review of the facility's policy entitled "Resident Protection Policy," dated 11/15/12, revealed the facility defined neglect as a failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. According to the policy, upon receipt of a report of mistreatment, abuse, misappropriation of property, or neglect, the Administrator (or his/her designee) or the Director of Nursing (DON) (or his/her designee) was to immediately report the incident to state agencies. In addition, the policy revealed all reports of resident abuse, neglect, and injuries of unknown source would be "promptly and thoroughly" investigated by Facility Management.</p> <p>A review of the medical record for Resident #22 revealed the resident was readmitted to the facility on 11/27/13 with diagnoses that included Legal Blindness, Chronic Airway Obstruction, and Anxiety. A review of physician orders dated November 2013 revealed Resident #22 was to receive oxygen, as needed, by means of BiPAP at a rate of 4 liters per minute.</p> <p>A review of the facility's Incident/Event Investigation Form, dated 12/06/13, revealed on 12/06/13 at approximately 12:30 AM, staff observed Resident #22's BiPAP mask positioned to the side of the resident's face and the oxygen</p>	F 225	<p>LPN Shefflett, ADON Anna Caldwell, LPN Mary Burgiss, and RN Leann Cantrell.</p> <p>Families and physician of involved residents were notified on 12-06-2013 by RN Leann Cantrell.</p> <p>Hospice was contacted on 12-06-2013 by RN Leann Cantrell, and resident #22 was assessed by Hospice nurse on 12-06-2013.</p> <p>It was speculated during the facility's investigation that resident #22's roommate may have adjusted resident #22's oxygen. Therefore, the family of the roommate was asked to come and sit with the roommate on 12-06-2013.</p> <p>A referral was made to the behavioral unit for resident #22's roommate on 12-06-2013 by Social Worker Kathy Mcadows, but the behavioral unit did not have a bed until 12-09-2013. The family of resident #22's roommate continued to sit with roommate until 12-09-2013 when he/she was sent out to the behavioral unit. The roommate was out of the facility from 12-09-2013 through 12-17-2013.</p> <p>Upon returning to the facility resident #22's roommate was moved to another area of the facility on 12-17-2013 to eliminate any future potential of incident.</p> <p>On 12-13-2013 Mary Arms, DON notified the facility Medical Director</p>	

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F 225	<p>Continued From page 3</p> <p>level was observed to be set at 0 liters per minute. Further review of the incident/event report revealed the night shift nurse, Licensed Practical Nurse (LPN) #6, adjusted Resident #22's oxygen up to 10 LPM until the resident was stable, and then tapered the oxygen down to 4 LPM over a 15 to 20-minute period. Continued review of the incident/event report revealed on 12/06/13, at approximately 8:00 AM, the day shift nurse, LPN #7, observed Resident #22's oxygen setting at 10 LPM, instead of 4 LPM as prescribed by the physician. However, review of the facility's incident/event report revealed the facility failed to conduct an investigation to determine why staff had failed to ensure the resident received oxygen as prescribed by the physician.</p> <p>Review of a witness statement, dated 12/06/13, revealed on 12/06/13, State Registered Nurse Aide (SRNA) #7 found Resident #22's BiPAP mask on the side of the resident's face and the resident's oxygen had been turned off. The statement revealed SRNA #7 immediately informed the nurse of the observation. Continued review of the witness statement revealed Licensed Practical Nurse (LPN) #6 turned the resident's oxygen to 10 LPM until the resident was stable and then tapered the resident's oxygen down to 4 LPM before the staff left the room.</p> <p>Interview on 12/19/13 at 12:48 PM with SRNA #8 revealed on 12/06/13 at approximately 12:40 AM, she and SRNA #7 were making resident rounds, found Resident #22's BiPAP mask on the side of the resident's face and the oxygen turned off, and immediately called for the nurse. The interview further revealed LPN #6 checked the resident's</p>	F 225	<p>Dr. Charles Hardin of the allegation and actions taken (to this point) by the facility to protect residents.</p> <p>2) Social Workers Kathy Meadows, Misty Pennington and Christa Kimbler conduct 12 resident interviews weekly regarding abuse, neglect and mistreatment (See Attachment #1). Social Worker Christa Kimbler also completes resident interviews regarding abuse, neglect and mistreatment weekly utilizing the Abaqis Computer System. No other residents were been found to be affected.</p> <p>All results of the resident interviews are reported weekly through the CQI Grievance/Complaint Committee meeting. Any identified allegations of abuse, neglect or mistreatment are reported immediately to the Administrator or Director of Nursing and other officials in accordance with state law.</p> <p>Staff members (other nurse aides and nurses who had worked during that shift) were interviewed by Anna Caldwell, ADON on 12-06-2013. No other residents were identified as being affected.</p> <p>3) Inservices were held on 09/12 – 09/24/2013 for all staff and 10/13-10/14/2013 for nursing staff by Beverly Moore, Staff Development Nurse regarding the Facility Abuse Prevention Policy. These inservices covered the abuse prevention policy</p>		

