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

PRINTED: 05/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185334		04/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAVER DAM NURSING & REHAB CENTER, INC	1695 US HWY 231 S. BEAVER DAM, KY 42320

(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 An annual survey was conducted 04/19-21/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal requirements with deficiencies cited at the highest S/S of an "E".	F 000	**Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.**	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	**F 278** **483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFICATION** The assessment shall accurately reflect the resident's status. A registered nurse shall conduct or coordinate each assessment with the appropriate participation of health professional. A registered nurse shall sign and certify that the assessment is completed. Each individual who completes a portion of the assessment shall sign and certify the accuracy of that portion of the assessment: **Criteria #1:** A MDS modification was completed on 5/6/11 by RN #2, MDS Coordinator, for Resident #7's annual assessment (originally completed on 3/15/11) to accurately reflect his/her fall status. **Criteria #2:** An audit of Items J1700-1900 of the MDS's for all residents sustaining a fall in the last 90 days was completed on 5/13/11 by the MDS Coordinators. MDS modifications were completed by the MDS Coordinators as indicated. **Criteria #3:** The facility MDS Coordinators received in-service education by the Director of Nursing (DON) on 5/13/11 instructing them to always review the resident's Fall Tracker	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: George Allen Meyer
TITLE: Administrator
(X6) DATE: 5-20-11

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

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F 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview, it was determined the facility failed to ensure the assessment accurately reflected the resident's status for one resident (#7), in the selected sample of 13, related to falls. Findings include: A record review revealed Resident #7 was admitted to the facility on 06/07/10, with diagnoses to include Dementia, Cerebral Vascular Disease, Peripheral Vascular Disease, Chronic Obstructive Pulmonary Disease and Open Wound Knee, Leg and Ankle. Further record review revealed Resident #6 sustained a fall, on 02/18/11. A review of the Annual Minimum Data Set (MDS), dated completed on 03/15/11, revealed at Section J1800, that the resident had no falls since admission or the previous quarterly assessment, completed on 01/15/11. An interview with Registered Nurse #2, MDS Coordinator, on 04/21/11 at 10:00 a.m., revealed she was responsible for completing Section J1800, relating to falls history. She reviewed the information in the Annual MDS with completion date 03/15/11 and the fall on 02/08/11 and stated, "I missed it. It should have been coded."	F 278	Log prior to completing items J1700-1900 of the MDS. **Criteria #4:** The QA tool for the monitoring of MDS fall status accuracy shall be utilized monthly X 2, then every 6 months under the supervision of the DON – who will report findings to the QA team each month that the tool is utilized. The QA team consists of the Administrator, DON, ADON's, Medical Director, Business Office Manager, Human Resources Director, Housekeeping/Laundry Supervisor, Dietary Manager, Activities Director, Social Services Director, Therapy Department Manager, Maintenance Supervisor and Administrative Nursing Assistant. **Criteria #5:** Target Date	5/20/11
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in	F 282	F 282 **483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS AS PER CARE PLAN** -See page 3-	

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F 282	Continued From page 2 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure services were provided in accordance with the resident's written plan of care for one resident (#6) in the selected sample of thirteen. The facility failed to ensure a lift recliner located in Resident #6's room was unplugged, when the resident was unattended. Findings include: A review of the facility policy, Comprehensive Care Plans, dated 03/01/06, revealed it was the facility policy that residents would have a plan of care for assessed needs. The procedure portion of the policy revealed residents would have a care plan developed based on assessed needs. Care plan approaches would be communicated to staff for use in providing direction for care. The plan of care would be reviewed and revised when indicated, based on resident's responses. Resident #6 was admitted to the facility 11/13/10, with diagnoses to include Spinocerebellar Ataxia and Unspecified Epilepsy. A review of the nurse's notes, dated 02/17/11 at 3:10 PM, revealed Resident #6 was found lying on the floor on his/her stomach. The resident had used the hand control to raise the recliner to the high position and fell onto the floor. Resident #6 was assessed to have a small cut to the left side of the upper lip, as a result of the fall.	F 282	F 282 **483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS AS PER CARE PLAN** The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care: **Criteria #1:** Resident # 6's electric lift chair is being kept unplugged, by staff, at all times, except while staff is assisting the resident in and out of the chair as per revised plan of care completed on 04/22/11 by the MDS Coordinator. **Criteria #2:** An audit of all residents with electric lift chairs has been completed 4/22/11 by the MDS Coordinators to ensure the chairs are utilized with any specific safety precautions as per their plan of care. **Criteria #3:** All facility staff members have received in-service education on 5/19/11, by the DON, on providing care as per each resident's plan of care. **Criteria #4:** The QA indicator for the monitoring of care plan implementation shall be utilized monthly X 2 months, then quarterly under the supervision of the DON -- who will report findings to the QA team each month that the tool is utilized. The QA team consists of the Administrator, DON, ADON's, Medical Director, Business Office Manager, Human Resources Director, Housekeeping/Laundry Supervisor, Dietary Manager, Activities Director, Social Services Director, Therapy Department Manager, Maintenance Supervisor and Administrative Nursing Assistant. **Criteria #5:** Target Date:	05/20/11

