

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

RECEIVED
JUN 15 2011
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/20/2011
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NAME OF PROVIDER OR SUPPLIER REGIS WOODS CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was initiated on 05/18/11 and concluded on 05/20/11 with regulatory violations cited at the highest scope and severity of an E. An abbreviated survey investigating KY#00016436 was initiated on 05/18/11 and the Division of Health Care did not substantiate the allegation and no regulatory violations were identified. A Life Safety Code survey was initiated on 05/18/11 and concluded on 05/19/11 with regulatory violations cited at the highest scope and severity of an F.</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Regis Woods Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	
F 205 SS=D	<p>483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR</p> <p>Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.</p> <p>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 205	<p>F205</p> <p>1. The bed for Resident #19 was held and the resident returned to the facility on 11/14/10. Resident #26 was discharged from the center on 4/4/11 and did not return to facility.</p> <p>2. A review of medical records was completed by the Social Worker on residents currently out of the facility to ensure the bed hold notice of policy and authorization was initiated. Identified residents will be notified by Social Services by 6/19/11 on the bed hold notice of policy and authorization.</p>	

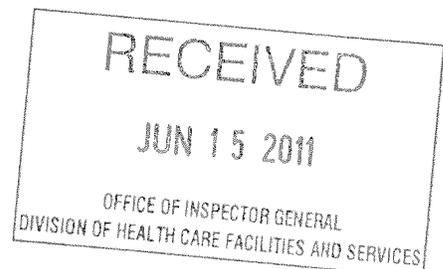
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Joseph East</i>	TITLE <i>X Adm. Director</i>	(X6) DATE <i>X 6/15/11</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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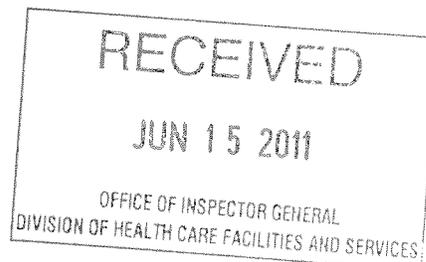
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F 205	<p>Continued From page 1</p> <p>Based on facility policy, resident record review, closed resident record review, and interview, the facility failed to provide notice of the bed-hold policy and readmission for two (2) of twenty-six (26) sampled residents, Resident #19 and Resident #26.</p> <p>The findings include:</p> <p>Review of the facility document, given to residents/legal representatives upon a resident's admission to the facility, Resident Rights and Information For Residents Living In Kentucky (undated) revealed: (b) Notice of bed-hold policy and readmission. (1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies - (i) the duration of the bed-hold policy. . . .during which the resident is permitted to return and resume residence in the nursing facility. . (2) . . .At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy. . .and. . .(3) Permitting resident to return to facility.</p> <p>The facility Bed-Hold Notice of Policy and Authorization (dated 9/09) states "You may request that we hold a bed while you are absent from the center for therapeutic leave or temporary stays in an acute hospital. You must request any desired bed-hold within 24 hours of receiving the notice of discharge or transfer."</p>	F 205	<p>3. Social Services and licensed nurses will be re-educated on the bed hold notice of policy and authorization by the Administrator on or before 6/13/11.</p> <p>4. An audit of the medical records for any resident discharged from the center to ensure implementation of the bed hold notice of policy and authorization will be completed by Social Services weekly times 4 weeks and then 5 discharged charts will be reviewed monthly times 2 months. A summary of the audit findings will be submitted to the Performance Improvement Committee (Administrator, Assistant Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Therapy, Activities, Solana Program Director, Health Information Manager, Maintenance Director and Housekeeping/Laundry Director) by Social Services monthly times 3 months for further review and recommendation.</p> <p>5. Date of compliance 6/20/2011.</p>	



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F 205	<p>Continued From page 2</p> <p>Review of the medical record of Resident #19 revealed the resident was admitted to the facility on 10/07/10 with a primary diagnosis of Dementia with behaviors. On 10/14/10 the resident was transferred to an acute care facility with a complaint of anemia. There was no evidence that the facility provided a Bed-Hold Notice and Authorization for Resident #19, the resident's family member or legal representative.</p> <p>Review of the closed medical record of Resident #26 revealed the resident was admitted to the facility on 03/24/11 with a primary diagnosis of Renal Disease. The resident was out of the facility for dialysis and subsequently transferred to an acute-care hospital for admission on 04/04/11. The facility failed, at the time of transfer of the resident for hospitalization, to provide to the resident and a family member or legal representative a Bed-Hold Notice and Authorization.</p> <p>Interview, on 05/20/11 at 3:00pm, with the Administrator revealed the Bed-Hold Notice of Policy and Authorization was missing from the medical record of Resident #19. It could not be located in Medical Records or within the medical record.</p> <p>Interview, on 05/20/11 at 5:50pm, with the Director of Nursing (DON) revealed when a resident is admitted to an acute-care hospital from the facility, without a bed-hold, "they could lose their bed. They (the resident) would have to do a whole new admission process".</p> <p>Interview, on 05/20/11 at 6:00pm, with the Administrator revealed the Bed-Hold Notice of</p>	F 205		



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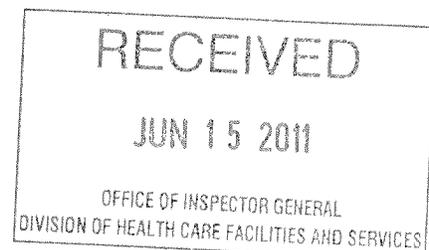
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F 205	Continued From page 3 Policy and Authorization was missing from the closed medical record of Resident #26. It could not be located in Medical Records or within the closed medical record. Interview, on 05/20/11 at 7:10pm, with the Assistant Director of Nursing (ADON) revealed the training for the bed-hold process is done during employee orientation. It was further revealed both nursing and social services are responsible for the bed-hold notice. The ADON stated that Social Services should be calling the family, to give the bed-hold notice, if the resident leaves unexpectedly or does not return to the facility. Interview, on 05/20/11 at 7:15pm, with the Social Services Director revealed the bed-hold notice was not done for Resident #26. She stated she does not call the family if the resident is on Medicaid, because they automatically get a fourteen (14) day bed-hold for the year. The Social Service Director stated she did not know the payer source for Resident #26. Upon clarification with the business office, it was determined that the payer source was Medicare. The Social Service Director acknowledged that she did not notify, but should have called the family or legal representative to inform them of the bed-hold policy and determine if they wanted to hold the bed.	F 205		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings	F 252	F252 1. The rooms of resident #4 (room 414-A), resident #19 (room 426-A), and rooms 412-A, 416-A, 420-A, 422-A, 424-A, 428-A, 432-A, and	

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F 252	<p>Continued From page 4 to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to provide an environment as close to that of the environment of a private home as possible for two (2) of twenty-six (26) sampled residents, Resident #4 in Room 414-A and Resident #19 in Room 426-A. The facility also failed to provide a homelike environment in the rooms of eight (8) additional unsampled residents, Rooms 412-A, 416-A, 420-A, 422-A, 424-A, 428-A, 432-A and 434-A. The facility failed to de-emphasize the institutional character of the setting and encourage links with the past and family members.</p> <p>The findings include:</p> <p>The facility provided no policy which defined or addressed a homelike environment.</p> <p>Observation on 05/18/11 during the initial tour of the facility which began at 11:15am found the following rooms to be void of personal items, pictures, decorations, familiar items, or any items which would allow the rooms to present a homelike environment: Rooms 412-A, 416-A, 420-A, 422-A, 424-A, 428-A, 432-A and 434-A.</p> <p>Record review for Resident #4 revealed he/she was admitted to the facility on 06/24/09 with a primary diagnosis of Dementia with behavior disturbance and a secondary diagnosis of Alzheimer's disease. Observation during the</p>	F 252	<p>434-A were supplied with pictures and familiar or personal items by the Solana Program Director as of 6/10/11 to enhance a more home-like environment.</p> <p>2. An audit of all facility rooms was completed by the Solana Program Director on 6/10/11 to ensure that a home-like environment was in place for all residents currently in the center. No further concerns were identified.</p> <p>3. Nursing staff, Solana Program Director, Maintenance, and Social Services have been re-educated to ensure that all resident rooms provide a home-like environment by the Administrator on 6/9/11.</p> <p>4. Rounds of the center will be conducted by the Solana Program Director or Assistant Administrator once (1) weekly times 4 weeks and then monthly times 2 months to ensure a home-like environment is in place for all residents rooms. A summary of the audit findings will be submitted to the Performance Improvement Committee (Administrator, Assistant</p>	



