

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

PRINTED: 10/20/2011
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/26/2011
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NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10456 US HWY 62 CALVERT CITY, KY 42029
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

An annual survey and an abbreviated survey (KY #16476) were conducted on 08/23/11 through 08/26/11 to determine the facility's compliance with Federal requirements. A Life Safety Code survey was conducted on 08/24/11. The facility was not in compliance with Federal requirements with deficiencies cited at the highest S/S of "D" KY #16476 was unsubstantiated with no deficiencies cited

F 246 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES

A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, it was determined the facility failed to ensure one resident (#1), in the selected sample of nineteen (19), had the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, as evidenced by Resident #1 being moved to another room without some of his/her personal belongings.

The findings include:

An interview with Resident #1, on 08/23/11 at 1:00 PM and on 08/25/11 at 3:47 PM, revealed

F 000

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F 246

F 246

Resident #1 has a television mounted on the wall in his/her room. The resident also has a refrigerator in his/her room and has had a refrigerator since being moved into the room. Other items moved into his/her room the day of the room move included personal clothing, poster/paintings, globes, and figurines. The 52 inch screen television was not moved as this is not a reasonable accommodation and could endanger the safety of the resident's roommate due to the large amount of space it occupied. Additionally, the resident's electric wheelchair was not moved as the resident could not sit on his/her bottom related to health issues and the wheelchair did not and had not worked since admission. Conversation was conducted with Resident #1 on 10/13/11 by the Administrator and the resident's facility Angel. The resident stated he is satisfied with his current room, TV and DVD player and had no concerns with anything related to his room.

All residents who request items which are not a reasonable accommodation related to space, safety considerations, and not

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

TITLE

Executive Director

(X6) DATE

10/21/11

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 246 Continued From page 1
concerns about a recent room change, on 08/16/11, due to a small fire in his/her room. Resident #1 stated he/she had a fifty two (52) inch big screen television, refrigerator, electric wheelchair, several figurines, and paintings prior to the move to the new room; however, none of the above listed items were brought to the resident's new room during the recent move. The resident stated he/she was in his/her new room for over one week and was not able to have the television or refrigerator moved from his/her old room due to the lack of room. Resident #1 also stated his/her family visited him/her one to two times a month and were not able to sit anywhere in the room due to the resident's bariatric bed and the lack of space in a semi-private room. The resident stated he/she would like for his/her family to be able to visit him/her more comfortably. Further interview revealed he/she was told recently by the Social Services Director (SSD) his/her television would be placed in storage and he/she would be charged for it.

A review of a Social Services note, dated 08/23/11 at 11:50 AM, revealed she "spoke with the resident related to contacting his/her family to get the television from the old room. She informed the resident if they were unable to get the television, it may have to be put in a storage unit and charged to him/her."

An interview with the SSD, on 08/25/11 at 11:50 AM, revealed "I believe I was the one who told him/her about the room change, and contacted the resident's family about the television. I am still unsure about the routine when it comes to a resident's belongings being moved at the time of a room change, or who would be responsible to

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permitted per fire code (493.10) would have the potential to be affected. No other residents have requested to bring personal possessions within the facility which would compromise the safety and space of others. Therefore, no one else has been affected.

Education will be completed with the new Social Services Director, Assistant Social Services Director and the Activities Director by the Administrator regarding room changes, documentation, and resident follow up. This will be conducted on 09/21/11. A log will be completed by the Social Services Director when a resident is going to have a room change. This log will contain current room number, room they will be moved to, date and time room move is discussed with the residents and where they will move to. This log will also include documentation of notification of the roommate the resident will be placed with. Residents are currently monitored for three days by nursing staff to ensure there are no physical and/or psychosocial concerns of the resident with the room move with documentation to be completed in the nurse's notes. The monitoring consists of every shift monitoring which includes any physical or

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F 246 Continued From page 2
ensure the items were moved. If that comes under me I am not aware of it." The SSD further revealed she spoke with Resident #1, on 08/24/11, about moving his/her refrigerator, which was eight (8) days after he/she was moved to the new room.

An observation, on 08/23/11 at 5:05 PM, revealed Resident #1's belongings, such as his/her large screen television, refrigerator, electric wheelchair, paintings and some boxed items, were still in his/her old room.

An interview with the Administrator, Director of Nursing (DON) and Facility Consultant, on 08/26/11 at 4:25 PM, revealed housekeeping was responsible for moving residents' belongings during room changes. The DON stated it was she or the Administrator who usually notified housekeeping of the need to move items. The DON further stated the expectation was for the resident and his/her belongings to be moved on the same day, unless there were items which would not fit in the new room. No explanation was provided in regards to Resident #1's belongings not being moved for a period greater than one week. The refrigerator and the television were moved to the resident's room after surveyor intervention.