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F 225	<p>Continued From page 4</p> <p>oxygen level, noted the level was very low, and the LPN turned the oxygen up to 10 LPM until the resident was stable. SRNA #8 stated when the resident was stable LPN #6 then tapered the oxygen down to 4 LPM before leaving the room. Continued interview revealed the staff assumed the resident's roommate turned Resident #22's oxygen down because the roommate had exited the room approximately 5 minutes prior to the staff finding Resident #22's oxygen off and the resident's roommate was talking about turning "that boiling water" off.</p> <p>Interview on 12/19/13 at 12:30 PM with LPN #6 also revealed on 12/06/13 at approximately 12:40 AM, an SRNA informed the LPN that Resident #22's oxygen was turned off and the BiPAP mask was to the side of the resident's face. LPN #6 stated he/she immediately went to the resident's room, checked the resident's oxygen level, which was very low, and turned the oxygen up to 10 LPM. LPN #6 stated he/she monitored the resident's oxygen level until the resident was stable, and then tapered the resident's oxygen down to 4 LPM before he/she left the room. Continued interview revealed LPN #6 suspected Resident #22's roommate had turned the oxygen off because the resident had been observed to leave the resident's room approximately five minutes prior to the oxygen being found turned off and had been overheard by the LPN talking about "turning off the pot of boiling water." LPN #6 stated Resident #22's roommate often wandered but was unaware if the roommate had ever tampered with Resident #22's oxygen.</p> <p>Interview on 12/19/13 at 10:50 AM with LPN #7 revealed the LPN had been informed in report on the morning of 12/06/13 that Resident #22's</p>	F 225	<p>and instructions employees should take when allegations of abuse, neglect or mistreatment is reported (see attachment #2).</p> <p>An inservice was conducted on 12-10-2013 for Nurses by Beverly Moore, Staff Development Nurse regarding following physician orders and oxygen titration (see attachment #3).</p> <p>An inservice was held on 01-14-2014 for department managers regarding abuse reporting. This was conducted by Beverly Moore Staff Development Nurse (see attachment #4)</p> <p>The Facility Abuse Prevention Policy is located in each department for all staff to review. The Facility Abuse Prevention Policy is also located in each Nursing Policy Book which is located at each nursing station and is available for all staff to review.</p> <p>4) Random interviews of 12 residents will be continued to be completed by Social Workers Kathy Meadows, Misty Pennington and Christa Kimbler as part of the CQI process. The results will be reported weekly in the Grievance/Complaint Committee Meeting by the Social Workers as well as quarterly through CQI.</p> <p>The Medical Director, Dr. Charles Hardin will be informed during the CQI meeting of the interview results any measures implemented as a result.</p>		

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F 225	<p>Continued From page 5</p> <p>oxygen had been found turned down during the night, had been set to 10 LPM until the resident was stable, and then turned back down to 4 LPM. However, according to the LPN, following report on 12/06/13, at approximately 8:00 AM, she observed Resident #22's oxygen to be set at 10 LPM. LPN #7 stated she adjusted the oxygen level to 4 LPM, and contacted the resident's physician and Administration to report the incident. The interview further revealed the night shift staff had speculated Resident #22's roommate had adjusted the resident's oxygen and had monitored the resident's roommate closely during the day. According to the interview, a family member of Resident #22's roommate stayed at the facility with the roommate during the evening.</p> <p>Interview on 12/19/13 at 10:40 AM with the Social Worker (SW) revealed she was informed of the incident on the morning of 12/06/13 and was informed that staff speculated Resident #22's roommate had adjusted the resident's oxygen two times during the night. The SW stated she immediately called the family members of Resident #22's roommate and arranged for the family to sit with the roommate and/or to arrange for the roommate's transfer to the hospital for a psychiatric evaluation. The interview further revealed the resident was monitored closely by staff until the resident's family arrived to the facility and until a psychiatric evaluation could be arranged for the resident.</p> <p>Interview on 12/19/13 at 10:30 AM with the Assistant Director of Nursing (ADON) revealed she had not considered the incident neglectful by staff and had only investigated the incident as staff adjusting Resident #22's oxygen without</p>	F 225	<p>The Facility will continue to follow its reporting policy of all allegations made. This facility will investigate all allegations and report the findings to all necessary state agencies. Mountain Manor of Paintsville will continue to in-service all new hire employees on our reporting practices and in-service all staff on our resident protection policy quarterly each year. In-services will be conducted and signed-off on by facility Staff Development nurse, Beverly Moore.</p> <p>Specific instructions for reporting abuse/neglect according to the Facility Abuse Prevention Policy is part of the new licensed nurse employee orientation folder as well, which is conducted by Beverly Moore, Staff Development Nurse.</p> <p>Dr. Charles Hardin, Medical Director will continue provide oversight during the compliance process.</p> <p>5) Date of completion: 01-14-2014</p>		