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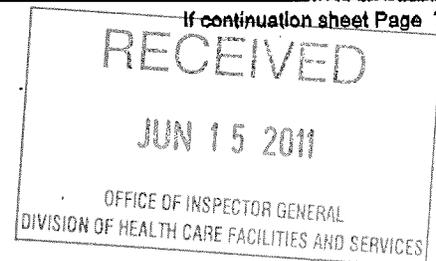
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F 252	<p>Continued From page 5</p> <p>initial tour of the facility on 05/18/11 found Resident #4's room to be void of any personal items. The name of the resident outside the door and a bedspread on the bed were the only evidence in view that the resident occupied the room.</p> <p>Record review for Resident #19 revealed he/she was admitted to the facility on 10/07/10 with a primary diagnosis of Dementia with behavior. Observation during the initial tour of the facility on 05/18/11 found the room of Resident #19 to be void of any personal items. The name of the resident outside the door and a bedspread on the bed were the only evidence in view that the resident occupied the room.</p> <p>Interview, on 05/19/11 at 8:50am, with Licensed Practical Nurse (LPN) #2 revealed it is dependent upon the residents' family members what the resident has or does not have to make his/her room have a "personal touch".</p> <p>Interview, on 05/19/11 at 9:40am, with the Solana Program Director revealed families are asked to bring personal things in, but not very many of them do. She stated the rooms need "stuff to feel like home".</p> <p>Interview, on 05/19/11 at 11:20am, with Registered Nurse (RN) #2 revealed what is in the room to make it homelike depends on what the family brings into the facility.</p> <p>Interview, on 05/19/11 at 11:20am, with Licensed Practical Nurse (LPN) #4 revealed families are encouraged to bring in residents' personal items. If there is a high participation with the family, the</p>	F 252	<p>Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Therapy, Activities, Solana Program Director, Health Information Manager, Maintenance Director and Housekeeping/Laundry Director) by the Administrator or Assistant Administrator monthly times 3 months for review and further recommendation.</p> <p>5. Date of compliance 6/20/2011.</p>	

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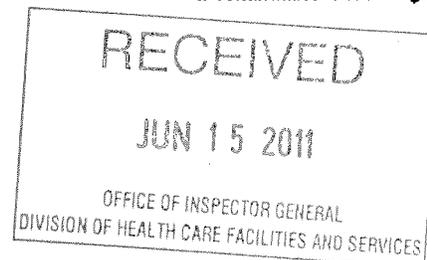
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F 252	<p>Continued From page 6</p> <p>resident is more likely to have personal items in his/her room. LPN #4 stated the room of Resident #4 "looks very institutionalized". It was further revealed by LPN #4 that, if the unit was more homelike, it would be more stimulating for the residents.</p> <p>Interview, on 05/20/11 at 8:50am, with the Solana Program Director revealed in order to ensure the rooms for the residents were homelike, she would need to talk to the Administrator to finance items for the rooms. In addition, she stated she could do an "audit" of available pictures and items in the facility that were not currently in use. She stated the rooms should reflect "them" (the residents).</p> <p>Interview, on 05/20/11 at 4:15pm, with the Maintenance Supervisor revealed he felt the rooms were not homelike. He stated the rooms could use more pictures, things on the walls, odds and ends.</p> <p>Interview, on 05/20/11 at 5:30pm, with the Administrator revealed the facility is always responsible to meet the needs of the resident. Some rooms are more homelike than others due to family participation.</p> <p>Interview, on 05/20/11 at 5:30pm, with the Director of Nurses (DON) revealed homelike means how one would decorate their home to feel comfortable. She stated families should be encouraged to bring in personal items, and if they do not, the facility should decorate to meet their likes and interests. It was revealed a lack of homelike, familiar things could have the potential for mood and behavior changes.</p>	F 252		



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F 252	Continued From page 7 Interview, on 05/20/11 at 6:05pm, with the DON revealed the Administrator is ultimately responsible for the homelike environment because he is responsible for the funds.	F 252		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT 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. (c) Linens	F 441	F441 1. Precaution signage and infection control carts with personal protective equipment were put in place by the Unit Manager for residents #1 and #9 on 5/20/11. 2. A review of residents with current infectious processes was completed by the Staff Development Coordinator on 5/20/11 to ensure that precaution signage and infection control carts with personal protective equipment were in place. No other residents found to be affected. 3. The Staff Development Coordinator was re-educated by the Director of Nursing on 5/20/11. Nursing staff have been re-educated to infection control procedures and processes by the Staff Development Coordinator as of 6/19/11. The education included the different types of isolation and precautions need based on type of isolation.	



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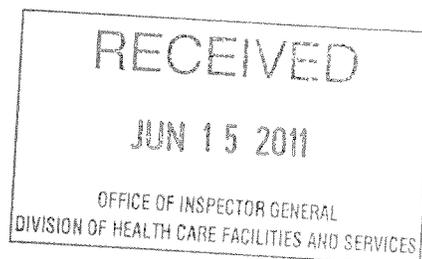
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F 441	<p>Continued From page 8</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident record review, policy review, review of the Internet website for The Centers for Disease Control and Prevention, and interviews, it was determined the facility failed to maintain an infection control program designed to ensure the prevention and transmission of disease and infection for two (2) of twenty-six (26) sampled residents, Resident #1 and Resident #9.</p> <p>The findings include:</p> <p>Review of an infection control standard from the facility Infection Control Manual (dated October 2009) revealed: . . . standardized precaution signs are used to alert staff, visitors, and residents of rooms where there is a potential exposure to infectious materials. . . this sign is placed on the resident doorframe. . .</p> <p>B. . . . Transmission-based precautions are used for residents who are known to be, or suspected of being infected or colonized with infectious agents, including pathogens that require additional control measures to prevent transmission. The category of transmission-based precaution determines the type of PPE (Personal Protective Equipment) to be used. . . Communication (e.g. verbal reports, signage) regarding the particular type of</p>	F 441	<p>4. A review of current resident with an infectious process will be completed by the Staff Development Coordinator weekly times 4 weeks and then five (5) residents will be reviewed monthly times 2 months to ensure that appropriate signage and precautions are in place. A summary of findings will be presented to the Performance Improvement Committee (Administrator, Assistant Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Therapy, Activities, Solana Program Director, Health Information Manager, Maintenance Director and Housekeeping/Laundry Director) by the Staff Development Coordinator monthly times 3 months for further review and recommendation.</p> <p>5. Date of compliance 6/20/2011.</p>	

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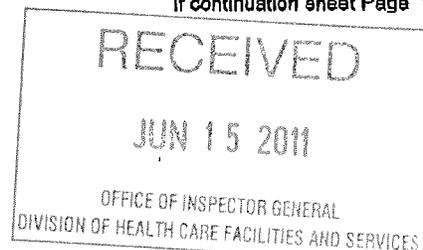
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NAME OF PROVIDER OR SUPPLIER REGIS WOODS CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220		
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F 441	<p>Continued From page 9</p> <p>precaution to be utilized is important. When transmission-based precautions are in place, PPE should be readily available. .</p> <p>.Transmission-based precautions are maintained for as long as necessary to prevent the transmission of infection. . . *A physician's order should be completed to document in the medical record the type and rationale for the selected transmission-based precautions. The Center for Disease Control Guidelines for Precautions are used to determine the infective material(s), precautions needed, and duration of the precautions. ^Contact Precautions: In addition to Standard Precautions, use Contact Precautions for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact such as handling environmental surfaces or resident care items. Examples include: . . . Clostridium Difficile (C. Diff) . . . In some instances, residents colonized with these organisms may also require contact precautions. . .II. Inform the resident and family of the need for precautions. . .III. Inform the staff of the need and type of precautions required. . .wear clean gloves and gown when entering the room. . .IV. Gather the necessary equipment: Precaution cart with supply of gowns, gloves, etc. . . Post appropriate signage outside of room. Discontinuing Precautions: The . . physician determines that a resident is either free from infection or is colonized before discontinuing or altering precautions. C-Difficile: ^ Continue Contact Precautions until treatment is complete and the resident is symptom free for 7-10 days.</p> <p>Review of The Centers for Disease Control and Prevention website dated 02/22/11 revealed. . surface contact with feces can hold C. Difficile</p>	F 441		



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F 441	<p>Continued From page 10</p> <p>spores. . . residents/patients should be in a private room or may be cohorted with another resident/patient who has or is suspected to have C. Difficile. . . dedicate or clean medical equipment used for a C. Difficile resident/patient with a bleach (Hypochlorite) solution, . . . and . . . a resident/patient with known or suspected C. Difficile should be placed in isolation using contact precautions.</p> <p>Record review for Resident #1 revealed he/she was admitted to the facility on 03/30/11 with diagnoses to include Peripheral Vascular Disease, Dysphagia, and Cerebral Palsy. Resident #1 was cultured positive (+) for Clostridium Difficile (C-Diff) on 04/07/11.</p> <p>Observation on 05/18/11 at 2:50pm revealed no precautions/isolation cart or signage for the diagnosis of + C-Diff outside the door of Resident #1's room. Observation of Resident #1's room on 05/19/11 at 8:25am revealed a precautions/isolation cart outside the room but no signage posted to alert staff or visitors of necessary precautions. Observation on 05/19/11 at 10:20am revealed staff taking Resident #1 in his/her hi-back wheelchair, which was in the resident's room, into the sitting room to watch television with six (6) other residents. The wheelchair from Resident #1's room was not cleaned outside of the room and before being taken into the sitting room with other residents.</p> <p>Interview with the Dietician on 05/19/11 at 10:40am revealed Resident #1 had tested + for C-Diff almost from the date of his/her admission (03/30/11) and had been symptomatic on and off since that time. The Dietician stated she has</p>	F 441		



