PRINTED: 11/04/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	10/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWENSBORO PLACE CARE AND REHABILITATION CENTER	1206 LEITCHFIELD RD. OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey was conducted, on 10/18/11 through 10/21/11, and a Life Safety Code survey was conducted on 10/20/11, to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "F". Abbreviated surveys, KY#16363, KY #16365, KY#16366, KY #16469, KY#16685, KY#17160, KY#17165, KY#16218, KY#16367 and KY#16368 were conducted in conjunction with the annual survey. KY#16365, KY#17165, KY#16363 and KY#16366 were Substantiated. KY#16368, KY#16685, KY#16218, KY#16367, KY#16469, and KY#17160 were unsubstantiated.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Owensboro Place 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."	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157	1. The physician for resident #26 was notified of the resident's change in condition on 10/19/2011 by the charge nurse. Resident #24 no longer resides in the facility. 2. The 24 hour report, medication administration records and skin assessment forms were reviewed by the Director of Nursing	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wendell A. Smith | TITLE: Administrator | (X6) DATE: 11/14/11

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 157	Continued From page 1 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, it was determined the facility failed to notify the physician when a change in the resident's condition occurred, which had the potential for physician intervention and/or alteration in treatment for one resident, (#24), in the selected sample of 24 and one resident (#26), not in the selected sample. Resident #24 developed a change in skin condition. The facility failed to notify and consult with the physician. Resident # 26's physician ordered medication was unavailable for administration. The facility failed to notify and consult with the resident's physician. The findings include: A review of the facility's, "Skin Care & Pressure Ulcer Management Program", dated January 2008, revealed the facility assessed risk factors and developed a plan of care to address resident	F 157	Services, the Assistant Director of Nursing Services, and Unit Managers to determine if any resident had a change in condition and that the physician or responsible party had been notified on 10/21/2011. No other residents were affected. 3. The licensed nursing staff were re-educated by the Staff Development Coordinator on 11/7/2011 regarding notification of change in condition and ordered medication not available to the physician. The Certified Medication Technicians were re-educated by the Staff Development Coordinator on 11/7/2011 on notifying the charge nurse of any medication not available.	

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F 157	Continued From page 2 skin concerns. According to the policy, a licensed nurse was to perform a head to toe skin check of the resident and document the findings. The policy contained forms to be utilized by the licensed nurse; a "Pressure Ulcer Documentation Form" and a "Non-Pressure Wound and Skin Condition Documentation Form". According to the policy, if an area was identified during care, the nursing assistant informed the licensed nurse who validated the observation by examining the resident. If the nurse determined the identified area was a new skin issue, the nurse completed an investigation process. The investigation process instructed the nurse to consider any new skin issue to be an "incident" and to complete an investigation to determine root cause. The nurse was also instructed to inform the physician and responsible party. 1. A review of the medical record, revealed Resident # 24 was admitted to the facility, on 01/19/10, with diagnoses which included End Stage Renal Disease with Dialysis and Peripheral Artery Disease. Further review of the "Non-Pressure Wound and Skin Condition Documentation" forms, dated 8/2/11 and 8/10/11, revealed identification of a rash on the resident's right and left axilla and a hematoma identified on the resident's right lower abdomen. According to the documentation on the forms, the physician was not notified, nor were there orders for treatment. An interview with Licensed Practical Nurse (LPN) #3, on 10/21/11 at 1:55 P.M., revealed LPN # 3 conducted the skin assessment, on 08/10/11, and documented the presence of the rash and hematoma. According to LPN # 3, she "thought"	F 157	4. The 24 hour shift report will be reviewed by the Unit Managers, Director of Nursing or Assistant Director of Nursing during the morning clinical meeting to determine if a resident has had a change of condition and they physician notified. The medication administration records and skin assessment forms will be audited 2 times a week by the Director of Nursing, Unit Manager or Assistant Director of Nursing to identify change in condition and physician notification. The results of the review will be reported by the Director of Nursing monthly to the Performance Improvement Committee for 3 months for further review and recommendations.	12/02/11