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F 282	Continued From page 3 A review of the post fall assessment, dated 02/17/11, revealed the immediate action taken was for the lift chair to be unplugged from the electrical outlet when the resident was in the chair and unattended. A review of the comprehensive care plan, dated 11/25/10, with a revision date of 02/23/11, revealed the problem "At risk for falls related to impaired mobility and unsteady gait". The intervention portion of the care plan revealed the lift chair was to be unplugged when no one was in the room with the resident. A review of the Individual Plan Report (Certified Nursing Assistant care guide) revealed, the lift chair was to be unplugged when no one was in the room with the resident to ensure the resident's safety. An observation, on 04/21/11 at 8:45 AM, revealed Resident #6 was in bed and no one else was in the room. The lift recliner was plugged into the wall outlet and operational. Observations, on 04/21/11 at 9:25 AM and on 04/21/11 at 9:50 AM, revealed Resident #6 was seated in the lift recliner and no one else was present in the room. The recliner remained plugged into the wall outlet and the hand control to recliner was in side the pocket of the recliner. The observation at 9:50 AM was conducted with Certified Nursing Assistant (CNA) #1, CNA #2 and CNA #3 in attendance. The staff members acknowledged that Resident #6 was in the room unattended and the lift recliner was plugged into wall outlet and functional.	F 282		

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F 282	Continued From page 4 An interview with CNA #1, on 04/21/11 at 9:50 AM, revealed Resident #6 played with the call light and at one time also played with the hand control to the lift recliner. CNA #1 revealed the chair was to be unplugged whenever the resident was in the room unattended for the resident's safety, because of the resident's history of a fall from the recliner. CNA #1 stated she was aware the resident's care plan directed the lift chair to be unplugged when the resident was unattended. An interview with the Director of Nursing, on 04/21/11 at 2:00 PM, revealed she expected staff to follow the resident's written plan of care for direction in providing care.	F 282		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure the resident environment remained as free from accident hazards as possible for one resident (#6), in the selected sample of thirteen and two residents (#14 and #15), not in the selected sample.	F 323	F 323 **483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** (1)The facility must ensure that the resident environment remains as free of accident hazards as is possible; and (2) each resident receives adequate supervision and assistant devices to prevent accidents. **Criteria #1:** Residents # 6, 14 and 15 have been assessed for safe usage of their electric lift chair on 4/22/11, by the MDS Coordinators, utilizing the facility's newly implemented Electric Lift Chair assessment form. Use of the chair and any restrictions applied are clearly documented on their plans of care. **Criteria #2:** All residents with electric lift chairs have been assessed, by the MDS Coordinators, to determine safe usage of their chairs utilizing the facility's newly developed Electric Lift Chair assessment form. Use of the chair and any restrictions applied are clearly	

