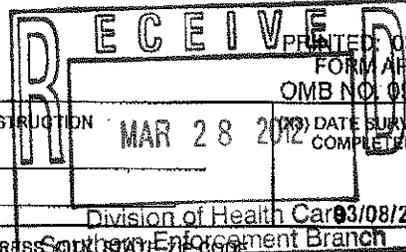


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 03/22/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED MAR 28 2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  SUMMIT MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS 400 BOMAR HEIGHTS COLUMBIA, KY 42728
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. A buildup of scale/mineral deposits was noted on the walls of the east and west hallways on the first floor, two fans were noted with a buildup of dust in resident room 104, missing tile and a loose commode were observed in resident room 112, and a chipped, splintered door was observed in resident room 104.</p> <p>The findings include: An interview conducted with the facility Maintenance Director on 03/08/12, at 2:10 PM, revealed the facility did not have a written policy regarding maintenance services. However, according to the Maintenance Director, it was facility practice/procedure for staff to notify the Maintenance Director of items in need of repair or log the items in a maintenance request log kept</p>	<p>The walls on the east and west wing hallways on the first floor were sanded, a water proof sealer was applied and the walls repainted on 03/14/12. The two fans in room 104 were cleaned and the commode was tightened down in room 112 immediately on 03/08/12. The missing tiles were replaced in room 112 and the door in room 104 was repaired and repainted on 03/09/12. All work was completed by the Maintenance Department.</p> <p>The Administrator, Maintenance Director and the Housekeeping Supervisor conducted a tour of the facility on 03/09/12 and completed a "to do list" of necessary repairs and cleaning to be done. The Administrator reminded the Housekeeping and Nursing Department of the Maintenance Log Book located at each nurses station where they have been instructed to document any needed repairs with emphasis on reporting to the Maintenance Director and the Administrator of any safety issues that must be taken care of immediately.</p> <p>The Administrator wrote a plan on 03/08/12 informing employees of procedure to follow when they observe any needed repairs or urgent safety hazards. The Administrator inserviced all Departments on 03/09/12 regarding procedure. A memo was posted at the time clock reminding staff of procedure to follow.</p> <p>The Administrator reminded the Housekeeping and Nursing Departments to be observant every-day of any needed repairs and to report accordingly.</p> <p>Continued.....</p>	03/28/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda Williams TITLE: Administrator (X5) DATE: 3/28/12

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

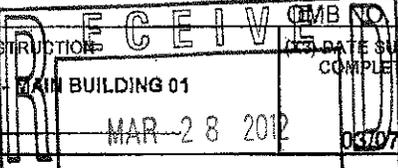
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/08/2012
NAME OF PROVIDER OR SUPPLIER  SUMMIT MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728	
(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 253	<p>Continued From page 1 at each nurses' station.</p> <p>Observations conducted during an environmental tour conducted on 03/08/12, from 2:10 to 3:00 PM, with the facility Maintenance Director, revealed a buildup of scale/mineral deposits on walls of the east and west hallways on the first floor, two fans with a buildup of dust in resident room 104, a missing tile and a loose commode in resident bathroom 112, and a chipped, splintered door in resident room 104.</p> <p>A review of the maintenance log for the months of December 2011, January 2012, February 2012, and March 2012 revealed no evidence the items identified in need of repair had been documented on the maintenance log.</p> <p>An interview conducted with the facility Maintenance Director on 03/08/12, at 3:00 PM, revealed the Maintenance Director made rounds daily in the facility and reviewed maintenance logs to identify items in need of repair. However, the Maintenance Director was not aware of the items in need of repair identified during the environmental tour. Further interview with the Director revealed the hallways on the first floor had been sanded and painted and the mineral deposits had returned. In addition, according to the Maintenance Director, there was no maintenance schedule to disassemble and clean fans used in resident rooms.</p>	F 253	<p>Continuation.....</p> <p>The Housekeeping Supervisor has been instructed to make a weekly tour of all rooms to observe for any additional needed repairs.</p> <p>The Maintenance Department has been reminded to check the Maintenance Log daily for needed repairs.</p> <p>The Quality Assurance Committee will review the Maintenance Log at our monthly meeting and the Administrator or designated team will conduct a monthly tour of the building to assure that all needed repairs have been identified and completed.</p>	

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

PRINTED: 03/22/2012  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185052	(X2) MULTIPLE CONSTRUCTION: A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  03/07/2012
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  SUMMIT MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728 Division of Health Care Enforcement Branch
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two story, Type 11(000)</p> <p>SMOKE COMPARTMENTS: 6</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detection</p> <p>SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system</p> <p>GENERATOR: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 03/07/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p>	K 000		
K 144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in</p>	K 144	<p>The Maintenance Director contacted "Nixon Power Service" on 03/07/12 and they immediately sent out a service man to check our generator.</p> <p>Continued.....</p>	03/08/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Brenda Williams* TITLE: *Administrator* (X6) DATE: 3/28/12

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

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

PRINTED: 03/22/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186052	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  03/07/2012
NAME OF PROVIDER OR SUPPLIER  SUMMIT MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 1 accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain the generator set by NFPA standards. This deficient practice effected six of six smoke compartments, staff, and all the residents. The facility has the capacity for 104 beds with a census of 100 on the day of the survey.  The findings include:  During the Life Safety Code tour on 03/07/12, at 10:40 AM, with the Director of Maintenance (DOM) a record review of the generator. monthly load test revealed the generator would transfer power in 15 seconds instead of the minimum of 10 seconds as required. The DOM demonstrated at the generator set that he would have to manually pull a transfer switch lever to put the generator under load for the monthly testing; Generator testing requires an automatic transfer switch for testing purposes. An interview with the DOM on 03/07/12, at 10:45 AM, revealed the DOM was not aware the generator was required to have an automatic transfer switch.  Reference: NFPA 110 (1999 Edition).	K 144	Continuation.....  The service man reported that the generator was in good working order and completed a load test revealing that the generator transferred power in 5 seconds rather than the 15 seconds that the Maintenance Director had documented. Please see attached report. The service man demonstrated the procedure to follow when conducting the load test and instructed the Maintenance Director to use the automatic transfer switch rather than manually pulling the lever. The Maintenance Director returned a demonstration to ensure that the he understood the procedure to be followed when conducting the load test.  The Maintenance Director and the Administrator reviewed the Preventative Maintenance Tels Program noting that the Maintenance Director is required to test the generator underload via engaging the transfer switch for emergency power weekly rather than monthly as required by regulations.  The Maintenance Director will time the load test accurately to ensure that the emergency power is engaged within 10 second requirement.  Continued.....	

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

PRINTED: 03/22/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  03/07/2012
NAME OF PROVIDER OR SUPPLIER  SUMMIT MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 2 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.  Reference: NFPA 99 (1999 Edition).  3-4.1.1.8 + Load Pickup. The generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. [110: 3-4.1] 3-6.3.1 Source. 4.1.1.2 and 3-4.1.1.3 so that all functions specified herein for the emergency system will be automatically restored to operation within 10 seconds after interruption of the normal source.	K 144	Continuation.....  The Medical Records Coordinator will review the Maintenance Director's weekly report to ensure the test has been completed and that the Emergency Power was engaged within the 10 second regulation. She shall submit the report to Tels.  A copy of the weekly test will be filed in the Life Safety Book in the Administrator's office for review.	