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
SS=D

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

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psychosocial changes related to the move change. This is completed by the charge nurse each shift for three days. Should there be an identified change either physically or psychosocially after the room change, charting will be extended for three more days and the reevaluation will occur by the charge nurse. The charting will continue to be extended times three days if a change in condition as noted above occurs. The resident's physician and family/responsible party will be notified of any condition change per policy. Residents with room moves will continue to have their personal items placed in the room if the items can safely be placed in the room to reasonably accommodate both residents. This will be completed by the Housekeeping Department upon room change. Housekeeping Supervisor and the Maintenance Director will together decide if items are safe to be placed in the resident's room. This will be decided related to the amount of space the items will require, safety considerations, and fire code permits. In relation to space, the item must fit within the allotted amount of space per regulation requirements without infringing upon the space of the roommate and/or others. Room

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F 282	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide services in accordance with the resident's written plan of care for one resident (#1), in the selected sample of nineteen (19) residents. The facility also failed to develop and implement revised interventions to promote pressure ulcer healing and prevent deterioration while Resident #1 was removed from an air mattress and placed on non air mattress for a period greater than thirty (30) hours. The facility removed Resident #1 from his/her specialty mattress, on 01/27/11 at 9:30 AM, and was placed on a regular mattress, until 01/28/11 at 2:00 PM. During this time the staff failed to revise the interventions to prevent wound deterioration and promote healing as staff could not safely turn, reposition, or provide physician ordered dressing changes to his/her sacrum and coccyx. This failure resulted in wound deterioration causing an increase in undermining of 0.4 centimeters (cm) and a 50% increase in the presence of necrotic tissue. (Refer to F314)</p> <p>The findings include:</p> <p>A record review revealed Resident #1 was admitted to the facility on 10/21/10 with diagnoses to include Pyelonephritis, Quadriplegia, Neurogenic Bladder, Diabetes Type II, Depression and Multiple Decubitus Ulcers. A review of Resident #1 quarterly Minimum Data Set (MDS) Assessment, dated 01/13/11, revealed that resident was assessed as cognitively intact, totally dependent on staff for bed mobility, transfer, personal hygiene, bathing, dressing and eating. A review of the care plan, dated 01/13/11,</p>	F 282	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</i></p> <p>changes will be discussed in the morning meeting which is attended by all department heads which includes Housekeeping Supervisor. Room changes will be documented on the White Board in the morning meeting and follow up will be conducted by the Unit Managers for the resident to ensure the transfer with the resident's items was conducted. The Unit Managers will follow up on any room change the day of the change to ensure the resident's personal items were moved with them.</p> <p>All residents within the facility are assigned an "Angel" who is an employee within the facility. The Angel communicates with the residents on a regular basis (at least weekly and in many cases daily) to ensure they have no concerns. The Angel program has been an established customer service program within the company for a long period of time. The Angel will ask the residents on a weekly basis if they are pleased with their room accommodations and if they need anything to make their environment more comfortable and homelike. "Angel" Staff have been in-serviced on ensuring the resident is asked about their room regarding</p>	

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revealed "Potential for Further Alterations in Skin Integrity related to decreased mobility/immobility." Interventions included to use a pressure redistribution mattress on the bed (STAT 4000). Further review of the care plan revealed "Actual Alteration in Skin Integrity related to being admitted with multiple skin ulcers on his/her hips, coccyx, and feet." Interventions included to provide these areas on his/her skin with treatments as ordered, twice per day. Dressing changes to Resident #1's sacrum and coccyx were done by Physical Therapist (PT) #1, Monday through Friday on day shift and nursing completed dressing changes on evening shift and all dressing changes on the weekend.

An interview with Resident #1, on 08/23/11 at 1:00 PM and on 08/25/11 at 3:47 PM, revealed he/she was moved from his/her specialty mattress to a regular mattress on the morning of 01/27/11 until "the next day (01/28/11) sometime in the afternoon." This was due to a malfunction with his/her bed, which caused a "small fire" in his/her room and it required he/she to be removed from the room and the bed.

An interview with PT #1, on 08/25/11 at 2:55 PM and 3:35 PM, and on 08/26/11 at 2:07 PM, revealed Resident #1 was placed in a regular bed versus a bariatric low air loss mattress, on 01/27/11, related to a malfunction in his/her bed. PT #1 stated Resident #1's body filled up the entire (regular) bed and there was no room on either side to position safely to complete the dressing change on 01/27/11. PT #1 reported Resident #1 needed to be turned completely to one side and positioned against the side rail to complete the dressing changes on his/her

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their comfort and homelikeness. This was conducted by the DNS and Administrator on 09/21/11. The resident's response will be documented on the Angel Care form.

Should any resident express concerns, the Angel will immediately notify the DNS and/or Administrator who will immediately take needed action on the concern. A grievance form will be completed on any concern. Additionally, the Administrator will review all Angel Care Books on a weekly basis to ensure concerns have been addressed. The results of the Angel Care interviews will be discussed in the Quality Assurance Meeting monthly. This will occur monthly times four months or until compliance is achieved.