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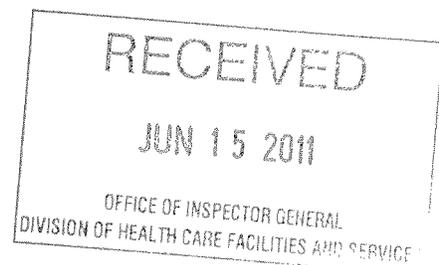
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F 441	<p>Continued From page 11 been trying different tube feeds since Resident #1's admission to address Resident #1's continuing symptoms of C-Diff.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 05/19/11 at 1:15pm revealed he knew Resident #1 was C-Diff + and that Resident #1 was placed in isolation on 05/18/11, but there was no cart available until 05/19/11. He stated the C-Diff was first identified on 04/11/11 and that Resident #1 was in isolation "on and off" since that time. LPN #1 also stated it was not appropriate to have Resident #1 in a semi-private room but it was okay because Resident #1's roommate was an older person.</p> <p>Interview with Certified Nursing Assistant (CNA) #6 on 05/19/11 at 3:50am revealed Resident #1 had C-Diff three weeks ago, but Resident #1's isolation was discontinued. He stated a resident's precautions/isolation is communicated in report. He also stated no isolation cart was available for Resident #1's room, and that if a private room is available, a resident with precautions/isolation would be moved to the private room. CNA #6 said he did not know if it was acceptable to use a semi-private room for a resident with precautions/isolation and he also stated that a resident in isolation should stay in his/her room.</p> <p>Interview with CNA #7 on 05/19/11 at 4:10pm revealed it was communicated to her that Resident #1 should have precautions/isolation on 05/18/11 but no cart was available on that date to place outside of Resident #1's room. She stated a gown and gloves would always be used for a resident in contact precautions/isolation and sometimes a mask, but she wasn't sure about the</p>	F 441		

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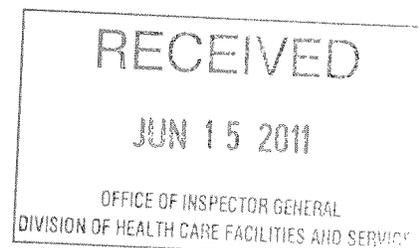
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F 441	<p>Continued From page 12</p> <p>mask as some workers used a mask and some did not. CNA #7 also stated that a resident in precautions/isolation should stay in his/her room even though she asked "the nurse" if she could take Resident #1 to the communal shower room and "the nurse" told her she could if the resident could "hold his/her stool".</p> <p>Interview with LPN #1 on 05/19/11 at 4:55pm revealed he was aware that Resident #1 was in contact precautions/isolation but he was unsure if Resident #1 should be taken out of his/her room. He stated Resident #1 should not go to the communal shower room due to potential contamination. His understanding of contact precautions/isolation was to wear gloves, gown, and a mask when working with that resident.</p> <p>Interview with Registered Nurse (RN) #3 on 05/19/11 at 5:10pm revealed Resident #1 was in C-Diff precautions/ isolation previously but was not now as the resident had tested negative for C-Diff after administration of an antibiotic. She stated Resident #1 could go to the communal shower as long as it was cleaned with bleach after his/her shower. RN #3 also stated Resident #1 could go anywhere in the facility even when on contact precautions/isolation.</p> <p>Interview with the Director of Nursing (DON) on 05/19/11 at 5:35pm revealed Resident #1 should not be taken into the communal shower room currently as he/she had tested + for C-Diff.</p> <p>Record review for Resident #9 revealed the resident was admitted to the facility on 10/19/09 with diagnoses to include: Status Post Cerebrovascular Accident (Stroke), Chronic</p>	F 441		



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F 441	<p>Continued From page 13</p> <p>Ischemic Heart Disease, Hypertension, and Depression. Resident #9 tested + for C. Diff on 04/20/11 with no documentation of precautions/isolation until 05/19/11. Review of the physician orders dated 05/11 revealed an order to "continue contact isolation" and did not reveal any order to remove Resident #9 from precautions/isolation on 05/20/11.</p> <p>Observation of Resident #9's room on 05/19/11 at 4:00pm revealed a precautions/isolation cart outside the room, but no signage to alert staff or visitors of precautions needed. Observation on 05/20/11 at 2:40pm revealed CNA #1 and CNA #5 (ungowned) in Resident #9's room, changing the resident's brief, and with their uniforms touching the bed rails. At that time the precautions/isolation cart was outside Resident #9's room without signage. Observation later on 05/20/11 at 5:00pm revealed the precautions/isolation cart had been removed from outside Resident #9's room.</p> <p>Interview with the ADON on 05/19/11 at 3:00pm revealed all residents who test + for C. Diff are automatically placed in isolation.</p> <p>Interview with LPN #3 on 05/19/11 at 5:20pm revealed the facility would use contact precautions/ isolation if a resident tested + for C-Diff and that would mean PPE of gloves, mask, and gown when going into the resident's room. However, LPN #3 stated she was not sure if this was consistent with the facility's policy. She stated she does not encourage residents to be taken into the communal shower room if they have C-Diff infection, however, the nursing staff would let the resident come out of his/her room to</p>	F 441			



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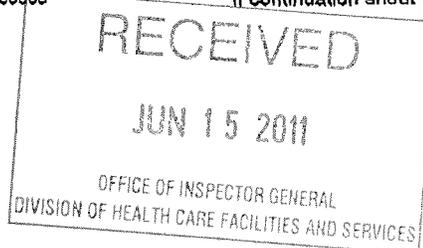
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F 441	<p>Continued From page 14 watch TV or go to the dining room because stool would be contained by his/her brief.</p> <p>Interview on 05/20/11 at 8:15am with CNA #1 revealed she thought the nursing staff only needed to put on gloves for resident's with C-Diff, not any other type of PPE. She also stated that she remembered being trained on infection control when hired two (2) years ago but not since.</p> <p>Interview with the Infection Control Nurse (ICN) on 05/20/11 at 5pm revealed the nursing staff were trained on Infection Control in the Fall of 2010. However, the ICN stated she would not be surprised to hear that staff are confused regarding infection control procedures for precautions/isolation. She stated it was the responsibility of the unit nurse to confer with the ADON, the DON, or the ICN when a + culture report was received for a resident regarding whether or not to put that resident in precautions/isolation and that this "might be in a facility policy". The ICN also stated a cart and signage is not required outside a resident's room when that resident is in precautions/isolation, but that a cart would be nice to have to hold gowns, and signage would alert staff and visitors as to necessary precautions.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 05/20/11 at 4:00pm revealed the cleaning solution used to clean medical equipment taken from a resident's room (who had tested positive [+] for C. Difficile) contained bleach. However, review of the cleaning solution label revealed the solution did not contain bleach (Hypochlorite).</p>	F 441			

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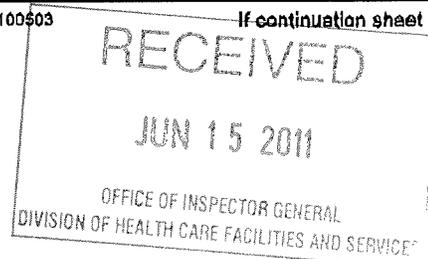
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F 441	Continued From page 15	F 441		
F 498 SS=D	<p>Interview with the DON on 05/20/11 at 5:30pm revealed the unit nurse managers were responsible for making sure precautions/isolation procedures were in place for residents with certain infections (including C-Diff) in consultation with the ICN. However, she did state that she was ultimately responsible for the unit nurse managers and the ICN. She stated the unit nurse manager should place a cart with PPE and signage outside the resident's door. The DON said Resident #1 and Resident #9 were not in private rooms as there were none and they were not cohorted as their roommates were already in the rooms at the time of their admissions. She also stated she felt the facility needed to do more in the way of staff education regarding Infection Control.</p> <p>Interview with the Administrator on 05/20/11 at 6:30pm revealed the ICN presents a tracking/trending report regarding facility infections monthly to the Performance Improvement Committee but he was unaware there were concerns regarding lack of staff knowledge or training needs in Infection Control.</p> <p>483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS</p> <p>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 498	<p>F 498</p> <p>1. Certified Nursing Assistant #6, #7, #1 and #5 were re-educated on infection control procedures by the Staff Development Coordinator as of 6/10/11.</p> <p>Precaution signage and infection control carts with personal protective equipment were put in place by the Unit Manager for residents #1 and #9 on 5/20/11.</p>	



