

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

PRINTED: 05/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2015
NAME OF PROVIDER OR SUPPLIER THE WILLOWS AT CITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1376 SILVER SPRINGS DRIVE LEXINGTON, KY 40511		
(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 Recertification Survey was initiated on 05/12/15 and concluded on 05/14/15 with deficiencies cited at the highest scope and severity of a "D".	F 000	N144 QUALITY OF LIFE Targeted Residents No residents were affected. The alleged deficient practice was observed on 5/13/15 at 10:00am, at this time, all resident breakfast trays had been passed and returned to the kitchen without any visible hair noted on food products. Identification of other Residents All residents have the potential to be affected. Upon notification on 5/13/15 of the alleged deficient practice, all resident trays were observed by the Director of Dining Services revealing that no residents trays were noted with any visible hair on food products. Systemic Changes On 5/13/15 following notification of the alleged deficient practice, the Executive Director and the Director of Health Services verbally educated SRNA #1 regarding the facility's procedure regarding hair restraint guidelines. The Executive Director formally in-serviced SRNA #1 again on 6/5/15 regarding the facility's procedure regarding hair restraint guidelines in the kitchen. On 6/8/15, the Plant Operations Director placed a sign in the kitchen that reads, "hairnets required past this point" and placed on the wall on the opposite side of the cooler. A black stripe was painted on the floor indicating the line that staff should not cross without proper hair restraint.	June 30, 2015	
F 441	483.65 INFECTION CONTROL, PREVENT SS=D SPREAD, LINENS 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.	F 441			

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

Emily Williams

TITLE

Executive Director

(X6) DATE

June 23, 2015

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.

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

PRINTED: 05/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2015
NAME OF PROVIDER OR SUPPLIER THE WILLOWS AT CITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1376 SILVER SPRINGS DRIVE LEXINGTON, KY 40511	
(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 441 Continued From page 1
(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of the facility's policy it was determined the facility failed to ensure a safe and sanitary environment as evidenced by a State Registered Nurse Assistant (SRNA) who entered the kitchen without a hair restraint after breakfast service.

The findings include:

Review of the facility's policy titled "Hair Restraint Guideline", revised 08/2012, revealed all employees were required to wear hair restraints as mandated by the 2009 Federal Food Code. Continued review revealed hair restraints were required to control possible contamination of all food production areas. Further review of the "Hair restraint Guideline" revealed employees should wear hair restraints, which included hats, hair coverings or nets, designed to keep hair from contacting exposed food, clean equipment, and utensils. In addition, the walk-in cooler areas were not to be entered by personnel not wearing hair restraints.

Observation, on 05/13/15 at 10:00 AM, revealed SRNA #1 stood in the kitchen behind the food cart, beyond the walk-in refrigerator, with no visible hair restraint.

F 441 Beginning on 6/5/15 through 6/12/15 all staff will be in-serviced on the facility's procedure regarding hair restraints by the Medical Records staff member and the Executive Director. This training will include systemic changes made.

Monitoring

The assigned meal manager for each meal as well as the Assistant Director of Dining Services and the Director of Dining Services will be responsible for observing 3 staff members during all 3 meals to ensure that staff adhere to the facility's policy regarding hair restraints. During each meal, the meal manager who has been assigned to observe each meal will monitor the kitchen to ensure that staff are adhering to the facility's procedure regarding hair restraints. During non-meal service times, the Director of Food Services and Assistant Director of Food Services will monitor the kitchen to ensure staff compliance with the procedure. All monitors will utilize an audit tool at each meal x 4 weeks to ensure sustained compliance.

Review of the facility's audit tools for compliance with the hair restraint procedure will be reviewed in the facility's monthly Quality Assurance meeting x 3 months beginning in June 2015 through August 2015 for review and recommendations as indicated.

Completed Date: June 30, 2015

June 30, 2015

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

PRINTED: 05/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2015
NAME OF PROVIDER OR SUPPLIER THE WILLOWS AT CITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1376 SILVER SPRINGS DRIVE LEXINGTON, KY 40511	
(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 441 : Continued From page 2

F 441

June 30, 2015

Interview with SRNA #1, on 05/13/15 at 10:30 AM, revealed she pushed the food cart back into the kitchen from the skilled unit, and past the walk-in refrigerators. She stated she had been instructed not to go past the walk-in refrigerators without wearing a hair net, and to stand only inside the doorway. Continued interview revealed she should have been wearing a hair net.

Interview with the Chef/Dietary Manager, on 05/13/15 at 1:30 PM, revealed all staff should wear a hair restraint upon entering the kitchen by the walk-in coolers. She stated hair restraints were worn to prevent contamination of food. She further stated nursing staff entered the kitchen without hair restraints from the skilled unit on a regular basis, and she had to re-educate staff to wear the hair restraints.

Interview with the Executive Director, on 05/13/15 at 1:40 PM, revealed all staff who entered the kitchen from the skilled unit side were required to wear a hair restraint if they went past the walk-in freezer. The ED stated hair restraints were necessary to prevent contamination of the food.