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F 157	Continued From page 3 the resident already had treatment orders at the time she assessed the resident's skin and she did not notify the physician or the resident's family. LPN# 3 further stated the nurse who had conducted the initial skin assessment, on 08/02/11, was no longer employed at the facility. An interview with the Unit Manager, on 10/21/11 at 2:35 P.M., revealed the nurse conducting the assessment should have notified the physician of the change in resident # 24's skin condition. The Unit Manager further stated she was responsible to monitor the nursing staff and that she, "tried to check to see they were doing skin assessments." The Unit Manager also stated she was not the Unit Manager at the time the incident occurred. 2. Record review revealed Resident #26 was admitted to the facility, on 07/11/08, with diagnoses which included Chronic Airway Obstruction, Shortness of Breath and Hypothyroidism. A review of the physician's orders, dated October 2011, revealed an order for Advair Diskus 500/50 micrograms (MCG)/dose Aerosol Powder Breath Activated Inhalation twice a day everyday (BID) at 7:00 AM and 4:00 PM. A review of the Medication Administration Record (MAR), dated October 2011, revealed on 10/12/11, on 10/13/11, on 10/14/11, and on 10/15/11, staff circled their initials at the time the Advair Diskus was due to be administered at 7:00 AM, and on the 10/12/11 and 10/13/11, staff circled their initials for the 4:00 PM dose of the Advair Diskus.	F 157		

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F 157	Continued From page 4 interview with Registered Nurse (RN) #2, on 10/19/11 at 11:15 AM, revealed if a dose of medication was not given, the nurse should initial the block and circle their initials. The nurse should document the reason the medication was not administered on the MAR and if a medication tech was responsible for the medication administration, they should notify the charge nurse. Review of nurses notes, dated 10/09/11 through 10/20/11, revealed no documented evidence the facility notified the physician regarding the fact the Advair Diskus was unavailable for administration, on 10/12/11, on 10/13/11, on 10/14, and on 10/15/11. Additionally, the record review revealed no documented evidence the facility notified the physician regarding the fact the Advair Diskus was administered late, on 10/19/11. An interview with Certified Medication Technician (CMT) #1, on 10/19/11 at 9:05 AM, revealed she was aware the medication was given outside of the required time frame. She stated she started the medication pass late and the breakfast trays were passed to the residents before she could begin the medication pass. CMT #1 stated the nurse on the unit was having the resident's medication times changed to be administered after breakfast and the Advanced Practice Registered Nurse (APRN) ordered the medication time changes. Further review of the MAR, dated October 2011, revealed no time changes for the administration of the Advair Diskus. An interview with Registered Nurse (RN) #2, on	F 157		

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F 157	Continued From page 5 10/19/11 at 1:50 PM, revealed she was the unit manager for two wings in the facility. The CMT should let the charge nurse know if they are having issues with the medications and the charge nurses should inform the unit manager. The unit manager should notify the Director of Nursing (DON) of the identified problem. She revealed she was not aware the physician was not contacted. Each time the medication was due and it was unavailable, the nurse should have informed the physician. She stated the nurses had not notified the physician regarding the missed doses of medication. Additionally, RN #2 was not informed CMT #1 was late administering medication for Resident #26, on 10/18/11, and the physician was not contacted. An interview with the APRN, on 10/21/11 at 10:55 AM, revealed she became aware of the failure to administer the inhaler for four days, on 10/19/11. She stated staff need to notify her if a medication was not given, refused or late.	F 157		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review to include policy review, it was determined the facility failed to ensure physician's orders were implemented for two residents (#26 and #27), not in the selected sample, related to medication administration. On 10/19/11, the Certified Medication Technician (CMT) #1	F 281	1. The Physician was notified on 10/19/2011 of administration of medications for residents #26 and #27 by the Unit Manager with no new orders received. 2. Administration of medication based on physician orders was reviewed by the Unit Managers on 10/19/2011 and no other residents were affected.	