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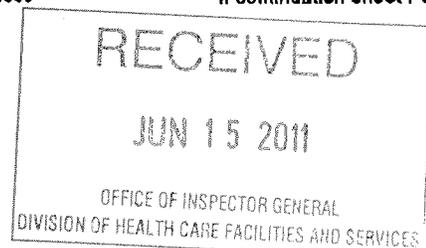
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F 498	<p>Continued From page 16</p> <p>Based on observation, resident record review, policy review, review of the Internet website for The Centers for Disease Control and Prevention, and interviews, the facility failed to ensure proficiency of nurse aides in the performance of appropriate infection control practices for two (2) of twenty-six (26) sampled residents, Resident #1 and Resident #9.</p> <p>The findings include:</p> <p>Review of an infection control standard from the facility Infection Control Manual (dated October 2009) revealed: . . .standardized precaution signs are used to alert staff, visitors, and residents of rooms where there is a potential exposure to infectious materials. . .this sign is placed on the resident doorframe. . .</p> <p>B. . . .Transmission-based precautions are used for residents who are known to be, or suspected of being infected or colonized with infectious agents, including pathogens that require additional control measures to prevent transmission. The category of transmission-based precaution determines the type of PPE (Personal Protective Equipment) to be used. . . Communication (e.g. verbal reports, signage) regarding the particular type of precaution to be utilized is important. When transmission-based precautions are in place, PPE should be readily available. .</p> <p>.Transmission-based precautions are maintained for as long as necessary to prevent the transmission of infection. . .*A physician's order should be completed to document in the medical record the type and rationale for the selected transmission-based precautions. The Center for Disease Control Guidelines for Precautions are</p>	F 498	<p>2. A review of residents with current infectious processes was completed by the Staff Development Coordinator on 5/20/11 to ensure that precaution signage and infection control carts with personal protective equipment were in place. No other residents found to be affected.</p> <p>3. Nursing Staff will be re-educated on infection control process and procedures by the Staff Development Coordinator on or before 6/19/11.</p> <p>The Staff Development Coordinator was re-educated by the Director of Nursing on 5/20/11 regarding infection control process and procedures.</p> <p>4. Five nursing staff members will be interviewed and observed weekly times 4 weeks and then monthly times 2 months by Staff Development to ensure implementation of infection control processes and procedures. A summary of findings will be submitted to the Performance</p>	



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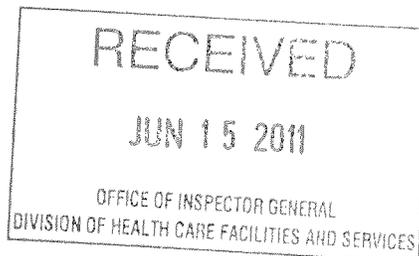
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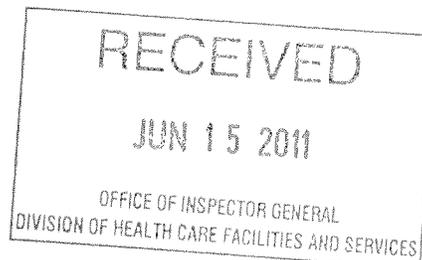
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F 498	<p>Continued From page 18</p> <p>Interview with the Assistant Director of Nursing (ADON) on 05/20/11 at 4:00pm revealed the cleaning solution used to clean medical equipment taken from a resident's room (who had tested positive [+] for C. Difficile) contained bleach. However, review of the cleaning solution label revealed the solution did not contain bleach (Hypochlorite).</p> <p>Record review for Resident #1 revealed he/she was admitted to the facility on 03/30/11 with diagnoses to include Peripheral Vascular Disease, Dysphagia, and Cerebral Palsy. Resident #1 was cultured positive (+) for Clostridium Difficile (C-Diff) on 04/07/11.</p> <p>Observation on 05/18/11 at 2:50pm revealed no precautions/isolation cart or signage for the diagnosis of + C-Diff outside the door of Resident #1's room. Observation of Resident #1's room on 05/19/11 at 8:25am revealed a precautions/isolation cart outside the room but no signage posted to alert staff or visitors of necessary precautions. Observation on 05/19/11 at 10:20am revealed nursing staff taking Resident #1 in his/her hi-back wheelchair, which was in the resident's room, into the sitting room to watch television with six (6) other residents. The wheelchair from Resident #1's room was not cleaned outside of the room and before being taken into the sitting room with other residents.</p> <p>Interview with Certified Nursing Assistant (CNA) #6 on 05/19/11 at 3:50am revealed Resident #1 had C-Diff three weeks ago but Resident #1's isolation was discontinued. He stated a resident's precautions/isolation is communicated in report. He also stated no isolation cart was available for</p>	F 498		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/20/2011
NAME OF PROVIDER OR SUPPLIER REGIS WOODS CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220	
(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 498	<p>Continued From page 19</p> <p>Resident #1's room and that if a private room is available, a resident with precautions/isolation would be moved to the private room. CNA #6 said he did not know if it was acceptable to use a semi-private room for a resident with precautions/isolation and he also stated that a resident in isolation should stay in his/her room.</p> <p>Interview with CNA #7 on 05/19/11 at 4:10pm revealed it was communicated to her that Resident #1 should have precautions/isolation on 05/18/11 but no cart was available on that date to place outside of Resident #1's room. She stated a gown and gloves would always be used for a resident in contact precautions/isolation and sometimes a mask, but she wasn't sure about the mask as some workers used a mask and some did not. CNA #7 also stated that a resident in precautions/isolation should stay in his/her room even though she asked "the nurse" if she could take Resident #1 to the communal shower room and "the nurse" told her she could if the resident could "hold his/her stool".</p> <p>Record review for Resident #9 revealed the resident was admitted to the facility on 10/19/09 with diagnoses to include: Status Post Cerebrovascular Accident (Stroke), Chronic Ischemic Heart Disease, Hypertension, and Depression. Resident #9 tested + for C. Diff on 04/20/11 with no documentation of precautions/isolation until 05/19/11. Review of the physician orders dated 05/11 revealed an order to "continue contact isolation" and did not reveal any order to remove Resident #9 from precautions/isolation on 05/20/11.</p> <p>Observation of Resident #9's room on 05/19/11 at</p>	F 498		



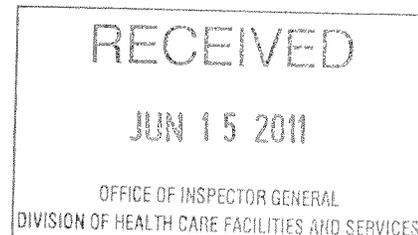
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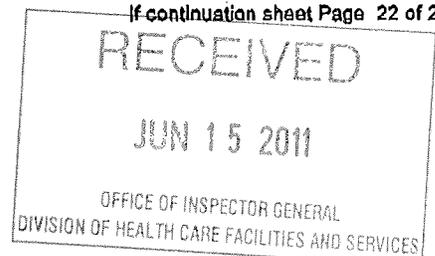
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F 498	<p>Continued From page 20</p> <p>4:00pm revealed a precautions/isolation cart outside the room but no signage to alert staff or visitors of precautions needed. Observation on 05/20/11 at 2:40pm revealed CNA #1 and CNA #5 (ungowned) in Resident #9's room, changing the resident's brief, and with their uniforms touching the bed rails. At that time the precautions/isolation cart was outside Resident #9's room without signage. Observation later on 05/20/11 at 5:00pm revealed the precautions/isolation cart had been removed from outside Resident #9's room.</p> <p>Interview with the ADON on 05/19/11 at 3:00pm revealed all residents who test + for C. Diff are automatically placed in isolation.</p> <p>Interview on 05/20/11 at 8:15am with CNA #1 revealed she thought the nursing staff only needed to put on gloves for resident's with C-Diff, not any other type of PPE. She also stated that she remembered being trained on infection control when hired 2 years ago but not since.</p> <p>Interview with the Infection Control Nurse (ICN) on 05/20/11 at 5pm revealed the nursing staff were trained on Infection Control in the Fall of 2010 and produced documentation of eighteen (18) CNA's having attended this training. However, the ICN stated she would not be surprised to hear that staff are confused regarding infection control procedures for precautions/isolation. She stated it was the responsibility of the unit nurse to confer with the ADON, the DON, or the ICN when a + culture report was received for a resident regarding whether or not to put that resident in precautions/isolation and that this "might be in a</p>	F 498		