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F 323	Continued From page 5 The facility failed to assess Residents #6, #14 and #15 for an assistive device (lift recliner). Resident #6 sustained a fall from the recliner, resulting in minor injury. Findings include: A review of the facility policy, Incident/Accident, undated, revealed to promote dignity and overall quality of life for each resident it was the policy of the of the facility to provide a safe and hazard free environment as is possible. A review of the facility policy, Restraint/Device Use, revised December 2007, revealed it was the policy of the facility to evaluate residents for restraint/device appropriateness. The protocol portion of the policy referred to the Resident Safe Environment Policy. A review of the facility policy, Resident Safe Environment, undated, revealed the purpose of the policy was to promote and maintain resident dignity and independence by utilizing chemical and physical restraints when medically justified to treat a medical symptom or condition that endangers the physical and/or psychosocial well being of the resident or other residents. The policy portion of the Resident Safe Environment revealed it was the policy of the facility to evaluate the residents for fall risk. 1. Resident #6 was admitted to the facility on 11/13/10, with diagnoses to include Spinocerebellar Ataxia and Unspecified Epilepsy. A review of nurse's notes, dated 02/17/11 at 3:10 PM, revealed Resident #6 was found lying on the floor on his/her stomach. The resident used the	F 323	documented on each of their plan of care. An audit of all residents with electric lift chairs has been completed by the MDS Coordinators on 05/17/11 to ensure the chairs are utilized with any specific safety precautions as per plan of care. **Criteria #3:** The facility has implemented a comprehensive Electric Lift Chair assessment that is to be completed for all residents utilizing an electric lift chair. The assessment shall be completed by a MDS Coordinator or the DON upon admission, quarterly, and with a significant change in condition. Use of the chair and any restrictions applied shall be clearly documented on each resident's plan of care by a MDS Coordinator or DON. Nursing staff members have received in-service education on 5/19/11 by the DON on the need for an assessment to determine safe electric lift chair use prior to implementation; and staff to review the care plan for specific interventions for each resident's use of their electric lift chair. All facility staff members have received in-service education on 5/19/11by the DON on providing care as per each resident's plan of care. **Criteria #4:** The QA tool for the monitoring of device assessments shall be utilized monthly X 2, then every 6 months under the supervision of the DON – who will report findings to the QA team each month that the tool is utilized. The QA indicator for the monitoring of care plan implementation shall be utilized monthly X 2 months, then quarterly under the supervision of the DON – who will report findings to the QA team each month that the tool is utilized. The QA team consists of the	

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F 323	Continued From page 6 lift recliner control to raise the chair to the high position and the resident fell onto the floor. Resident #6 was noted to have a small cut to the left side of the upper lip, as a result of the fall. A review of the Incident/Accident report, dated 02/17/11, revealed Resident #6 used the chair remote to lift the chair to the standing position and the resident fell out of the chair. A review of the post fall assessment, dated 02/17/11, revealed the immediate action taken was for the lift chair to be unplugged from the electrical outlet when the resident was in the chair. A review of the comprehensive care plan, dated 11/25/10, with a revision date of 02/23/11, revealed the problem "At risk for falls related to impaired mobility and unsteady gait". The intervention portion of the care plan revealed the lift chair was to be unplugged when no one was in the room with the resident. A review of the Individual Plan Report (Certified Nursing Assistant care guide) revealed the lift chair was to be unplugged when no one was in the room with Resident #6, to ensure the resident's safety. An observation on 04/21/11 at 8:45 AM, revealed Resident #6 was in bed and no one else was in the room. The lift recliner was plugged into the wall outlet and operational. Observations on 04/21/11 at 9:25 AM and on 04/21/11 at 9:50 AM, revealed Resident #6 was in the lift recliner and no one else was present in the	F 323	Administrator, DON, ADON's, Medical Director, Business Office Manager, Human Resources Director, Housekeeping/Laundry Supervisor, Dietary Manager, Activities Director, Social Services Director, Therapy Department Manager, Maintenance Supervisor and Administrative Nursing Assistant. **Criteria #5:** Target Date:	05/20/11

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F 323	Continued From page 7 room. The recliner remained plugged into the wall outlet with the control to recliner in side the pocket of the recliner. The observation at 9:50 AM was conducted with Certified Nursing Assistant (CNA) #1, CNA #2 and CNA #3 in attendance. The staff acknowledged Resident #6 was in the room unattended and the lift recliner was plugged into wall outlet and functional. An interview with CNA #1, on 04/21/11 at 9:50 AM, revealed Resident #6 played with the call light and at one time also played with the control to the lift recliner. CNA #1 revealed the chair was to be unplugged whenever the resident was in the room unattended for the resident's safety, because the resident had a fall from the recliner in the past. An interview with Licensed Practical Nurse (LPN) #1, on 04/21/11 at 10:15 AM, revealed she had responded to Resident #6's fall on 02/17/11 and the resident had raised the chair up as far as it would rise and fell out onto the floor. LPN #1 revealed the administrative nurses were responsible for assessing the residents, prior to the use of an assistive device. She revealed the purpose of the assistive device assessment was to determine what was safe for the resident to assist in meeting his/her needs. An interview with the Nursing Administrative Assistant (RN) #3, on 04/21/11 at 10:25 AM, revealed the purpose of the assistive device assessment was basically to determine what devices the resident required to meet his/her needs. RN #3 revealed the purpose of a lift recliner was for a resident who required assistance to get to a standing position. She felt	F 323		