Completion date: 09/30/11

9/30/11

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F 282	<p>Continued From page 5</p> <p>sacrum and coccyx. He stated that due to the size of the bed with no side rails, it was not safe to complete the dressing change on 01/27/11. A review of the Treatment Administration Record (TAR), dated January 2011, revealed dressing changes, on 01/27/11, were signed and circled which meant they were not completed. LPN #1 documented, at 3:00 PM, "PT was unable to do the wound care to the coccyx and sacrum related to the bed." A review of the nurses' note, dated 01/27/11 at 1:00 PM, revealed wound care was not completed related to the resident's bed.</p> <p>Further review of care plan revealed that no revisions or updates had been developed or implemented on the date of the occurrence to prevent deterioration of wounds related to Resident #1 not receiving wound treatments or being placed on regular sized bed with non air mattress. There was no documented evidence in the Nurses Notes that the facility had implemented any new interventions to prevent deterioration of the wound related to the facility placing resident #1 in a regular sized non air mattress where the resident could not be safely turned, repositioned or have physician ordered dressing changes completed. Nurses Note, dated 01/27/11 at 11:30 PM, stated that resident was "turned and repositioned every two (2) hours and as needed (PRN) per staff"; which was the same intervention in place prior to resident being moved to regular sized non air mattress. However, interview with Resident #1, on 08/25/11 at 3:47 PM, revealed "the staff were not able to turn or reposition me, because the bed was too small. That was why they did not do my dressing change that night. They were afraid to turn me because the bed was too small. I did not sleep all</p>	F 282	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F 282</p> <p>Resident #1's wounds were evaluated by the Unit Manager and the Wound Champion who both have advanced wound training and all wounds have improved. The Resident was placed on the ordered air mattress as soon as the company representative brought the mattress into our facility. Resident #1's care plan has been updated to include q 1 hour turning and repositioning should the resident be transferred to any other type of mattress.</p> <p>All residents within the facility on a specialty mattress have the potential to be affected. All residents were evaluated and no residents have been adversely affected with regards to their mattresses.</p> <p>All residents with specialty mattresses are monitored by the charge nurse each shift to ensure mattresses are working appropriately. This evaluation is documented on the Treatment Administration Record (TARS) by the nurse. If a mattress is identified as needing service of any type a call will be made to the company representative immediately as has</p>	

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night." Additionally, the resident stated "it felt like my butt was on fire."

A review of the Physical Therapy progress note, dated 01/28/11, revealed "due to a malfunction with the resident's bed, he/she was placed in a smaller bed, with no rails, no low air loss for greater than thirty hours, with no treatment or bandage changes on 01/27/11. During today's (01/28/11) dressing change, the wound was noted to have increased drainage, necrotic tissue and a foul odor." Further review revealed the Physical Therapist (PT) #1 provided "sharp debridement with forceps/scissors to remove necrotic tissue from the wound bed and to facilitate healing of the wound." The progress note further revealed there was minimal decrease in the measurements of the wound, with an increase of necrotic tissue from twenty five (25) percent on 01/21/11, to seventy five (75) percent on 01/28/11, and an increase in undermining from 1.8 centimeters (cm) on 01/21/11, to 2.2 cm on 01/28/11. A review of the Rehab's daily activity report revealed treatment was started, on 01/28/11 at 2:49 PM, and was completed at 4:20 PM, for a total of ninety one (91) minutes. Continued interview with PT #1 revealed that PT#1 attributed the deterioration of the wound, on 01/28/11, to the failure to complete dressing changes on 01/27/11, and the resident being on a regular mattress versus a low air loss mattress for greater than thirty (30) hours.

F 314 483 25(c) TREATMENT/SVCS TO
SS=D PREVENT/HEAL PRESSURE SORES

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores

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F 314 always been the facility practice. When a call is made to the Facility Representative for the specialty mattresses, the representative will be contacted by speakerphone with the Case Manager and the DNS and/or Administrator present to ensure effective communication with the Company Representative. Additionally, a form has been established which will be completed by the two parties present for the call which documents date, time and purpose of the call with representative response. If a malfunction should occur on the weekend, the Weekend Manager will make the call in the presence of one of the Charge Nurses. The same form and criteria will be completed with this call. Care plans are developed and revised by Charge Nurses and Minimum Data Set (MDS) Coordinators as deemed necessary. An in-service was conducted with all licensed nursing staff regarding revision of care plans. This was conducted by the Director of Nursing (DNS) on 09/29/11. This in-service addressed revision of individual care plans for any resident who is on a specialty mattress if there is a malfunction in either the bed or the mattress. This included additional turning and repositioning (exp q 1 hour versus q 2