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F 225	Continued From page 6 physician notification. Interview on 12/17/13 at 2:30 PM with the Administrator revealed staff had discussed the incident related to Resident #22's oxygen being turned off and adjusted during the night of 12/06/13. The Administrator stated the facility felt the resident's roommate had tampered with the resident's oxygen and had put interventions in place in an effort to prevent the incident from happening again. However, the interview revealed the facility had not conducted an investigation to be certain the roommate had tampered with the oxygen. According to the Administrator, the facility determined the incident did not warrant an investigation or to be reported to state agencies.	F 225			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure services provided by the facility met professional standards of quality for one of twenty-two sampled residents (Resident # 1). A review of facility policies revealed each resident would receive a two-step tuberculin (TB) skin test upon admission. However, a review of documentation revealed Resident #1 was admitted to the facility on 10/30/13, and staff administered a total of five tuberculin skin tests during the timeframe of 10/30/13 through	F 281	F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS It is the policy of Mountain Manor of Paintsville to provide or arrange services that meet professional standards of quality. This is evidenced by the following: 1) Resident #1 did receive an appropriate Step I TB test from the facility which was read to have a "negative" result by Ashley Ward, LPN on 11-01-2013. Resident #1 did receive an appropriate Step II TB test from the facility which was read to have a "negative" result by Ashley Ward, LPN on 11-15-2013. A medication/treatment error report was completed by Mary Arms, DON on 12-19-2013 in regards to resident #1. The resident's attending physician Dr. Charles Hardin (who is also the Medical Director) was notified on 12-19-2013 by Mary Arms, DON. The facility policy was reviewed and changed for administration of TB tests to residents which will prevent resident # 1 or any other facility resident from receiving more than one TB test annually unless deemed medically necessary. This was done by Mary Arms, DON on 01-13-2014 (see attachment #5). An inservice was conducted by infection control nurse, Chanity Purcell, LPN for licensed nursing		