Interview, on 05/14/15 at 2:30 PM Director of Health Services, revealed staff should wear hair restraints to protect food from possible contamination by bacteria carried or contained on the hair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185396	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - THE TRANSITIONAL CARE CENTER OF OWENSBORO B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2015
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303		
(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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 2011.</p> <p>SURVEY UNDER: 2000 New.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: Nine (9) stories, Type I (332).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 2012 with smoke detectors and heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 2012.</p> <p>GENERATOR: Three (3) Type I generators installed in 2012. Fuel source is Diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 05/13/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for thirty (30) beds with a census of sixteen (16) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000			

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

TITLE

(X6) DATE

06/24/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185396	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - THE TRANSITIONAL CARE CENTER OF OWENSBORO B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2015
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	Continued From page 1	K 000			
K 076 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff and visitors. The facility has the capacity for thirty (30) beds and at the time of the survey, the census was sixteen (16).</p> <p>The findings include:</p> <p>Observation, on 05/13/15 at 2:52 PM, with the Manager of Safety and Security revealed an ignition source (wall receptacle) was installed below five (5) from the floor, located in the Oxygen Storage Room.</p>	K 076			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185396	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - THE TRANSITIONAL CARE CENTER OF OWENSBORO B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2015
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303		
(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 076	Continued From page 2 Interview, on 05/13/15 at 2:53 PM, with the Manager of Safety and Security revealed he was not aware of the ignition source located in the Oxygen Storage Room. The census of sixteen (16) was verified by the Administrator, on 05/13/15. The findings were acknowledged by the Administrator and verified by the Manager of Safety and Security at the exit interview on 05/13/15. Actual NFPA Standard: Reference: NFPA 99 (1999 Edition). 8-3.1.11.2 8-3.1.11.2 Storage for nonflammable gases less than 85 m3 (3000 ft3) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid	K 076			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185396	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - THE TRANSITIONAL CARE CENTER OF OWENSBORO B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2015
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303		
(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 076	Continued From page 3 storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14. 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING	K 076			
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185396	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - THE TRANSITIONAL CARE CENTER OF OWENSBORO B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2015
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303		
(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 This STANDARD is not met as evidenced by: Based on generator testing record review and interview, the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility has the capacity for thirty (30) beds with a census of sixteen (16) on the day of the survey. The findings include: Generator testing record review, on 05/13/15 at 4:20 PM, with the Manager of Safety and Security revealed the facility did not document the transfer times monthly when the power was transferred during the monthly testing of the generator transfer switch. Interview, on 05/13/15 at 4:21 PM, with the Manager of Safety and Security revealed he was not aware the transfer times were not being documented. The census of sixteen (16) was verified by the Administrator on 05/13/15. The findings were acknowledged by the Administrator and verified by the Manager of Safety and Security at the exit interview on 05/13/15. Actual NFPA Standard: Reference: NFPA 99 (1999 Edition) 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source.	K 144			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185396	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - THE TRANSITIONAL CARE CENTER OF OWENSBORO B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2015
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303		
(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 5</p> <p>The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1.</p> <p>(b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b).</p> <p>Actual Standard: NFPA 110, 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p> <p>Actual Standard: NFPA 99, 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>(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.</p> <p>(b) Inspection and Testing.</p> <p>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,</p>	K 144			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185396	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - THE TRANSITIONAL CARE CENTER OF OWENSBORO B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2015
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303		
(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 6 Chapter 6.</p> <p>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.</p> <p>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.</p> <p>Actual Standard: NFPA 99, 3-3-4.4.2. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.</p> <p>Reference: NFPA 99 (1999 Edition) 6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction</p> <p>Reference: NFPA 99 (1999 Edition) 6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established</p> <p>Reference: NFPA 99 (1999 Edition) 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.</p> <p>Reference: NFPA 99 (1999 Edition) 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch</p>	K 144			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185396	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - THE TRANSITIONAL CARE CENTER OF OWENSBORO B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2015
NAME OF PROVIDER OR SUPPLIER THE TRANSITIONAL CARE CENTER OF OWENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 PLEASANT VALLEY ROAD OWENSBORO, KY 42303		
(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 7</p> <p>shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p> <p>Reference: NFPA 101 (2000 edition) 7.9.1.2 Where maintenance of illumination depends on changing from one energy source to another, a delay of not more than 10 seconds shall be permitted. Reference: NFPA 110 (1999 ed.) 5-7 Heating, Cooling, and Ventilating. 5-7.1* Consideration shall be given to properly sizing the ventilation or air-conditioning systems to remove all the heat rejected to the EPS equipment room by the energy converter, uninsulated or insulated exhaust pipes, and other heat-producing equipment. 5-7.2 Adequate ventilation shall be provided to prevent temperatures or temperature rises in the EPS and related accessory equipment that exceed the recommendations of the manufacturer. 5-7.3 For the EPS equipment room, the ventilation or cooling equipment, or both, shall be sized so that the ambient temperature shall not exceed the EPS equipment manufacturer ' s criteria or allowable maximum temperatures.</p>	K 144			