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F 314	<p>Continued From page 7</p> <p>does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable, and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of service detail and skin assessment, it was determined the facility failed to provide the necessary treatment and services to promote wound healing for one resident (#1), in the selected sample of nineteen (19). The facility failed to ensure wound care interventions were implemented to prevent the worsening of wounds and to promote healing while Resident #1 was without a specialty mattress for 30 hours. On 01/27/11, the facility transferred Resident #1 to another room and a regular bed due to an electrical fire. The facility failed to provide appropriate wound care and interventions for 30 hours. This failure resulted in the deterioration of the wound causing an increase in undermining of 0.4 centimeters (cm) and a 50% increase in the presence of necrotic tissue.</p> <p>The findings include:</p> <p>A record review revealed Resident #1 was admitted to the facility on 10/21/10 with diagnoses to include Pyelonephritis, Quadriplegia, Neurogenic Bladder, Diabetes Type II, Depression and Multiple Decubitus Ulcers.</p> <p>A review of the care plan, dated 01/13/11,</p>	F 314	<p><i>This Plan of Correction is the center's credible allegation of compliance</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>hours). This will be documented on the care plan update sheet along with the Certified Nursing Assistant (C.N.A.) care plans.</p> <p>An audit form will be completed by the Case Manager and/or DNS on a daily basis Monday through Friday which will include review of individual air mattresses, documentation by the nurses regarding functioning and any calls made to the Company Representative. This audit will be conducted by the Weekend Manager on Saturday and Sunday. This will be completed daily times four weeks. After the four week period, the form will be completed weekly times four weeks. The form will then be completed monthly times four months. All results of the audits will be taken to Quality Assurance on a monthly basis or until compliance is achieved.</p> <p>Completion date: 09/30/11 9/30/11</p> <p>F314</p> <p>Resident #1 was placed back on a specialty mattress as soon as the Company</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/26/2011
NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10456 US HWY 82 CALVERT CITY, KY 42029	
(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 314	<p>Continued From page 8</p> <p>revealed "Potential for Further Alterations in Skin Integrity related to decreased mobility/immobility." Interventions included to use a pressure redistribution mattress on the bed (STAT 4000). Further review of the care plan revealed "Actual Alteration in Skin Integrity related to being admitted with multiple skin ulcers on his/her hips, coccyx, and feet." Interventions included to provide these areas on his/her skin with treatments as ordered, twice a day. Dressing changes were completed Monday through Friday on day shift by physical therapy to Resident #1 sacrum and coccyx and nursing was responsible for the dressing changes on evening shift and all dressing changes on the weekend. A review of the quarterly Minimum Data Set (MDS), dated 01/17/11, revealed the resident was assessed as cognitively intact, totally dependent on staff for bed mobility, transfer, dressing, eating, toilet use, personal hygiene and bathing.</p> <p>Review of wound documentation completed by Physical Therapy revealed: on 01/21/11 "stage four (4) sacral decubitus: 7.0 centimeters (cm) X 11.8 cm X 5.6 cm with up to 1.8 cm undermining at the eleven (11) o'clock position, twenty five (25) percent slough, seventy five (75) percent granulation with decreased necrotic tissue from a couple of days ago"; 01/24/11 "stage four(4) sacral decubitus: fifty (50) percent slough, fifty (50) percent beefy red granulation. Good granulation in wound bed"; 01/25/11 "stage four (4) sacral decubitus: ten (10) to twenty (20) percent slough, very bloody with clots in wound bed. Decreased slough, drainage more sanguinous"; 01/26/11 "stage four (4) sacral decubitus: twenty five (25) percent slough, twenty five (25) percent darkened area, and fifty (50)</p>	F 314	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</i></p> <p>Representative delivered the mattress to the facility after the bed spark occurred.</p> <p>Resident #1 has been provided wound care per physician orders. Therapy staff has been in-serviced to alert nursing staff should there be any reason why wound care cannot be completed. This was completed on 09/22/11 by the Director of Nursing (DNS). Additionally, staff has been in-serviced regarding more frequent turning and repositioning with care plan update. This was conducted on 09/29/11 and conducted by the Director of Nursing (DNS).</p> <p>All residents with pressure wounds and/or are on specialty mattresses have the potential to be affected. There were no other residents in the facility with pressure ulcers. Residents with specialty mattresses were reviewed with no concerns identified with the function of the mattresses and/or bed.</p> <p>Resident #1's pressure ulcers are assessed on a daily basis by the Charge Nurse who completes the wound dressing on a daily basis. Should there be any change in the condition of the wound, the physician will be contacted as well as the responsible party.</p>

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F 314	<p>Continued From page 9 percent beefy red granulation tissue. No changes in condition."</p> <p>A record review revealed, on 01/27/11 at 9:00 AM, the facility moved Resident #1 from a bariatric sized air mattress, with side rails to a regular sized non air mattress, without side rails. A review of the Fire Department report, dated 01/27/11, revealed they were called to the facility at 9:07 AM and responded at 9:08 AM, related to the incident with Resident #1's bed. Further review of the report revealed "last unit cleared" at 9:26 AM. Interviews with Licensed Practical Nurse (LPN) #1, on 08/24/11 at 3:24 PM, Certified Nurse Aide (CNA) #1 on 08/25/11 at 11:05 AM, and Registered Nurse (RN) #2, on 08/25/11 at 11:12 AM, revealed Resident #1 was moved from the air mattress using a hoier lift, after the incident with his/her bed on 01/27/11 and placed on a non air mattress, without side rails, in a room across the hall. A review of a nurse's note documented by LPN #1, dated 01/27/11 at 1:00 PM, revealed dressing changes were not completed to Resident #1's coccyx and sacrum "related to the resident's bed." An interview with Resident #1, on 08/23/11 at 1:00 PM, and on 08/25/11 at 3:47 PM, revealed his/her room "caught on fire" around December 2010 or January 2011. The resident revealed staff was unable to move his/her bed as it was too large to get out of the room. He stated he/she spent the night across the hall on a regular bed, due to the malfunction of his/her bed.</p> <p>Further review of care plan, dated 01/13/11, revealed there was no documented evidence the facility had implemented new interventions prevent decline in the wound, related to Resident</p>	F 314	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</i></p> <p>The resident has had no new pressure ulcers since admission to the facility. All of the resident's wounds have shown improvement with 7 of the 13 admitted with wounds successfully healed.</p> <p>The Staff Development Coordinator has in-serviced nursing staff in delivery of necessary treatments and services to promote healing of pressure ulcers. In-services included providing treatments according to physician's orders, use of appropriate pressure relieving surface and turning and repositioning per plan of care. This in-service was conducted on 09/15/11. Education will be provided with the therapy department on 09/22/11 by the Director of Nursing to ensure therapy is aware to notify the Unit Managers when dressing changes will occur so assistance can be provided as needed. Additionally, therapy will notify the Director and/or Unit Manager when additional assistance is needed to conduct dressing changes.</p> <p>The Director of Nursing and/or the Wound Champion will review treatment records and pressure ulcer monitoring reports daily to ensure appropriate interventions are in place</p>	