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F 498	Continued From page 21 facility policy". The ICN also stated a cart and signage is not required outside a resident's room when that resident is in precautions/isolation, but that a cart would be nice to have to hold gowns, and signage would alert staff and visitors as to necessary precautions. Interview with the DON on 05/20/11 at 5:30pm revealed the unit nurse managers were responsible for making sure precautions/isolation procedures were in place for residents with certain infections (including C-Diff) in consultation with the ICN. She stated the unit nurse manager should place a cart with PPE and signage outside the resident's door. She also stated the unit nurses were responsible to communicate these procedures to the CNA's to ensure they were followed. However, she did state that she was ultimately responsible for the ICN and all of the nursing staff including the CNA's. The DON stated she felt the facility needed to do more in the way of staff education regarding Infection Control.	F 498		
F 502 SS=E	Interview with the Administrator on 05/20/11 at 6:30pm revealed the ICN presents a tracking/trending report regarding facility infections monthly to the Performance Improvement Committee but he was unaware there were concerns regarding lack of staff knowledge or training needs in Infection Control. 483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502	F502 1. The NF 2 Unit Manager, RN #2, Solona Unit Manager and NF Unit Manager were re-educated by the	



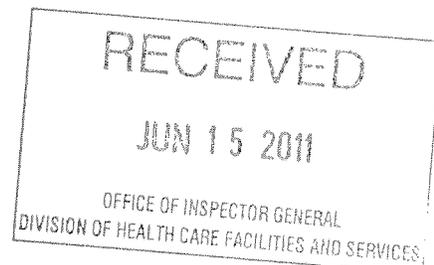
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F 502	<p>Continued From page 22</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure laboratory supplies were not expired and properly stored. Observations revealed one hundred ninety-four (194) expired vacutainer needles, one (1) expired viral specimen collection kit, two (2) expired blood culture sets, and one (1) vacutainer needle stored uncapped with sharp exposed.</p> <p>The findings include:</p> <p>The facility did not provide a policy on monitoring the laboratory supplies for expiration dates by day of exit 05/20/11.</p> <p>Observation of the NF-2 medication room on 05/19/11 at 9:30am revealed one hundred forty-four (144) vacutainer needles which expired 04/2011 and forty-eight (48) vacutainer needles which expired 09/2010.</p> <p>Interview with the NF-2 Unit Manager on 05/19/11 at 9:45am revealed the potential problem with having expired needles could be the lack of sterility and a potential source of infection. The expired needles could also potentially cause inaccurate laboratory results which could result in inappropriate, or insufficient treatment. The NF-2 Unit Manager stated all nurses should be checking the dates of laboratory equipment prior to use. She further revealed there was no system in place to monitor the laboratory supplies and confirmed she was responsible for ensuring laboratory supplies on the NF-2 unit were monitored for expiration dates.</p>	F 502	<p>Director of Nursing on 5/19/11 regarding process for monitoring laboratory supplies for expiration dates. Identified expired laboratory supplies were discarded by the nursing staff on 5/19/11 and 5/20/11.</p> <p>2. Expired laboratory supplies were removed from the medication rooms and needles assessed to ensure the caps were in place on NF1, NF2, and Solana Unit by the Unit Managers on 5/19/11 and 5/20/11. Identified issues were corrected by 5/20/11.</p> <p>3. Licensed nurses will be re-educated by the Staff Development Coordinator on or before 6/19/11 regarding the process for discarding expired supplies and ensuring unused needles are stored with caps in place. The Unit Managers will audit laboratory supplies weekly to ensure no expired products or uncapped needles in storage.</p> <p>4. The Unit Managers will complete an audit weekly to validate no storage of expired laboratory supplies or uncapped needles. A summary of findings will be</p>	



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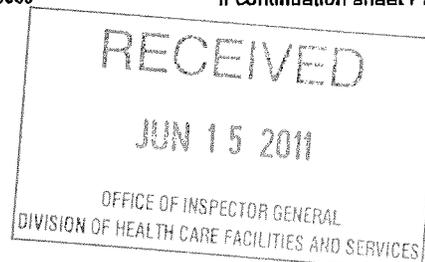
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F 502	<p>Continued From page 23</p> <p>Observation of the Solana Unit medication room on 05/19/11 at 10:05am revealed two (2) vacutainer needles which expired 4/2011, and a viral specimen collection kit which expired 05/2010. One (1) vacutainer needle was stored uncapped and resulted in a needlestick to the surveyor.</p> <p>Interview with Registered Nurse (RN) #2 on 5/19/11 at 10:15am revealed uncapped needles could cause injury and infection. The needles needed to be monitored to ensure they were properly stored and capped. RN #2 further revealed expired needles could potentially cause infection and false results of blood work. The expired viral specimen kit could cause false results. RN #2 also stated inaccurate results could potentially lead to inappropriate or inadequate treatment of the residents. RN #2 revealed no one was assigned to monitor the expiration dates of the laboratory supplies or the safety of stored needles.</p> <p>Interview with the Solana Unit Manager on 5/20/11 at 5:30pm revealed no one was assigned to monitor safe storage of needles and laboratory supply expiration dates. She further revealed there was no system to ensure all laboratory stock was properly stored and not expired. The Solana Unit Manager accepted responsibility for monitoring laboratory supplies on the Solana Unit.</p> <p>Observation of the NF-1 medication room on 05/19/11 at 10:35am revealed two (2) blood culture sets which expired 10/2010.</p> <p>Interview with Licensed Practical Nurse (LPN) #1</p>	F 502	<p>submitted to the Performance Improvement Committee (Administrator, Assistant Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Therapy, Activities, Solana Program Director, Health Information Manager, Maintenance Director and Housekeeping/Laundry Director) by the Director of Nursing monthly times 3 months for review and further recommendation.</p> <p>5. Date of compliance 6/20/2011.</p>	
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F 502	<p>Continued From page 24</p> <p>on 10/19/11 at 10:35am revealed using expired blood culture sets could cause abnormal readings, chemical reactions within the medium, and potentially inappropriate treatments or medications ordered for the residents. The LPN stated the night shift nursing staff was responsible for checking the expiration dates of the laboratory supplies.</p> <p>Interview with NF-1 Unit Manager on 5/19/11 at 10:55am revealed night shift nursing staff was to monitor laboratory supply expiration dates, however, review of the night shift task sheet did not include monitoring laboratory supplies. The NF-1 Unit Manager acknowledged monitoring laboratory supply expiration dates was not on the task sheet and stated no one had been assigned to the task. The NF-1 Unit Manager accepted responsibility for ensuring laboratory supplies were not expired on the NF-1 Unit.</p> <p>Interview with the Director of Nursing (DON) on 05/20/11 at 5:50pm revealed there was no system in place to monitor the laboratory supplies in the facility. The DON revealed the potential for harm to the resident for inaccurate laboratory results and inaccurate treatment of the residents based on inaccurate laboratory results. She stated she was ultimately responsible to ensure laboratory supplies were monitored for expiration dates and safe storage.</p>	F 502		

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K 000	INITIAL COMMENTS	K 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Regis Woods Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>K018</p> <p>1. The trash cans holding doors 103, 202, 101, 107 and 225 were removed and the door hinges for these rooms were replaced by the Maintenance Assistant on 6-10-11.</p> <p>2. A round of the facility was completed by the Maintenance Assistant and Housekeeping Supervisor on 6-10-11 to ensure that no other doors were being propped open with trash cans or other devices. No other rooms found to be affected.</p>	
K 018 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.8.3.6 are permitted. 19.3.8.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure there were no impediments to the closing of corridor doors, according to NFPA standards. The deficiency</p>	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Joseph Mawett* TITLE *X Administrator* (X8) DATE *6/15/2011*

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.