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F 281	<p>Continued From page 7 12/04/13.</p> <p>The findings include:</p> <p>Review on 12/18/13 at 4:30 PM of the facility's policy titled "Immunization Record," revealed that upon admission, a two-step Tuberculin (TB) Skin Test would be administered unless otherwise specified.</p> <p>Review of 902 KAR 20:200 Tuberculosis Testing in Long-Term Care Facilities revealed that "two (2) step skin testing" means a series of two tuberculin skin tests administered seven (7) to fourteen (14) days apart.</p> <p>A review of the medical record revealed the facility admitted Resident #1 on 10/30/13 with diagnoses of hypothyroidism, dementia, senile depressive disorder, esophageal reflux, failure to thrive, gastrostomy status, dysphagia, generalized muscle weakness, pain in limb, and urinary tract disease. A review of physician orders for Resident #1 at the time of admission dated 10/30/13, revealed staff was to administer an injection of Tubersol (test for Tuberculosis) intradermally, one time, and to repeat the injection of Tubersol on 11/15/13. Documentation also revealed on 11/01/13 the facility transferred the resident to an acute care facility for evaluation of the resident's mental status and readmitted the resident to the facility on 11/12/13.</p> <p>Resident #1 stated in an interview conducted on 12/17/13 at 8:05 AM during initial tour that the facility "gave me six TB skin tests." The resident stated he/she asked staff what they were administering when she received an injection and was told on approximately six occasions he/she was being tested for Tuberculosis.</p>	F 281	<p>staff on new the TB administration policy and procedure on 01/06/2013 by the Infection Control Nurse Chanity Purcell (see attachment #6).</p> <p>A note was placed at each nurse's station by Mary Arms, DON to notify licensed nursing staff that the infection control nurse Chanity Purcell would be entering all TB skin see attachment #7)</p> <p>2) An audit of all resident charts was completed by infection control nurse, Chanity Purcell, LPN, to assure that no other residents had been affected by this practice. This audit was completed on 12-19-2013. All other residents were found to have received the appropriate TB test and were not affected by this practice.</p> <p>3) The facility infection control nurse Chanity Purcell, LPN will be responsible for the data entry, administration and documentation of the step I and step II PPDs on all new residents.</p> <p>The Infection Control Nurse Chanity Purcell, LPN will also do the data entry for annual PPDs in order for the EMR to properly flag when all annual PPDs are due for residents.</p> <p>In the event of the infection control nurse's absence, the Director of Nursing Mary Arms, and Assistant Director of Nursing Anna Caldwell, or Staff Development Nurse Beverly Moore will full-fill the duties of the Infection Control</p>	
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F 281	Continued From page 8 Review of the Medication Administration Record (MAR) for Resident # 1 revealed staff administered an injection of Tubersol (test for Tuberculosis) to Resident #1 on 10/30/13, 11/13/13, 11/20/13, 11/27/13, and 12/04/13. An interview conducted on 12/19/13 at 2:25 PM with Registered Nurse (RN) #4 revealed staff administered a TB skin test to Resident # 1 upon the resident's admission on 10/30/13. RN #4 stated Resident #1 was transferred to a behavioral unit outside of the facility on 11/01/13 and returned to the facility on 11/12/13. According to RN #4, upon the resident's return to the facility, a new set of admission orders was generated, the interval codes were entered incorrectly and, as a result, the order for the TB skin test was carried over to the readmission and monthly orders. An interview conducted on 12/19/13 at 2:25 PM with RN #3 revealed she reviewed immunization records and physician orders to ensure the residents received their Step I and Step II TB Skin Tests. The RN stated, "I'm not sure what happened, I don't think anybody goes back and double checks the MARs." An interview conducted with the Director of Nursing (DON) on 12/19/13 at 3:30 PM revealed the facility had a system in place to review physician orders and MARs for accuracy. However, the DON stated the facility staff failed to identify Resident #1 received an excessive number of TB skin tests.	F 281	Nurse in regards to administration and reading of resident PPDs. Licensed nursing staff was in-serviced on the new TB administration policy and procedure on 01/06/2013 by the Infection Control Nurse Chanity Purcell, LPN (see attachment #6). 4) A log was developed for tracking and follow-up of all step I and step II PPD tests for all new residents and annual PPD's. The log will be completed by the Infection Control Nurse Chanity Purcell, LPN (see attachment #8). All results of the PPD log will be reported quarterly through CQI by the infection control nurse Chanity Purcell, LPN. Dr. Charles Hardin, Medical Director, will provide oversight during the compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI. 5) Date of completion: 01-14-2014	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/19/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240		
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F 441	Continued From page 9 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS It is the policy of Mountain Manor of Paintsville to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. This is evidenced by the following: 1) Residents were monitored by nursing staff for any adverse affects due to deficient practices, none were found. LPN # 6 was terminated from facility due to unsafe practice (see attachment #9). RN #5 was provided further education on infection control and safe preventive practices on 12/19/2013 by Staff Development Nurse Beverly Moore (see attachment #10 & #11). All facility licensed nursing staff was in-serviced on infection control policies on 12/18/2013 and 12/19/2013 by facility Staff Development Nurse, Beverly Moore (see attachment #10 & #11). Specific portions of in-service included glove changing and hand washing as well as safe use of glucose monitoring devices.		