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F 323	Continued From page 8 the lift recliner would not be appropriate for residents who were cognitively impaired or could not stand independently, if placed in a standing position. RN #3 revealed the facility had not assessed any residents who had a lift recliners for the safe use of the devices. An interview with the Director of Nursing (DON), on 04/21/11 at 2:00 PM, revealed the purpose of an assistive device assessment was to determine what the resident required to meet the individual's needs. The assessment weighed the risks of the device against the benefits to determine if the device was safe and appropriate for the resident. The DON revealed a lift recliner was used for resident comfort and to increase mobility for the resident and should be considered an assistive device. She revealed the facility had not assessed any residents for the use of the lift recliners at any point and felt the lift recliner could be a potential safety hazard for confused residents and residents at risk for falls. 2. Resident #14 was admitted to the facility on 01/01/08, with diagnoses to include Neoplasm Unspecified Nature Respiratory System, Muscle Disuse Atrophy and Muscle Weakness. Observation during the initial tour of the facility, on 04/19/11 between 9:30 AM and 11:00 AM, revealed the resident had a lift recliner in his/her room. A review of the Fall Risk Assessment, dated 03/02/11 revealed Resident #14 had a score of 16 with a score of 10 or higher indicating a high risk for falls.	F 323		

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F 323	Continued From page 9 A review of the quarterly Minimum Data Set (MDS), dated 03/15/11, revealed Resident #14 was moderately impaired related to cognitive skills for daily decision making and required a two person assist for transfers. 3. Resident #15 was admitted to the facility on 03/01/07, with diagnoses to include Muscle Disuse Atrophy and Cerebral Vascular Accident. Observation during the initial tour of the facility, on 04/19/11 between 9:30 AM and 11:00 AM, revealed the resident had a lift recliner in his/her room. A review of the Fall Risk Assessment, dated 01/24/11, revealed Resident #15 had a score of 20 with a score of 10 or higher indicating a high risk for falls. A review of the quarterly Minimum Data Set (MDS), dated 02/02/11, revealed Resident #15 was severely impaired, related to cognitive skills for daily decision making and required a two person assist for transfers.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility shall (1) procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute, and serve food under sanitary conditions. **Criteria #1:** The fan in the walk-in cooler was cleaned on 4/19/11 by the Dietary Manager. The free standing fan in the dishwasher room was cleaned on 4/19/11 by the Dietary Manager. The	

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NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1595 US HWY 231 S. BEAVER DAM, KY 42320	

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F 371	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of the facility's policy/procedure, it was determined the facility failed to ensure food was prepared, stored and distributed under sanitary conditions. A build-up of dust was observed on multiple kitchen fans, a black build-up of substance was observed around the heating and air conditioning vents on the ceiling, a large amount of black crust and crumbs were observed on the oven drip pans and a black fuzzy dust was observed hanging from ceiling tiles over steam table. Findings include: A review of the facility's policy and procedure, "Sanitation of Food Service Department," revealed the food service manager would record all cleaning and sanitation tasks needed for the department. Tasks would be designated to be the responsibility of specific positions in the department. All staff would be trained on the frequency of cleaning necessary. The method and guidelines to be used and agents used for cleaning would be developed for each task or piece of equipment to be cleaned. A cleaning schedule would be posted for all cleaning tasks, and staff would initial the tasks as completed. Staff would be held accountable for cleaning assignments. Observations of the kitchen, on 04/19/11 at 9:40 AM and 10:30 AM revealed: 1. The fan in the walk-in cooler had a dust build-up.	F 371	soiled ceiling tiles over the steam table and around the heating and air conditioning vents were replaced on 4/19/11 by the Maintenance Director. The stove top drip pans were cleaned and lined with aluminum foil on 4/20/11 by the Dietary Manager. The heating and air conditioning vents in the kitchen were cleaned and/or replaced/on 4/20/11 by the Maintenance Director. **Criteria #2:** All facility residents have the potential to be affected by this alleged deficient practice. **Criteria #3:** The dietary cleaning schedule was reviewed and revised on 4/21/11 by Dietary Manager, to include the above mentioned items for routine cleaning. All dietary staff members received in-service education on 5/19/11 by the Dietary Manager on changes made to the cleaning schedule. **Criteria #4:** The QA tool for the monitoring of dietary sanitation shall be utilized weekly X 4, then monthly under the supervision of the Administrator – who will report findings to the QA team each month that the tool is utilized. The QA team consists of the Administrator, DON, ADON's, Medical Director, Business Office Manager, Human Resources Director, Housekeeping/Laundry Supervisor, Dietary Manager, Activities Director, Social Services Director, Therapy Department Manager, Maintenance Supervisor and Administrative Nursing Assistant. **Criteria #5:** Target Date:	5/20/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	186334		04/21/2011