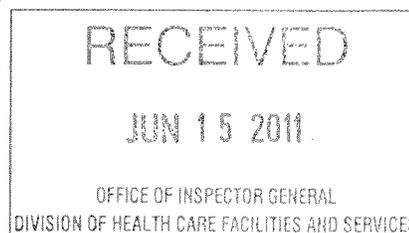
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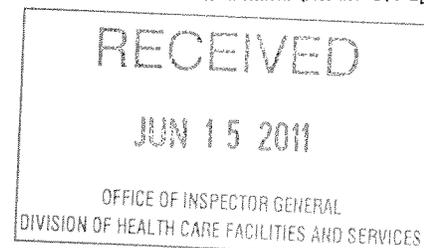
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K 018	<p>Continued From page 1</p> <p>had the potential to affect six (6) of twelve (12) smoke departments, approximately one-hundred (100) residents, staff and visitors. The facility is licensed for one-hundred and eighty-six (186) beds and the census was one-hundred and sixty-nine (169) on the day of the survey.</p> <p>The findings include:</p> <p>Observations on 05/18/2011, between 11:45 AM and 12:50 PM, revealed trash cans holding resident room doors 103 and 202 open.</p> <p>Further observation on 05/19/201, between 9:00 AM and 9:30 AM, revealed trash cans holding resident room doors 101, 107, and 225 open.</p> <p>Interview on 05/18/2011 at 11:45 AM, with the Maintenance and Housekeeping Supervisors, revealed that they were unaware that the trash cans were being used to hold open the resident room doors.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.</p> <p>A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.</p>	K 018	<p>3. The Maintenance staff and Housekeeping Director were re-educated by the Administrator on 6/9/2011 regarding resident doors not being propped open by trash cans or other devices.</p> <p>4. The Director of Maintenance, Maintenance Assistant or Housekeeping Director will monitor the doors throughout the center three (3) times per week for two (2) months and then become part of the monthly Preventative Maintenance Program Schedule. A summary of these findings will be submitted to the Performance Improvement Committee (Administrator, Assistant Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Therapy, Activities, Solana Program Director, Health Information Manager, Maintenance Director and Housekeeping/Laundry Director) by the Maintenance Director, Maintenance Assistant or Housekeeping Director monthly times 3 months for review and further recommendations.</p> <p>5. Date of compliance 6/20/2011.</p>	



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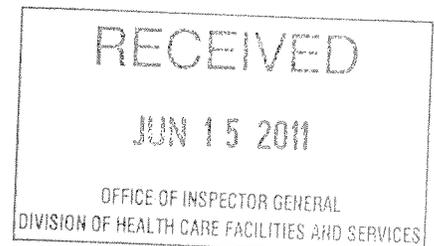
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K 029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved 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</p> <p>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. This deficiency had the potential to affect three (3) of twelve (12) smoke compartments, approximately one-hundred (100) residents, staff and visitors. The facility is licensed for one-hundred and eighty-six (186) beds and the census was one-hundred and sixty-nine (169) on the day of the survey.</p> <p>The findings include:</p> <p>Observation on 05/18/2011 at 12:10 PM, with the Maintenance and Housekeeping Supervisors, revealed the door to the Bio-Hazard room, located in the NF1 wing, did not have a self closing device installed on the door. Further observations during the survey revealed the</p>	K 029	<p>K029</p> <ol style="list-style-type: none"> 1. Self closing hinges were installed on the Bio-Hazard room on NF1, central supply storage room and the mechanical room on Solana on 6-9-11 by the Maintenance Assistant. 2. The Maintenance Assistant made rounds of the facility to ensure that self closing devices are in place on all appropriate doors on 6/9/11 and no other issues were identified. 3. The Maintenance staff were re-educated to the Life Safety Code for Protection of Hazards by the Administrator on 6/9/2011 regarding self closing doors to the Bio-Hazard room on NF1, central supply storage room and door to the mechanical room on Solana. 4. The Maintenance staff or Assistant Administrator will complete an audit of the center monthly times three (3) months to ensure doors close properly. A summary of these findings will be submitted to the PI Committee (Administrator, Assistant Administrator, Medical Director, Director of Nursing, and Assistant 	



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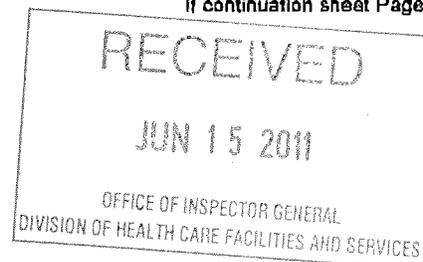
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K 029	<p>Continued From page 3</p> <p>closer on the door to the central supply storage room was broken, and the door to the Mechanical room located in the Solara wing, did not have a self closing device installed on the door. This was confirmed by the Maintenance Director.</p> <p>Interview on 05/18/2011 at 12:10 PM, with the Maintenance and Housekeeping Supervisors, revealed they were not aware that the door to the Bio-Hazard room required a closing device. Further interviews during the Survey, revealed they were unaware of the closing device on the door to the central supply room being broken and the doors to the Mechanical room required a closing device.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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 ft²</p>	K 029	<p>Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Therapy, Activities, Solana Program Director, Health Information Manager, Maintenance Director and Housekeeping/Laundry Director) by the Maintenance Director monthly times three (3) months for review and further recommendations.</p> <p>5. Date of Compliance 6/20/2011.</p>	



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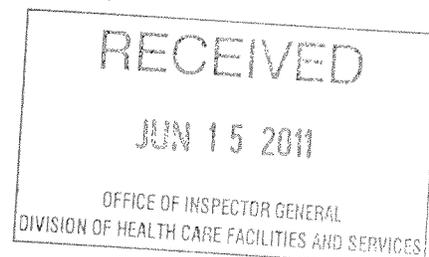
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/19/2011
NAME OF PROVIDER OR SUPPLIER REGIS WOODS CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220	
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K 029	Continued From page 4 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (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	K 029		
K 038 SS=F	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access and exit doors were maintained to be clearly recognizable as a means of egress, per NFPA standards. The deficiency had the potential to affect all smoke compartments, residents, staff	K 038	K038 1. Mini blinds mounted on exit doors located throughout the building were removed by the Maintenance staff on 6-9-11. 2. The Maintenance Assistant made rounds of the facility on 6/9/11 to check for other mini blinds or other devices mounted over exit doors and no other issues were identified. 3. The Maintenance staff were re-educated by the Administrator on 6/9/2011 regarding mini blinds and other devices mounted on exit doors.	



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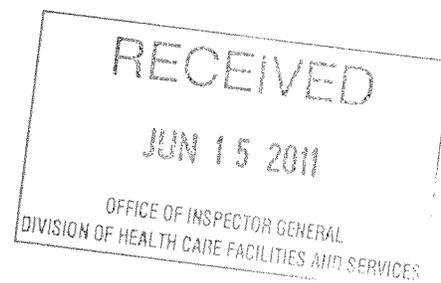
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NAME OF PROVIDER OR SUPPLIER REGIS WOODS CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4804 LOWE RD LOUISVILLE, KY 40220	
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K 038	Continued From page 5 and visitors. The facility is licensed for one-hundred and eighty-six (186) beds and the census was one-hundred and sixty-nine (169) on the day of the survey . The findings include: Observation on 05/18/2011, between at 11:30 AM and 3:00 PM, with the Maintenance and Housekeeping Supervisors, revealed mini-blinds mounted on the exit doors located throughout the facility. Interview on 05/18/2011, at 11:35 AM, with the Maintenance and Housekeeping Supervisors, revealed they were unaware that mini-blinds were prohibited to be mounted on exit doors. Reference: NFPA 101 (2000 Edition) 7.5.2.2 Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit.	K 038	4. The Maintenance Director or Maintenance Assistant will complete an audit once a week for four (4) weeks and then once a month for two (2) months and then become part of the monthly Preventative Maintenance Program Schedule. A summary of these findings will be submitted to the PI Committee (Administrator, Assistant Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Therapy, Activities, Solana Program Director, Health Information Manager, Maintenance Director and Housekeeping/Laundry Director) by the Maintenance Director monthly times three (3) months for review and further recommendations. 5. Date of Compliance 6/20/2011.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 062	K 062 1. Items in the clean linen closet, kitchen walk-in freezer, and therapy room closet were removed by the Maintenance staff on 6-9-11 so that no stored items are within 18" of a sprinkler head.	



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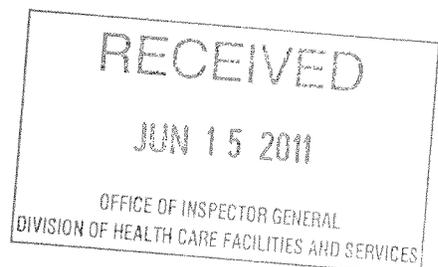
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K 062	<p>Continued From page 6</p> <p>Based on observation and interview it was determined the facility failed to maintain the sprinkler system according to NFPA standards. The deficiency had the potential to affect three (3) of twelve (12) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred and eighty-six (186) beds and the census was one-hundred and sixty-nine (169) on the day of the survey.</p> <p>The Findings Include:</p> <p>Observation on 05/18/2011 between 12:15 PM and 12:45 PM, with the Maintenance and Housekeeping Supervisors, revealed items stored within 18" of a sprinkler head in three different locations. The locations were within the clean linen closet, the kitchen walk-in freezer, and the therapy room closet.</p> <p>Interview on 05/18/2011 at 12:15 PM, with the Maintenance and Housekeeping Supervisors, confirmed the initial observation and acknowledged that stored items can not be within 18" of a sprinkler head.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing</p>	K 062	<p>2. The Maintenance Assistant completed rounds of the facility on 6/9/11 to ensure no stored items are within 18" of a sprinkler head. No other issues were identified.</p> <p>3. Maintenance, Housekeeping/Laundry, Central Supply and Dietary staff were re-educated by the Assistant Administrator on 6/9/2011 regarding no storage of items within 18 inches of a sprinkler head.</p> <p>4. The Maintenance Director or Maintenance Assistant will complete an audit once a week for four (4) weeks and then once a month for two (2) months and then become part of the monthly Preventative Maintenance Program Schedule to ensure no storage of items within 18 inches of a sprinkler head. A summary of these findings will be submitted to the PI Committee (Administrator, Assistant Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Therapy, Activities, Solana Program Director, Health Information Manager,</p>	