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F 314	Continued From page 10 #1 being placed in regular sized bed with non air mattress. Nurses Note, dated 01/27/11 at 11:30 PM, stated that resident was "turned and repositioned every two (2) hours and as needed (PRN) per staff"; which was the same interventions in place prior to the incident on the morning of 01/27/11. However, further interview with Resident #1 revealed "the staff could not turn/reposition me because the bed was too small." An interview with Licensed Practical Nurse (LPN) #1, on 08/24/11 at 3:24 PM, revealed Physical Therapy (PT) was unable to complete the dressing change on 01/27/11, because the bed was not big enough to turn him/her on his/her side. LPN #1 documented, on the Treatment Administration Record (TAR), on 01/27/11 at 3:00 PM, that "PT was unable to complete the wound care on the resident's coccyx and sacrum related to the bed." A review of the nurses' notes, dated 01/27/11 at 1:00 PM, revealed the coccyx and sacrum wound care was not completed related to the bed. Additionally, a review of the TAR, dated 01/27/11, revealed the PM treatment was not completed as well. Review of the PT daily progress not revealed no wound treatment was completed on 01/27/11. An interview with PT #1, on 08/25/11 at 2:55 PM and 3:35 PM, and on 08/26/11 at 2:07 PM, revealed Resident #1 was placed in a regular bed versus a bariatric low air loss mattress, on 01/27/11, related to a malfunction in his/her bed. Staff was unable to turn Resident #1 properly to do his/her dressing changes because of resident's size, the size of the bed, and the fact that the bed did not have side rails. PT #1 reported that Resident #1 needed to be turned over completely on one side and positioned on the side rail to be able to complete dressing changes to sacrum and	F 314	<p><i>This Plan of Correction is the center's credible allegation of compliance</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>and treatments have been completed per physician orders to promote wound healing. This review will occur Monday through Friday. The Weekend Manager will review these records on Saturday and Sunday. This review will occur daily times four weeks. The review will then occur weekly times four weeks if no issues have been found. The review will then occur monthly times four months. The Wound Champion has always observed wounds on a weekly basis and will continue to do so. Additionally, if there is any change noted in a resident's wound during a dressing change the Wound Champion will observe the wound at that time. The Quality Assurance pressure ulcer tool will be completed monthly. This will be reviewed at the QA meeting monthly times four months or until compliance is achieved.</p> <p>Completion date: 09/30/11</p> <p>9/30/11</p>

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F 314	<p>Continued From page 11</p> <p>coccyx. PT #1 stated Resident #1's body filled up the entire (regular) bed and there was no room on either side to position the resident safely to complete the dressing change on 01/27/11. He stated it was not safe to turn/reposition the resident in the bed at that time.</p> <p>Additionally, there was no documented evidence in the Nurses Notes that revealed the facility had implemented any new interventions to prevent worsening of the wounds, related to resident being in regular sized non air mattress and the inability to turn and reposition the resident in the bed.</p> <p>An interview with Resident #1, on 08/23/11 at 1:00 PM, and on 08/25/11 at 3:47 PM, revealed staff could not turn/reposition me because the bed was too small and that was why they did not do my dressing change that night." Resident #1 stated he/she was uncomfortable, did not sleep all night and had reported to staff that "my butt [was] on fire." An interview with Certified Nurse Aide (CNA) #1, on 08/25/11 at 11:05 AM, revealed "I know he/she was uncomfortable" in reference to the resident being on a regular bed.</p> <p>An interview with RN #1, on 08/25/11 at 3:40 PM, revealed she was uncertain if she or someone else contacted the technician to come to the facility to replace the mattress. She expected the call to the technician to be made immediately and stated "I am sure I probably did, and I do not remember, but he came right away." A review of the facility's investigation, dated 01/28/11 at 2:00 PM, revealed the technician "brought a new air mattress for Resident #1's bed and the resident was put back on it." RN #1 verified the</p>	F 314	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</i></p>	

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F 314 Continued From page 12
documentation on the investigative report as well as her signature. She stated if she "documented the date to be 01/28/11, then it was 01/28/11;" however, she thought it was the same day .