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F 371	Continued From page 11 2. A free-standing fan in dishwasher room had a large dust build-up. Fan was on and blowing air across clean dishes sitting in front of fan. 3. Several areas of black fuzzy dust hanging from ceiling tiles over steam table. 4. Two drip pans on the stove contained a large amount of black crust and crumbs on the trays. 5. Four heating and air conditioning vents on ceiling had a black substance built up approximately 2 inches around the entire vent. Interviews with the Dietary Manager, on 04/19/11 at 9:40 AM and 10:30 AM, revealed the dietary staff was responsible to ensure the drip pans, the stove fan and free-standing fan were cleaned. She stated she had cleaned the drip pans about three months ago. She stated maintenance was responsible to ensure the fan in the walk-in cooler and heating and air conditioning vents on the ceiling were cleaned. She was unable to identify the last time the fan in the walk-in cooler or the heating and air conditioning vents had been cleaned. Additionally, she stated, there was not a cleaning schedule in place to identify designated days to clean the drip pans or fans.	F 371		

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

PRINTED: 05/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185334		04/19/2011

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted on 04/19/11 to determine Federal compliance with Title 42, Code of Federal Regulations, 482.41 (b) (Life Safety from Fire) and found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest deficiency at an E.	K 000	**Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.**	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and staff interviews conducted on 04/19/2011, the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments. This condition affected one (1) smoke compartment, including approximately 15 rooms (30 residents), staff, and visitors. Findings include: A tour of the facility conducted on 04/19/2011, revealed the concrete wall in the laundry room penetrated with new communication wiring	K 025	**K 025** **482.41(b) NFPA 101 LIFE SAFETY CODE STANDARD** The facility will maintain smoke barriers that would resist the passage of smoke between smoke departments, considered satisfactory by NFPA 101 Life Safety Code 2000 Edition 8-2.4.4 Penetrations and Miscellaneous Openings in Smoke Partitions. **Criteria #1:** The concrete wall in the laundry room, containing 1-1/2 inch hole, for the passage of phone wires - was filled on 4/20/11 by the Maintenance Director, with a sealant to prevent the transfer of smoke to another room or compartment. **Criteria #2:** The NFPA 101 Life Safety Code 2000 Edition 8-2.4.4 Penetrations and Miscellaneous Openings in Smoke Partitions in-service for the Maintenance Director was conducted on 4/21/11 by the Administrator. **Criteria #3:** Outside vendor work will be reviewed by the Maintenance Director after their completion to ensure that all necessary smoke barriers are maintained. **Criteria #4:** The QA tool for the monitoring of smoke barriers shall be utilized Quarterly and as needed. **Criteria #5:** Target Date	5/20/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: George Allen Meyer
TITLE: Administrator
(X6) DATE: 5-12-11

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

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K 025	Continued From page 1 through an approximately 1-1/2 inch hole. The space surrounding the cables was not filled with a material which would resist the passage of smoke. An interview with the Maintenance Director 04/19/2011 at 11:15 AM, revealed he was aware of the fire code requirement but had overlooked the lack of sealant around the conduit in this particular room. Reference to: NFPA 101 Life Safety Code 2000 Edition 8-2.4.4 Penetrations and Miscellaneous Openings in Smoke Partitions. 8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows: (1) The space between the penetrating item and the smoke partition shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke.	K 025		