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F 281	Continued From page 6 administered medications ordered to be administered at 7:00 AM at 8:53 AM for Resident #26 and ordered for administration at 8:00 AM at 9:37 AM, for Resident #27. The findings include: A review of the policy, "Administration of Medication", dated 10/15/05 and revised 04/01/06, revealed medications were to be given at the time ordered, or within 60 minutes before or after the designated time, except mediations ordered before meals (AC) or after meals (PC), or as specifically ordered by physician. I. Record review revealed Resident #26 was admitted to the facility, on 07/11/08, with diagnoses which included Chronic Airway Obstruction, Shortness of Breath and Hypothyroidism. Observation during a medication pass, on 10/19/11 at 8:53 AM, revealed Certified Medication Technician (CMT) #1, administered Advair Diskus one puff, Spiriva Inhalation, Meloxicam 15 milligrams (mg), Asprin 325 mg, Cymbalta 120 mg, Colace 240 mg, Lactulose 30 milliliter (ml) and Levothyroxine 100 micrograms (mcg) for Resident #26. A review of the physician's orders, dated October 2011, revealed an order for 7:00 AM medications included: Levothyroxine Sodium 100 micrograms (mcg); Lactulose (stool softener) 10 grams (gm)/ 15 milliliters (ml) give 30 ml every day; Cymbalta (antidepressant) 120 milligrams (mg) daily; Docusate Calcium (stool softener) 240 mg daily; Asprin EC (325 mg) daily and Advair Diskus	F 281	3. Licensed nursing staff were re-educated by the Staff Development Coordinator on 11/7/2011 regarding physician notification if medication not administered at time ordered. The Certified Medication Technicians were re-educated by the Staff Development Coordinator on 11/7/2011 regarding notification to the charge nurse if medication not administered at time ordered. 4. The medication administration records and physician orders will be reviewed monthly by the Director of Nursing Services, Assistant Director of Nursing Services, or Unit Managers to ensure timely medication administration based on physician orders. The results will be reported by the Director of Nursing to the Performance Improvement Committee for 3 months for further review and recommendations.	12/02/11

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F 281	Continued From page 7 500/50 MCG/dose Aerosol Powder Breath Activated Inhalation, twice a day everyday (BID), at 7:00 AM. Review of the Medication Administration Record (MAR), dated October 2011, revealed on 10/12/11, on 10/13/11, on 10/14/11 and on 10/15/11, staff circled their initials at the time the Advair Diskus was due to be administered at 7:00 AM. On the 10/12/11 and 10/13/11, staff circled their initials for the 4:00 PM dose of the Advair Diskus. Additionally, CMT #1 did not document on the MAR the time she administered the resident's medication. Interview with Registered Nurse (RN) #2, on 10/19/11, revealed CMT #1 did not make her aware she was late administering Resident #26's medication. An interview with Certified Medication Technician (CMT) #1, on 10/19/11 at 9:05 AM, revealed she was aware the medication was given outside of the required time frame. She stated she had an hour before or after the designated time to administer the medication. CMT #1 revealed she started the medication pass late and the breakfast trays were passed to the residents before she could begin the medication pass. CMT #1 stated she would notify the nurse on the unit when medications were given late. An interview with Registered Nurse (RN) #2, on 10/19/11 at 1:50 PM, revealed she was the unit manager for two wings in the facility (D & E). The CMT should let the charge nurse know if they are having issues with the medication administration and the charge nurses should inform the unit	F 281		