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F 441	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined the facility failed to establish and maintain an effective infection control program designed to provide a safe and sanitary environment to prevent the transmission of disease and infection for three of twenty-two residents (Resident A, Resident B, and Resident C). Observation during medication administration on 12/18/13 revealed Licensed Practical Nurse (LPN) #6 failed to wear gloves while disposing of blood glucose test strips that were soiled with blood and placed the blood glucose device intended for Resident C on Resident B's overbed table. Continued observation revealed on 12/19/13 at 9:00 AM Registered Nurse (RN) #5 dropped a medication on the floor, picked the medication up from the floor with gloved hands, and continued to prepare medication for administration to Resident A without changing her soiled gloves.</p> <p>The findings include:</p> <p>A review on 12/19/13 at 2:30 PM of the facility's policy titled "Administering Medications," revision date of 10/20/08, revealed staff would follow established facility infection control procedures (e.g., hand washing, antiseptic technique, gloves, isolation precautions, etc.) when they administered medications.</p> <p>A review on 12/18/13 at 5:00 PM of the facility's policy titled "Infection Control/CQI Responsibilities" (undated) revealed staff was to use clean technique when they performed procedures and in disinfection of equipment to decrease the risk of infection.</p>	F 441	<p>Nurse Aides were inserviced on 12-17-2013 by Christy Moore, RN and Staff Development Nurse Beverly Moore regarding infection control (see attachment #12).</p> <p>All staff have been continuously inserviced about infection control/handwashing including the most recent dates of 09/3-9/10/2013 (Scrub-Hub), 10/09/2013 (handwashing), 09/03-10/28/2013 (Glo-Germ), 10/29-10/30/2013 (cleaning) and 01-14-2014 (handwashing). (see attachment #13).</p> <p>2) On 12-20-2013, 01-06-2014, 01-09-2014, 01-13-2014, 01-15-2014, and 01-16-2014 Brenda Humphrey, Quality Assurance Nurse observed medication administration provided to a total of ten (10) residents by eleven (11) licensed nurses to ensure that proper procedure was followed during administration, including infection control. Staff followed proper procedure. No other residents were identified.</p> <p>On 01-06-2014 Beverly Moore, Staff Development Nurse observed medication administration provided to a total of two (2) residents by two</p>	

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F 441	<p>Continued From page 11</p> <p>1. Observation on 12/18/13 at 4:00 PM of blood glucose monitoring for Resident B and Resident C revealed LPN #6 placed both of the residents' blood glucose monitoring devices on Resident B's overbed table, put on gloves, performed a blood glucose test on Resident B, removed her gloves, and proceeded to remove the blood soiled blood glucose monitoring strip from the device with her bare hands. The LPN was then observed to wash her hands, put on gloves, and proceed to perform blood glucose monitoring for Resident C with the resident's blood glucose monitoring device that had been positioned on Resident B's overbed table.</p> <p>Interview conducted with LPN #6 on 12/18/13 at 5:15 PM revealed that she was required to wear gloves when she removed the soiled blood glucose strips from the blood glucose monitoring device. LPN #6 stated the facility provided staff with frequent in-services related to infection control. The LPN stated she was not aware she should not have placed Resident C's blood glucose monitoring device on Resident B's overbed table.</p> <p>2. Observation on 12/19/13 at 9:00 AM revealed RN #5 dropped a medication on the floor during a medication administration for Resident A. RN #5 was observed to pick the medication up from the floor with gloved hands. However, RN #5 failed to remove her gloves after she picked up the medication from the floor and continued to prepare medications for administration while wearing the soiled gloves.</p> <p>Interview conducted with RN #5 on 12/19/13 at 9:15 AM revealed that she was aware she should</p>	F 441	<p>(2) licensed nurses to ensure that proper procedure was followed during administration, including infection control. Staff followed proper procedure. No other residents were identified.</p> <p>No other residents were found to be affected by the practice.</p> <p>All facility licensed nursing staff was in-serviced on infection control policies on 12/18/2013 and 12/19/2013 by facility Staff Development Nurse, Beverly Moore (see attachment #10 & #11). Specific portions of in-service included glove changing and hand washing as well as safe use of glucose monitoring devices.</p> <p>Nurse Aides were in-serviced on 12-17-2013 by Christy Moore, RN and Staff Development Nurse Beverly Moore regarding infection control (see attachment #12).</p> <p>All staff have been continuously in-serviced about infection control/handwashing including the most recent dates of 09/3-9/10/2013 (Scrub-Hub), 10/09/2013 (handwashing), 09/03-10/28/2013 (Glo-Germ), 10/29-10/30/2013 (cleaning) and 01-14-2014 (handwashing). (see attachment #13).</p>		