An interview with a Delivery Technician, on 08/25/11 at 1:45 PM, revealed he was required to respond within a four (4) hour time frame when a facility called him. He reported it was approximately two (2) hours from the time he received the call until the time he got the bed changed. He stated he was on-call twenty four (24) hours a day, seven (7) days a week and had a four (4) hour time frame in which he was expected to respond. A review of the "Service Request Detail" revealed a dispatch history, dated 01/28/11 at 9:18 AM, which was approximately twenty four (24) hours after Resident #1 was moved to a smaller non air mattress where he/she could not be turned or repositioned. An interview with Resident #1, on 08/25/11 at 3:47 PM, revealed he/she was moved to a regular non air mattress following the fire, until "the next day, sometime in the afternoon." Further review of the outlet audit form, dated 01/28/11 at 2:00 PM, revealed documentation by RN #1 stating the bed technician "brought a new air mattress for Resident #1. Resident #1 was put back on it."

An interview with PT #1, on 08/25/11 at 2:55 PM and 3:35 PM, and on 08/26/11 at 2:07 PM, PT#1 revealed Resident #1 was returned to a bariatric low air loss mattress, on 01/28/11, and the dressing change was completed at that time. A review of the Physical Therapy daily progress note, dated 01/28/11, revealed Resident #1 "states his/her backside had been "on fire" earlier and then went numb. Sacral decubitus

F 314 *This Plan of Correction is the center's credible allegation of compliance.*

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F 314	Continued From page 13 measurements were, 6.5 centimeters (cm) X 11.5 cm X 5.4 cm with 2.2 cm undermining at the twelve (12) o'clock position. Foul odor noted from saturated dressing from 01/26/11. Increased slough, drainage, and odor. Purple areas to wound perimeter." Physical Therapy weekly progress note dated 01/28/11 stated, "Progress was noted with decrease in length, width, and depth. Due to a malfunction with the resident's bed, he/she was placed in a smaller bed, without rails, no low air loss for greater than thirty (30) hours, with no treatment or bandage changes on 01/27/11. During today's (01/28/11) dressing change, the wound was noted to have increased drainage, necrotic tissue and a foul odor. The resident's current bed is similar to the previous mattress." Additionally, the Physical Therapy weekly progress note revealed there were changes from the previous week, to include an increase in undermining from 1.8 centimeters (cm), at the eleven (11) o'clock position, to 2.2 cm at the twelve (12) o'clock position, and an increase in necrotic tissue from twenty five (25) percent to seventy five (75) percent. Note stated that potential for achieving stated goals was good, based on "return to correct bed." PT #1 note on 01/28/11 stated that he completed "sharp debridement with forceps/scissors to remove necrotic tissue from the wound bed and facilitate healing of the wound." A review of the Rehab's daily activity report revealed treatment was started, on 01/28/11 at 2:49 PM, and was completed at 4:20 PM, for a total of ninety one (91) minutes. Further interview with PT #1 revealed he attributed the deterioration of the wound, on 01/28/11, to failure to complete dressing changes on 01/27/11, and the resident being on a regular mattress versus a low air loss	F 314	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</i>	

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F 314 Continued From page 14
mattress for greater than thirty (30) hours.

An interview with the Director of Nursing (DON), Administrator, and Facility Nurse Consultant, on 08/26/11 at 4:25 PM, revealed they could provide no explanation as to why Resident #1 was not on the specialty mattress for over thirty (30) hours. In reference to notification of the technician, the DON stated "we called him and he came," but she could not provide a reason as to why a specialty mattress was not brought to the facility until 01/28/11. The DON revealed the resident's wound had not declined, and when questioned about PT #1's progress note, dated 01/28/11, which revealed changes in the resident's wound, she stated the nurse assessed the wound better than PT. The DON stated, that on the evening of 01/28/11, the nurse did not report any decline in the wound. Upon further review of the nurses' note, provided by the DON, dated 01/28/11 at 11:30 PM, revealed the treatment was done by the nurse after PT #1 had already spent ninety one (91) minutes to complete the dressing change that same day.

Interviews with CNA #1, RN #2, and the DON revealed that resident was turned and repositioned every hour due to resident not being in his/her bed; however Resident #1 interview on 08/25/11 at 3:47 PM revealed that "staff could not turn and reposition me because the bed was too small." PT#1 interview on 08/25/11 at 3:35 PM also revealed that resident was "in regular sized bed with no bed rails and it was not safe to turn him to his side. His body filled up the entire bed and there was no room on either side."

An interview with the resident's physician, on

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F 314	Continued From page 15 08/26/11 at 5:54 PM, revealed he was in the facility on 01/28/11 and was aware of the 01/27/11 incident with Resident #1's bed. "The resident was put in a safe place. I think the staff did what they had to do and put him/her in another bed." When questioned about Resident #1's dressing change not being completed on the day of the bed's malfunction, he stated, "I do not think I knew there was no dressing change on the day of the malfunction. I do not know about those circumstances." A review of the annual MDS, dated 07/21/11, revealed the facility continued to assess Resident #1 as having no evidence of cognitive impairment. Observation during the facility's skin assessment, on 08/24/11 at approximately 4:00 PM, revealed Resident #1's wound measurements of sacral decubitus was 5.2 cm X 10.7 cm X 2.5 cm, with 1.5 cm undermining at the one (1) o'clock position.	F 314	<i>This Plan of Correction is the center's credible allegation of compliance</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</i>
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, review of the electrical contractor's report and interview, it was determined the facility failed to maintain permanent wiring and ensure essential electrical equipment was in safe operating condition, for one resident (#1), in the selected sample of nineteen (19), as evidenced by electrical outlet	F 456	F 456 Resident #1 was the resident in the bed which had an electrical spark. The resident was immediately moved off of the bed across the hall into another bed within the facility. The resident was not harmed. An electrical contractor came into the building immediately after the electrical spark on 01/27/11 to inspect the outlet involved with no issues identified. All outlets in the facility were checked in the facility on the day of the spark with no problems identified.