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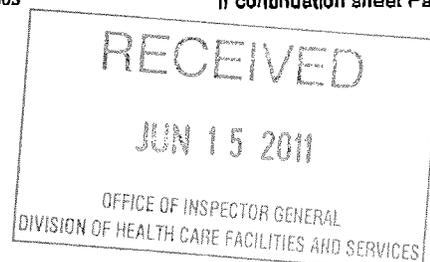
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K 062 K 066 SS=D	Continued From page 7 shall comply With 5-5.5.2. NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to follow the smoking policy to ensure designated smoking areas were safe, per NFPA standards. The deficiency had the potential to affect residents, staff and visitors. The facility is licensed for one-hundred and eighty-six (186) beds and the census was one-hundred and	K 062 K 066	Maintenance Director and Housekeeping/Laundry Director) by the Maintenance Director monthly times three (3) months for review and further recommendations. 5. Date of Compliance 6/20/2011. K066 1. The open ash tray in the courtyard was removed on and replaced on 6/9/11 by the maintenance staff with an approved NFPA ashtray. 2. The Maintenance Assistant completed rounds of the facility on 6/9/11 to ensure that only NFPA ash trays are present in designated smoking areas. No other issues were identified. 3. The Maintenance staff were re-educated by the Administrator on 6/9/2011 regarding the use of approved NFPA ash tray in all designated smoking areas. 4. The Maintenance Director or Maintenance Assistant will complete an audit once a week for four (4) weeks and then once a	



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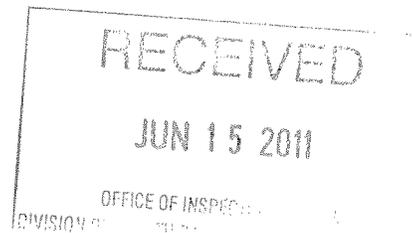
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K 066	Continued From page 8 sixty-nine (169) on the day of the survey. The findings include: Observation on 05/18/2011 at 2:10 PM, with the Maintenance and Housekeeping Supervisors, revealed the designated smoking area located in an open courtyard outside at the building, had an open ash tray in use and no hot ash dump for tobacco product waste. Interview on 05/18/2011 at 2:10 PM, with the Maintenance and Housekeeping Supervisors, revealed that the ashtray in use, at the designated smoking area, was not of the approved type and could potentially pose a hazard to staff and residents. Interview on 05/19/2011 at 11:30 AM, with the Administrator and Maintenance Supervisor, revealed that the unapproved ashtray had been removed from the premises. Reference: NFPA 101 (2000 Edition). 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO	K 066	month for two (2) months and then become part of the monthly Preventative Maintenance Program Schedule to ensure the use of approved NFPA ash tray in all designated smoking areas. A summary of these findings will be submitted to the PI Committee (Administrator, Assistant Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Therapy, Activities, Solana Program Director, Health Information Manager, Maintenance Director and Housekeeping/Laundry Director) by the Maintenance Director monthly times 3 months for review and further recommendations. 5. Date of Compliance 6/20/2011.	



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K 073	Continued From page 10 Observation on 05/18/2011, between 11:30 AM and 3:00 PM, with the Maintenance and Housekeeping Supervisors, revealed hanging decorations were mounted on the residents' room doors in various locations throughout the facility. Interview on 05/18/2011 at 11:40 AM, with the Housekeeping Supervisor, revealed that hanging decorations have been treated with a fire retardant spray but have no written policy for documentation. She indicated that a written policy would be implemented. Reference: NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Item 1. Based on observation and interview, it was determined the facility failed to maintain the locking mechanism on doors per NFPA standards. The deficiency had the potential to affect all smoke compartments, patients, staff and visitors. The facility is licensed for one-hundred	K 073	3. The Maintenance Director and Housekeeping Director were re-educated by the Administrator on 6/9/2011 to ensure no doors have hanging decorations without proper flame retardant treatment and documentation to support. 4. The Maintenance Director, Maintenance Assistant or Housekeeping Director will complete an audit once a week for four (4) weeks and then once a month for two (2) months and then become part of the monthly Preventative Maintenance Program Schedule to ensure no doors have hanging decorations. A summary of these findings will be submitted to the PI Committee (Administrator, Assistant Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Therapy, Activities, Solana Program Director, Health Information Manager, Maintenance Director and Housekeeping/Laundry Director) by the Maintenance Director monthly times 3 months for review and further recommendations. 5. Date of Compliance 6/20/2011.	
K 130 SS=F		K 130		



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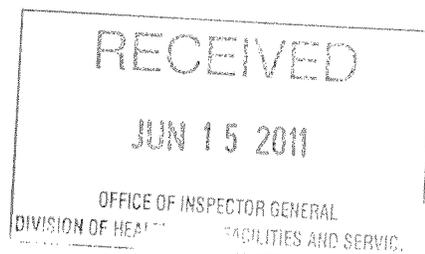
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K 130	<p>Continued From page 11 and eighty-six (86) beds and the census was one-hundred and sixty-nine (169) on the day of the survey.</p> <p>The findings include:</p> <p>Observation on 05/18/2011, between 11:30 AM and 3:00 PM, with the Maintenance and Housekeeping Supervisors, revealed unapproved locks (slide bolt type) installed on doors throughout the facility. The rooms observed were: the storage room at the NF1 TV area, the room behind the dryers in the laundry room, the NF1 dining room, the NF2 dining room, the Solara dining room, the activities room and activities office.</p> <p>Interview on 05/18/2011, at 11:40 AM, with the Maintenance Supervisor, revealed that he was unaware that slide bolt locks could potentially pose a hazard for anyone inadvertently being locked within a room where unapproved locking devices are installed.</p> <p>Reference: NFPA 101 (2000 Edition) 19.2.2.2.2 Locks shall not be permitted on patient sleeping room doors. Exception No. 1: Key-locking devices that restrict access to the room from the corridor and that are operable only by staff from the corridor side shall be permitted. Such devices shall not restrict egress from the room.</p>	K 130	<p>K130</p> <ol style="list-style-type: none"> Slide bolt type locks were removed from the storage room at the NF1 TV area, the room behind the dryers in the laundry room, the NF1 dining room, the NF2 dining room, the Solana dining room, the activities room and activities office by the Maintenance Director and Maintenance Assistant on 5/20/11. The safety chain for the helium tank was replaced on 5/20/11 by the maintenance staff and the helium tank is now secured to the wall. The Maintenance Assistant completed rounds of the facility to ensure that no other slide bolt type locks or other unapproved locks were in place and that helium tanks are secured appropriately on 6/8/11 and no other issues were identified. The Maintenance and Housekeeping Director were re-educated by the Administrator on 6/9/2011 to standards of maintaining approved locking mechanisms on doors per NFPA standards and appropriate storage of helium tanks. The Activities staff were re-educated to the proper storage of 	
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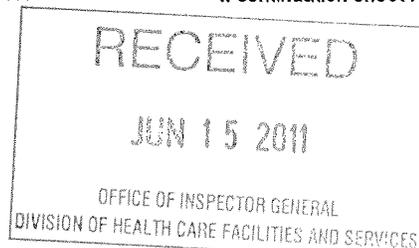
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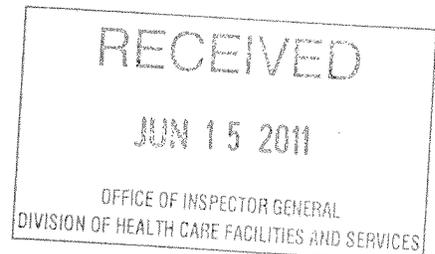
K 130	<p>Continued From page 12</p> <p>Exception No. 2: Door-locking arrangements shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that keys are carried by staff at all times. 19.2.2.2.3</p> <p>Doors not located in a required means of egress shall be permitted to be subject to locking. 19.2.2.2.4</p> <p>Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.</p> <p>Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.)</p> <p>Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path.</p> <p>Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. 19.2.2.2.5</p> <p>Doors located in the means of egress that are permitted to be locked under other provisions of this chapter shall have adequate provisions made for the rapid removal of occupants by means such as remote control of locks, keying of all locks to keys carried by staff at all times, or other such reliable means available to the staff at all times. Only one such locking device shall be permitted on each door.</p> <p>Exception No. 1: Locks in accordance with</p>	K 130	<p>helium tanks by the Assistant Administrator on 6/10/11.</p> <p>4. The Maintenance Director, Maintenance Assistant or Housekeeping Director will complete an audit once a week for four (4) weeks and then once a month for two (2) months and then become part of the monthly Preventative Maintenance Program Schedule to ensure no doors have unapproved locking devices and that the helium tank is secured to the wall with a safety chain. A summary of these findings will be submitted to the PI Committee (Administrator, Assistant Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Therapy, Activities, Solana Program Director, Health Information Manager, Maintenance Director and Housekeeping/Laundry Director) by the Maintenance Director monthly times 3 months for review and further recommendations.</p> <p>5. Date of Compliance 6/20/2011.</p>	
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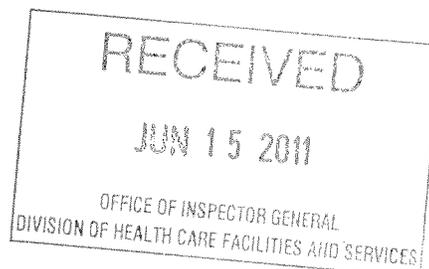
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K 130	Continued From page 13 Exception Nos. 2 and 3 to 19.2.2.2.4. Exception No. 2: More than one lock shall be permitted on each door subject to approval of the authority having jurisdiction. Item 2. Based on observations and interviews, it was determined that the facility failed to store a helium tank in a safe manner, per NFPA standards. The deficiency had the potential to affect two (2) of twelve (12) smoke compartments, approximately fifty (50) residents, staff and visitors. The facility is licensed for one-hundred and eighty-six (186) beds and the census was one-hundred and sixty-nine (169) on the day of the survey. The findings include: Observations on 05/18/2011 at 1:35 PM, with the Maintenance Supervisor, the Housekeeping Supervisor, and the Activities Director, revealed that there was a 2200 cubic foot cylinder of helium that was sitting on the floor in the corner of the Activities Office. The cylinder had no safety chain or strap on it to keep it from being knocked over. Interview on 05/18/2011 at 1:35 PM with the Activities Director, revealed that the chain securing the tank to the wall had been broken	K 130		