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F 281	Continued From page 8 manager. The unit manager should notify the Director of Nursing (DON). She revealed she was not aware the physician was not contacted. Each time the medication was due and it was unavailable, the nurse should have informed the physician and the nurses did not inform the physician about the missed doses of medication. Additionally, RN #2 was not informed CMT #1 was late administering Resident #26's medication, on 10/19/11, and the physician was not contacted. An interview with the APRN, on 10/21/11 at 10:55 AM, revealed staff should call her and let her know when a medication was not given, refused or late. She revealed the staff did inform her regarding the Synthroid, but was not sure they mentioned the Advair Diskus being late. 2. Record review revealed Resident #27 was admitted to the facility, on 06/01/06, with diagnoses which included Asthma, Anxiety, Hypertension and Depressive Disorder. Observation during a medication pass, on 10/19/11 at 9:38 AM, revealed CMT #1 administered Celexa 40 mg, Colace 100 mg two tablets, Exelon 4.6 mg patch, Lisinopril 5 mg tablet, Synthroid 100 mcg tablet for Resident #27. At 9:50 AM, Vitamin D-3 1000 units one tablet and Loratadine one tablet were given by CMT #1. Review of the MAR for October 2011 revealed medications ordered for 8:00 AM included Celexa 40 mg (antidepressant), Loratadine 10 mg (allergy), Docusate Sodium 200 mg (stool softener), Exelon 4.6 mg patch (for mild dementia medication), Lisinopril 5 mg (lowers blood	F 281		

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F 281	Continued From page 9 pressure), Synthroid 100 mcg, Vitamin D 1000 units and Artifical Tears one drop in affected eye. The CMT initialed the medications as if administered when they were ordered and did not document on the MAR the actual time she administered the residents medication. Interview with CMT #1, on 10/19/11 at 9:40 AM, revealed she was aware she had administered the resident's medication late. She revealed the medications were due at 8:00 AM and the earliest she could administer the medication was 7:00 AM and the latest was 9:00 AM. CMT #1 she did not have problems giving the resident's medication as ordered. She stated the trays were delivered before she started the medication pass and she could not administer medications while the residents were eating their breakfast. An interview with Registered Nurse (RN) #2, on 10/19/11 at 1:50 PM, revealed she was the unit manager for two wings in the facility (D & E). She stated the CMT should let the charge nurse know if they are having issues with the medications and the charge nurses should inform the unit manager. The unit manager would let the Director of Nursing (DON) know about the problem. RN #2 revealed she was not aware CMT #1 was late administering Resident #27's medication, on 10/19/11. An interview with the Director of Nursing (DON), on 10/19/11 at 2:45 PM, revealed she was not informed by the unit manager the medications were given late. Medications were expected to be given as ordered. An interview with the APRN, on 10/21/11 at 10:55	F 281		

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F 281	Continued From page 10 AM, revealed staff should let her know if a medication was given late. She stated staff called her regarding the Synthroid being given late, however, she was unsure whether she was informed about all the medications being given late. An interview with Licensed Practical Nurse (LPN) #3, on 10/21/11 at 11:20 AM, revealed CMT #1 made her aware she was late giving the residents their medication. She stated the times were changed and an order was obtained from the APRN to change the times. Review of the MAR for Resident #27, conducted on 10/21/11, revealed the times noted for administration of the medication was 8:00 AM.	F 281		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, which included review of policy and procedure, it was determined the facility failed to ensure residents who were incontinent of bladder	F 315	1. RN #1 was re-educated on incontinence care process by the Director of Nursing Services on 10/21/2011. Resident # 14 had incontinence care provided by the nursing staff on 10/20/11. 2. Observation of incontinence care was conducted by the Unit Managers on 10/21/11 and no other residents were identified to have been affected.	