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F 441	<p>Continued From page 12</p> <p>have removed her gloves, washed her hands, and put on new gloves after she picked up the medication from the floor and before she continued with medication preparation. RN #5 stated the facility had provided frequent in-services on infection control and hand washing, and observed her for proper hand washing.</p> <p>Interview conducted with the Infection Control Nurse on 12/19/13 at 2:25 PM, revealed that staff was selected at random throughout the day and monitored for effective infection control procedures such as hand washing and changing gloves. According to the Infection Control Nurse, if a staff person was observed to move from a clean environment to a dirty environment they were required to wash their hands and change gloves. The Infection Control Nurse also revealed if a medication was dropped the nurse was required to remove their gloves and wash their hands after the medication was picked up and disposed of.</p> <p>Interview conducted with the Director of Nursing (DON) on 12/19/13 at 3:30 PM revealed she made rounds several times a day and came in during off hours to make rounds. The DON stated if nursing staff failed to follow proper infection control procedures, they were made aware immediately and reeducated. The DON stated if a nurse dropped a medication, it should be picked up, disposed of, the medication cart locked, gloves removed, and hands washed before the nurse continued with medication preparation. The DON revealed staff was recently provided with an in-service regarding infection control procedures. In addition, the DON stated it was a standard of care to wear</p>	F 441	<p>3) LPN # 6 was terminated from the facility due to unsafe practice (see attachment #9). RN #5 provided further education on infection control practiced and policy by the facility Staff Development Nurse Beverly Moore on 12-19-2013 (see attachment #10 & #11).</p> <p>All nursing staff was in-serviced on infection control polices on 12/18/2013 and 12/19/2013 by the Staff Development Nurse Beverly Moore. Specific portions of in-service included glove changing and hand washing as well as safe use of glucose monitoring devices. The facility will continue to conduct annual competencies on use of blood glucose meters, cleaning and handling techniques to prevent spread of infection (see attachment #10 & #11).</p> <p>4) The facility Staff Development Nurse Beverly Moore, the Infection Control Nurse Chanity Parcell and the Quality Assurance Nurse Brenda Humphrey will audit two licensed nurses per week for a minimum of 6 months on proper use of glucose monitoring devices and proper infection control (see attachment # 14).</p> <p>The results of the audit will be reviewed by the QA committee</p>	
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F 441	Continued From page 13 gloves when removing a soiled blood glucose strip.	F 441	<p>quarterly by the infection control nurse Chanity Purcell, LPN. Continued education will be given when needed to licensed nurses.</p> <p>Dr. Charles Hardin, Medical Director, will provide oversight during the compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI.</p> <p>All new licensed nurses will be in-serviced on facility infection control policies by the Staff Development Nurse Beverly Moore during orientation.</p> <p>5) Date of completion: 01-14-2014</p>	
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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1993 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 111 (211) SMOKE COMPARTMENTS: Eight COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (WET SYSTEM) EMERGENCY POWER: Type II diesel generator A life safety code survey was initiated and concluded on 12/17/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The census on the day of the survey was 108. The facility is licensed for 126. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	Mountain Manor of Paintsville does not believe and does not admit that any deficiencies existed, either, before, during or after the survey. Mountain Manor of Paintsville reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is it meant to establish any standard of care, contract obligation or position, and Mountain Manor reserves the right to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance, or self-critical examination privileges which Mountain Manor of Paintsville does not waive, and reserves the right to assert in any administrative, civil, criminal claim, action or proceeding. Mountain Manor of Paintsville offers its responses, credible allegation of compliance, and plan of correction as part of its ongoing effort to provide quality care to its residents. K 062 NFPA 101 LIFE SAFETY CODE STANDARD It is the policy of Mountain Manor of Paintsville that the automatic sprinkler systems are continuously maintained in a reliable operating condition and are inspected and tested periodically. This is evidenced by: 1) No residents were affected by this practice.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

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

TITLE

(X6) DATE

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

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K 062	<p>Continued From page 1</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure sprinkler systems were inspected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one of nine smoke compartments.</p> <p>The findings include:</p> <p>Record review of the of the facility's sprinkler inspection reports on 12/17/13 at 3:30 PM, revealed the sprinkler system contained an antifreeze loop over the loading area. An antifreeze loop must have a specific gravity test conducted yearly to ensure the sprinkler system will operate in temperatures below freezing. Further record review revealed the antifreeze loop was last inspected on 02/11/12 by an outside contractor. The information was confirmed with the Maintenance staff person.</p> <p>Interview on 12/17/13 at 3:30 PM, with the Maintenance staff person, revealed he was unaware the outside contractor had not conducted the yearly test for the antifreeze loop. Further interview revealed the Maintenance staff person was unaware of the requirement for the yearly inspection of the antifreeze loop.</p> <p>The findings were acknowledged by the</p>	K 062	<p>2) No residents were affected by this practice.</p> <p>3) Once the facility was made aware that our service contractor had not completed the inspection on the antifreeze loops of our sprinkler systems, we immediately notified Simplex Grinnel of the issue. Simplex inspected the antifreeze loops on 12/18/2013 and found both to be at compliant levels. The State agency was notified of inspection.</p> <p>4) The Administrator will sign-off on the annual antifreeze loop inspection by contracted sprinkler company for one year.</p> <p>5) Date of completion: 12-18-2013</p>	