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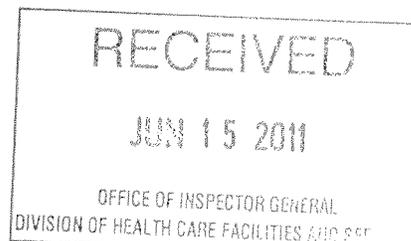
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/19/2011
NAME OF PROVIDER OR SUPPLIER REGIS WOODS CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4804 LOWE RD LOUISVILLE, KY 40220	
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K 130	Continued From page 14 and in need of repair. The Maintenance Supervisor acknowledged that the tank could be knocked over and pose a hazard for residents and staff. Reference: NFPA 55, (1998 Edition). 6-6 Securing Cylinders. Compressed or liquefied gas cylinders in use or in storage shall be secured to prevent them from falling or being knocked over. Exception No. 1: Compressed gas cylinders in the process of examination, servicing, and refilling. Exception No. 2: At cylinder-filling plants and distributors' warehouses, the nesting of cylinders shall be permitted to secure cylinders.	K 130		
K 147 SS=F	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 panels were maintained according to NFPA standards. The deficiency had the potential to affect all smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred and eighty-six (186) beds and the census was one-hundred and sixty-nine (169) on	K 147	K147 1. The Maintenance Director repaired malfunctioning locks on the electrical panels located in the resident corridors of NF2 and one electrical panel located outside of the Administration Office on 6/3/2011. The Maintenance and Housekeeping Supervisors immediately moved stored items in front of the electrical panels located in the kitchenettes of both the Solana and NF1 Nursing Stations on 5/18/11.	



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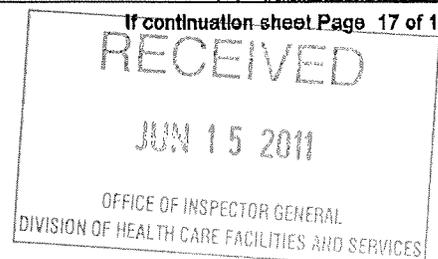
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K 147	<p>Continued From page 15 the day of the survey .</p> <p>The findings include:</p> <p>Observations on 05/18/2011 between 11:30 AM and 3:00 PM, with the Maintenance and Housekeeping Supervisors revealed two (2) electrical panels located in the resident corridors of NF2, and one (1) electrical panel located outside of the Administration Office were unlocked.</p> <p>Interview on 05/18/2011 at 1:07 PM, with the Maintenance Supervisor, revealed that they were unaware that the electrical panels were unlocked.</p> <p>Observations on 05/18/2011 between 11:30 AM and 3:00 PM, with the Maintenance and Housekeeping Supervisors, revealed items stored within three (3) feet of the electrical panels located in the kitchenettes of both the Solara and NF1 Nursing Stations.</p> <p>Interview on 05/18/2011 at 12:00 PM, with the Maintenance and Housekeeping Supervisors, revealed that they were not aware of the stored items in front of the electrical panels and immediately moved them.</p> <p>Observation on 05/18/2011 at 1:37 PM, with the Maintenance and Housekeeping Supervisors, revealed an open junction box without a cover plate, located at the ceiling of the restroom within the Admissions Office.</p> <p>Interview on 05/18/2011 at 1:07 PM, with the</p>	K 147	<p>2. The Maintenance Assistant reviewed the locks of all electrical panels and the area within 3 feet of the electrical panes throughout the facility on 6/3/2011. No other concerns identified.</p> <p>3. The Maintenance staff and Housekeeping Supervisor were re-educated on electrical panels being locked and maintaining clearance within 3 feet of electrical panels by the Administrator on 6/9/2011.</p> <p>4. The Maintenance Director or Maintenance Assistant will review electrical panels to ensure they are locked appropriately and that a three (3) foot clearance is maintained near all electrical panes throughout the facility during weekly rounds. A summary of these findings will be submitted to the Performance Improvement Committee (Administrator, Assistant Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Therapy, Activities, Solana Program Director, Health Information Manager, Maintenance Director and</p>	



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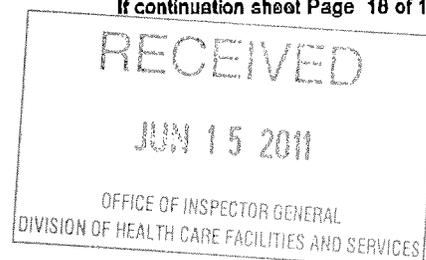
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K 147	Continued From page 16 Maintenance and Housekeeping Supervisors, revealed that they were unaware that the cover plate had been removed from the open junction box. Reference: NFPA 70 (1999 edition) 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. 370.28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147	Housekeeping/Laundry Director) by the Maintenance Director monthly times 3 months for further review and recommendations. 5. Date of Compliance 6/20/2011.	
K 211 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide	K 211	K211 1. Alcohol Based Hand Rub dispensers were relocated by the	



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K 211	<p>Continued From page 17</p> <ul style="list-style-type: none"> o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 <p>This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 05/18/2011 it was determined the facility failed to ensure that Alcohol Based Hand Rub dispensers were not installed over or adjacent to an ignition source, per NFPA standards. The deficiency had the potential to affect all smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred and eighty-six (186) beds and the census was one-hundred and sixty-nine (169) on the day of the survey .</p> <p>The findings include:</p> <p>Observation on 05/18/2011, between 11:30 AM and 3:00 PM, with the Maintenance and</p>	K 211	<p>Maintenance Director and Maintenance Assistant on 6/10/11 to ensure they are not installed over or adjacent to an ignition source throughout the building.</p> <p>2. The Maintenance Assistant completed rounds of the facility on 6/10/11 to ensure no other Alcohol Based Hand Rub dispensers were located above or adjacent to an ignition source and no other issues were identified.</p> <p>3. The Maintenance staff were re-educated by the Administrator on 6/9/2011 to ensure no Alcohol Based Hand Rub dispensers are not installed over or adjacent to an ignition source.</p> <p>4. The Maintenance Director, Maintenance Assistant or Housekeeping Director will complete an audit once a week for four (4) weeks and then once a month for two (2) months and then become part of the monthly Preventative Maintenance Program Schedule to ensure no Alcohol Based Hand Rub dispensers are not installed over or adjacent to an ignition source. A summary of</p>	



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K 211	Continued From page 18 Housekeeping Supervisors, revealed Alcohol Based Hand Rub dispensers were installed over or adjacent to the light switch in rooms throughout the facility. Interview on 05/18/2011, at 12:20 PM, with the Maintenance and Housekeeping Supervisors revealed they were unaware that Alcohol Based Hand Rub dispensers were prohibited to be mounted over or adjacent to an electrical ignition source. Reference: Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211	these findings will be submitted to the PI Committee (Administrator, Assistant Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Therapy, Activities, Solana Program Director, Health Information Manager, Maintenance Director and Housekeeping/Laundry Director) by the Maintenance Director monthly times 3 months for review and further recommendations. 5. Date of Compliance 6/20/2011.	