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F 456	<p>Continued From page 16</p> <p>boxes which protruded two inches out from the walls with no barriers in place. On 01/27/11, Resident #1's bed was raised by the staff and a "popping" noise was heard. Observations revealed electrical sparks came out from the outlet box which resulted in the melting of the bed's cord. Additionally, the outlet box cover turned black, the resident's pillow case was singed, and the air mattress and the pump on the bed shorted out. The resident had to be placed in another bed.</p> <p>The findings include:</p> <p>An interview with Resident #1, on 08/23/11 at 1:00 PM and on 08/25/11 at 3:47 PM, revealed the plug on his/her bed "caught on fire," in December 2010 or January 2011, and he/she was moved to another room. Resident #1 revealed Certified Nurse Aide (CNA) #1 raised the head of his/her bed for breakfast and he/she heard a "popping noise." Resident #1 stated CNA #1 called for assistance but no one responded, so she left the room to go get help. CNA #1 returned with Licensed Practical Nurse (LPN) #1 and Registered Nurse (RN) #2. He/she stated RN #2 pulled out the plug with her foot. The resident revealed, in the past, the head of his/her bed would not raise or lower properly. The staff would have to "hold" the plug in the socket while the head of the bed was raised or lowered.</p> <p>An interview with CNA #1, on 08/25/11 at 11:05 AM, revealed she was in the room with Resident #1 at the time of the incident, which happened on 01/27/11. She stated she raised the head of the bed with a controller and heard a noise, observed a spark, and then she observed a "black mark"</p>	F 456	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>All resident beds were placed away from the outlet to ensure when the bed was raised or lowered there would be no contact with the outlet. All nursing staff were educated on ensuring the bed is not placed where the bed can make contact with the outlet when raising or lowering the bed. This was completed by the Staff Development Director on 09/15/11 and will also be included in new hire orientation on a regular basis.</p> <p>The Maintenance Director and/or his Assistant will complete a maintenance log on all bed cords to ensure no loose screws on the bed cords, which was the cause of the spark, in the facility on a weekly basis. Any concerns will be addressed immediately. The log will be reviewed by the Administrator weekly to ensure completion of the logs. An Audit will be completed by the Administrator on a weekly basis times four, then monthly times four months. The results of the audits will be taken to Quality Assurance monthly times four months or until compliance is achieved.</p> <p>Completion date: 09/30/11</p>	

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PRINTED: 10/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/26/2011
NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10466 US HWY 62 CALVERT CITY, KY 42029	
(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)

F 456 Continued From page 17
on the wall. She called a "Code Red," yelled "fire," and pushed Resident #1's bed away from the wall.

An interview with RN #2, on 08/25/11 at 11:12 AM, revealed she was on her way to the morning meeting, on 01/27/11, when she was called to Resident #1's room by CNA #1. She revealed there was a spark and some smoke. The fire alarm was pulled and she unplugged Resident #1's bed with her foot.

An interview with LPN #1, on 08/24/11 at 3:24 PM, revealed he and RN #2 were summoned to Resident #1's room due to "fire," on the morning of 01/27/11. He reported the bed cord sparked and the "fire" was extinguished.

An interview with the Maintenance Director, on 08/24/11 at 3:45 PM and 4:00 PM, revealed he was called to Resident #1's room from the morning meeting, on 01/27/11. He saw "outlet smoke but no fire." A "Code Red" was called and the fire department responded. He stated there was black smoke on the wall of Resident #1's room and the end of the cord to the bed was melted. He further stated the power went out because "a breaker blew." There was a loose screw which connected the cord to the bed and caused the "over amp." He could not provide an explanation as to why the screw was loose. He revealed there was not a barrier or cover over the outlet boxes to protect them from being struck when the beds were moved, raised or lowered.