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K 062	Continued From page 2 Administrator during the exit conference on 12/17/13. Reference: NFPA 25 (1998 Edition). 2-3.4* Antifreeze Systems. The freezing point of solutions in antifreeze shall be tested annually by measuring the specific gravity with a hydrometer or refractometer and adjusting the solutions if necessary. Solutions shall be in accordance with Tables 2-3.4(a) and (b). The use of antifreeze solutions shall be in accordance with any state or local health regulations. [See Table 2-3.4(b).] 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 record review and interviews, it was determined the facility failed to ensure generators were tested according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect eight of eight smoke compartments, 126 residents, staff, and visitors. The findings include:	K 062	K 144 NFPA 101 LIFE SAFETY CODE STANDARD It is the policy of Mountain Manor of Paintsville to ensure the generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. This is evidenced by: 1) No residents were affected by this practice. 2) No residents were affected by this practice. 3) The generator will continue to be tested on a full-load once per month. The facility has created a new form for logging the monthly generator test. On the form is a section for recording generator transfer time. The maintenance department will manually transfer the load to the generator with maintenance department timing transfer time with a stopwatch. The time will be recorded on generator form. If the transfer is not within 10-second requirement then the service company for facility generator will be called-in for inspection and any needed adjustments. Nixon Power	

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K 144	<p>Continued From page 3</p> <p>Record review of the emergency generator inspection logs for the previous 12 months, at 3:03 PM on 12/17/13, with the Maintenance staff person revealed the facility had not recorded the transfer times for the emergency generator. Generators must transfer upon the loss of power within 10 seconds. The information was confirmed with the Maintenance staff person.</p> <p>Interview on at 3:07 PM on 12/17/13, with the Maintenance staff person and the Administrator, revealed the facility did not record the transfer times for the emergency generator when monthly testing was performed. Further interview revealed the emergency generator transferred within the 10-second requirement but the facility was not aware of the need for recording the transfer time.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>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 3-4.3.1. 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</p>	K 144	<p>Services Company did come to the facility to inspect generator on 12/31/2013 and conduct load test. The generator had an acceptable transfer time of 8-seconds.</p> <p>4) The monthly load test will be logged by maintenance department and log must be taken to Administrator for approval. Administrator sign-off is required for 6 months.</p> <p>5) Date of completion: 12-31-2013</p>		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240		
(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 4 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.	K 144			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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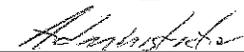
PRINTED: 01/08/2014
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240		
(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	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 2007 SURVEY UNDER: 2000 New FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 111 (211) SMOKE COMPARTMENTS: One COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (WET SYSTEM) EMERGENCY POWER: Type II diesel generator A life safety code survey was initiated and concluded on 12/17/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility (New Therapy Addition) was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	Mountain Manor of Paintsville does not believe and does not admit that any deficiencies existed, either, before, during or after the survey. Mountain Manor of Paintsville reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is it meant to establish any standard of care, contract obligation or position, and Mountain Manor reserves the right to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance, or self-critical examination privileges which Mountain Manor of Paintsville does not waive, and reserves the right to assert in any administrative, civil, criminal claim, action or proceeding. Mountain Manor of Paintsville offers its responses, credible allegation of compliance, and plan of correction as part of its ongoing effort to provide quality care to its residents. K 144 NFPA 101 LIFE SAFETY CODE STANDARD It is the policy of Mountain Manor of Paintsville to ensure the generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. This is evidenced by: 1) No residents were affected by this practice.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised	K 144		