A review of the electrical contractor's report, dated 01/27/11, revealed the "wire mold raceway and boxes were UL listed and met the Federal

F 456 *This Plan of Correction is the center's credible allegation of compliance.*

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F 456	<p>Continued From page 18</p> <p>Specs," and "the only maintenance to be done was to lighten the two (2) screws which held the back of the box to the front of the box."</p> <p>An observation of Room #110 (Resident #1's previous room), on 08/26/11 at 9:45 AM, revealed the outlet protruded from the concrete walls approximately two inches on all sides and was in direct line of the bed frame.</p> <p>An interview with CNA #2, on 08/26/11 at 4:25 PM, revealed the resident was moved to another room (#112), after the incident on 01/27/11. She further revealed Resident #1's bed "sparked out again." On this occasion, the CNA revealed she assisted the resident to move up while in the bed. This caused the bed to move against the wall and the outlet "arched out again."</p> <p>An interview with the Director of Nursing (DON), on 08/26/11 at 10:45 AM, revealed the facility did not have a cover on the outlet box and was not made aware they needed one.</p>	F 456	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed safely because it is required by the provisions of federal and state law.</i></p>	

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NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10456 US HWY 62 CALVERT CITY, KY 42028
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: Unknown SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type III (000) SMOKE COMPARTMENTS: Six (6) smoke compartments. COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Type II LP generator. A life safety code survey was initiated and concluded on 08/24/11. 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. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</i>	
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a	K 027		

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

[Handwritten Signature]

TITLE

Executive Director

(X6) DATE

9/22/2011

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 OAKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10456 US HWY 62 CALVERT CITY, KY 42029		
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K 027	<p>Continued From page 1</p> <p>20-minute fire protection rating or are at least 1 1/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>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. These doors must close all the way to help prevent fire/smoke from reaching other parts of the building in a fire situation. The deficiency has the potential to affect three (3) of six (6) smoke compartments, (100) residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 08/24/11 at 8:51 AM, with the Maintenance Supervisor, revealed the smoke doors located in Hall 1, Hall 2 and Hall 3 would not close completely.</p> <p>Interview on 08/24/11 at 8:51 AM, with the Maintenance Supervisor, revealed the facility would adjust doors to close properly.</p> <p>Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving</p>	K 027	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Hall I, II, and III smoke doors were adjusted on 08/24/11. Doors will be audited as part of Preventative Maintenance program, and will be checked monthly to ensure proper function. The Performance Improvement Committee will review monthly to ensure compliance.</p>	09/30/11	

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NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10466 US HWY 62 CALVERT CITY, KY 42029		
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K 027	Continued From page 2 only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.	K 027	<i>This Plan of Correction is the center's credible allegation of compliance.</i>		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to meet the requirements of Protection of Hazards, per NFPA Standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred (100) beds and the census was ninety-four (94) on the day of the survey. The findings include: Observation, on 08/24/11 at 9:26 AM, with the Maintenance Supervisor revealed the door to the Housekeeping Supply Room did not have a self	K 029	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> The Housekeeping Supply room door had a self closing device installed on 09/15/11. The Housekeeping Supply door will be included in the monthly door PM. Performance Improvement Committee will review monthly to ensure compliance.	09/30/11	

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NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10456 US HWY 62 CALVERT CITY, KY 42029	
(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 029	Continued From page 3 closing device installed on the door. Interview, on 08/24/11 at 9:26 AM, with the Maintenance Supervisor revealed he was unaware the door to the Housekeeping Supply Room was required to be self-closing. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms / (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction	K 029	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</i>	

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NAME OF PROVIDER OR SUPPLIER DAKVIEW NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10456 US HWY 62 CALVERT CITY, KY 42029
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K 029	Continued From page 4 (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD SS=F Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure means of egress were maintained free and clear of obstructions according to NFPA standards. The deficiency has the potential to affect three (3) of six (6) smoke compartments, all residents, staff and visitors. The facility is licensed for one hundred (100) beds; the census on the day of the survey was ninety-four (94). The findings include: Observation during the Life Safety Code Survey on 08/24/11 between 9:05AM and 10:00 AM, with the Maintenance Supervisor, revealed med carts by Room 117 in Hall 1, wheelchairs and Resident Chairs in Hall 3, two (2) wheelchairs in Hall 2.	K 029	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
K 072		K 072	Staff were in-serviced on 09/15/11 regarding the storage of med carts, wheel chairs, and resident chairs in halls. Audits of Hall I, II, and III will be conducted by the Executive Director, Director of Nursing, or Unit Managers 5 times weekly to ensure compliance and then routinely as needed. Food storage carts were removed from the means of egress. Staff were in-serviced on 09/15/11 regarding the storage of food carts. Audits will be conducted by Executive Director, Food Service Manager, or Director of Nursing 5 times weekly for 1 month, then 3 times weekly for 1 month to maintain compliance.	09/30/11

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K 072	Continued From page 5 Also Food Storage Carts were stored in the Exit Corridor off of the Dining Room. The items observed in the corridors were stored and not in use for a period of more than thirty (30) minutes. Interview with the Maintenance Supervisor, confirmed the items located in the corridors and indicated that was not where they are kept. 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.	K 072	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, including residents, staff, and visitors. The facility is licensed for one hundred (100) beds with a census of Ninety-Four (94) on the day of the survey. The findings include:	K 147	The open junction box on Hall III was covered on 08/24/11.	09/30/11	

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K 147	<p>Continued From page 6</p> <p>Observation, on 08/24/11 at 9:05 AM, with the Maintenance Supervisor revealed one (1) open junction box located in Hall 3 between rooms # 348 and# 350.</p> <p>Interview, on 08/24/11 at 9:05 AM, with the Maintenance Supervisor revealed he was unaware of the open electrical junction.</p> <p>Reference: NFPA 70 (1999 edition) 370.28(c) Covers.</p> <p>All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22.</p>	K 147	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</i></p>	