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

TITLE

(X6) DATE

1/16/2014

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

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240		
(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	<p>Continued From page 1</p> <p>under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to ensure generators were tested according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one smoke compartment, 16 residents, staff, and visitors.</p> <p>The findings include:</p> <p>Record review of the emergency generator inspection logs for the previous 12 months, at 3:03 PM on 12/17/13, with the Maintenance staff person revealed the facility had not recorded the transfer times for the emergency generator. Generators must transfer upon the loss of power within 10 seconds. The information was confirmed with the Maintenance staff person.</p> <p>Interview at 3:07 PM on 12/17/13, with the Maintenance staff person and the Administrator, revealed the facility did not record the transfer times for the emergency generator when they performed monthly testing. Further interview revealed the emergency generator did transfer within the 10-second requirement but the facility was not aware of the need for recording the transfer time.</p> <p>Reference: NFPA 99 (1999 Edition).</p>	K 144	<ol style="list-style-type: none"> 2) No residents were affected by this practice. 3) The generator will continue to be tested on a full-load once per month. The facility has created a new form for logging the monthly generator test. On the form is a section for recording generator transfer time. The maintenance department will manually transfer the load to the generator with maintenance department timing transfer time with a stopwatch. The time will be recorded on generator form. If the transfer is not within 10-second requirement then the service company for facility generator will be called-in for inspection and any needed adjustments. Nixon Power Services Company did come to the facility to inspect generator on 12/31/2013 and conduct load test. The generator had an acceptable transfer time of 8-seconds. 4) The monthly load test will be logged by maintenance department and log must be taken to Administrator for approval. Administrator sign-off is required for 6 months. 5) Date of completion: 12-31-2013 		

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240	
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K 144	Continued From page 2 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 3-4.3.1. 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.	K 144		

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240	
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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1993 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 111 (211) SMOKE COMPARTMENTS: Eight COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (WET SYSTEM) EMERGENCY POWER: Type II diesel generator A life safety code survey was initiated and concluded on 12/17/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The census on the day of the survey was 108. The facility is licensed for 126. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

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

TITLE

(X6) DATE

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

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K 062	<p>Continued From page 1</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure sprinkler systems were inspected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one of nine smoke compartments.</p> <p>The findings include:</p> <p>Record review of the of the facility's sprinkler inspection reports on 12/17/13 at 3:30 PM, revealed the sprinkler system contained an antifreeze loop over the loading area. An antifreeze loop must have a specific gravity test conducted yearly to ensure the sprinkler system will operate in temperatures below freezing. Further record review revealed the antifreeze loop was last inspected on 02/11/12 by an outside contractor. The information was confirmed with the Maintenance staff person.</p> <p>Interview on 12/17/13 at 3:30 PM, with the Maintenance staff person, revealed he was unaware the outside contractor had not conducted the yearly test for the antifreeze loop. Further interview revealed the Maintenance staff person was unaware of the requirement for the yearly inspection of the antifreeze loop.</p> <p>The findings were acknowledged by the</p>	K 062		

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K 144	<p>Continued From page 3</p> <p>Record review of the emergency generator inspection logs for the previous 12 months, at 3:03 PM on 12/17/13, with the Maintenance staff person revealed the facility had not recorded the transfer times for the emergency generator. Generators must transfer upon the loss of power within 10 seconds. The information was confirmed with the Maintenance staff person.</p> <p>Interview on at 3:07 PM on 12/17/13, with the Maintenance staff person and the Administrator, revealed the facility did not record the transfer times for the emergency generator when monthly testing was performed. Further interview revealed the emergency generator transferred within the 10-second requirement but the facility was not aware of the need for recording the transfer time.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>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 3-4.3.1. 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</p>	K 144		

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K 144	Continued From page 4 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.	K 144			

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240	
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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: 2007</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type 111 (211)</p> <p>SMOKE COMPARTMENTS: One</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (WET SYSTEM)</p> <p>EMERGENCY POWER: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 12/17/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility (New Therapy Addition) was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p>	K 000		
K 144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised</p>	K 144		

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

TITLE

(X6) DATE

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K 144	<p>Continued From page 1</p> <p>under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to ensure generators were tested according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one smoke compartment, 16 residents, staff, and visitors.</p> <p>The findings include:</p> <p>Record review of the emergency generator inspection logs for the previous 12 months, at 3:03 PM on 12/17/13, with the Maintenance staff person revealed the facility had not recorded the transfer times for the emergency generator. Generators must transfer upon the loss of power within 10 seconds. The information was confirmed with the Maintenance staff person.</p> <p>Interview at 3:07 PM on 12/17/13, with the Maintenance staff person and the Administrator, revealed the facility did not record the transfer times for the emergency generator when they performed monthly testing. Further interview revealed the emergency generator did transfer within the 10-second requirement but the facility was not aware of the need for recording the transfer time.</p> <p>Reference: NFPA 99 (1999 Edition).</p>	K 144			

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K 144	Continued From page 2 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 3-4.3.1. 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.	K 144			