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F 315	Continued From page 11 received appropriate treatment and services to prevent infection for one resident (#14), in the selected sample of 24. The findings include: A review of the policy, "Continence Management Program", revised 12/10, revealed the facility was responsible to ensure residents with or without a catheter received appropriate care and services to prevent infections, to the extent possible. A record review revealed Resident #14 was admitted to the facility, on 08/06/08, with diagnoses to include Obesity. A review of the significant change Minimum Data Set (MDS), dated 09/20/11, revealed the facility assessed the resident as severely cognitively impaired and required extensive assist of two staff for hygiene. The facility assessed the resident as incontinent of bowel and bladder. An observation of incontinent care for Resident #14, on 10/20/11 at 10:50 AM, revealed Registered Nurse (RN) #1 used a washcloth with soap to cleanse under the resident's breasts. She placed the washcloth on the resident's bedside table. The resident was observed to have a thick cream to his/her perineal area. RN #1 used the soiled washcloth to cleanse the resident's perineal area. Afterwards, she placed the washcloth back on the bedside table. The resident was repositioned on his/her side, and RN #1 used the same soiled washcloth to cleanse the resident's buttocks. After incontinent care, RN #1 was observed to remove the washcloth from the bedside table, however, RN #1 did not clean the bedside table, prior to exiting the resident's room.	F 315	3. Licensed and certified nursing staff were re-educated on the procedure for incontinence care by the Staff Development Coordinator on 11/7/2011. Licensed and certified nursing staff will perform a skills check off of incontinence care conducted by the Staff Development Coordinator by 12/1/11. 4. Observations of 5 residents receiving incontinence care will be performed by the Director of Nursing Services, Assistant Director of Nursing Services or Unit Managers monthly for the next 3 months. The results will be reported by the Director of Nursing to the Performance Improvement Committee for further review and recommendations.	12/02/11

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F 315	Continued From page 12 An interview with RN #1, on 10/20/11 at 11:10 AM, revealed she was aware she should not have placed the soiled washcloth on the resident's bedside table. She revealed the same washcloth was used, however, she had cleansed the resident from "clean" to "dirty." An interview with the Director of Nursing (DON), on 10/20/11 at 1:15 PM, revealed she expected staff to use a clean washcloth when cleansing different areas of the body. She revealed soiled washcloths should be placed in a bag, not on the resident's bedside table. She expected staff to clean the bedside table after soiled linen was removed.	F 315		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure trash and refuse was disposed of properly. The facility failed to ensure dumpsters were placed on a smooth, washable, nonabsorbent surface, as required by the Kentucky Retail Food Code (KRS 217.127) and failed to ensure trash was properly contained. The findings include: Observation on 10/18/11 at 10:00 AM, revealed three (3) dumpsters were located outside the	F 372	1. The tires, wheel, cardboard boxes, floor tiles, wooded framed chair, wooden pallets and other debris were picked up and discarded by the Maintenance Department on 10/19/11. The Administrator instructed the Owensboro Sanitation Department on 10/20/11 to place the dumpsters on the asphalt parking area adjacent to the graveled area. 2. The areas outside the facility around the dumpster area were checked for any other debris by Maintenance Staff and the Administrator on 10/19/11.	

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F 372	Continued From page 13 facility on a loose gravel surface. In addition, observation, on 10/18/11 at 10:00 AM, revealed two (2) tires, one (1) tire contained a rusted metal wheel, lying on the ground adjacent to the dumpsters. Additionally, two (2) large rain soaked card board boxes were observed behind the dumpsters. Further observation revealed one (1) large wooden framed chair, eighteen (18) wooden pallets and a large pile of broken pieces of kitchen floor tiles were on the ground, adjacent to the dumpsters, along with disposable gloves and other litter. An interview with the facility Maintenance Director, on 10/19/11, at 3:00 PM, revealed the facility did not have a policy on disposal of waste and refuse. An interview with the Administrator, on 10/19/11 at 4:00 PM, revealed the administrator was unaware the dumpsters were required to be placed on a smooth, nonabsorbent, washable surface. An interview was conducted with the facility Maintenance Director, on 10/19/11 at 3:00 PM, revealed the the maintenance department staff were responsible for keeping the dumpster area clean. Additionally, the facility had a schedule with preplanned exterior/interior inspections and cleaning. The Maintenance Director stated the floor tiles were discarded when the kitchen floor tiles were installed in January of 2011 and he did not know why the discarded tiles had not been placed in the dumpster(s) to be picked up by the trash collectors. The Maintenance Director stated he was unaware the dumpsters should be placed on a smooth nonabsorbent washable surface.	F 372	3. The Dietary Department and Maintenance Department staff were re-educated by the Administrator on 10/19/11 on maintaining a debris free area around the dumpster sight and that the dumpsters need to be placed on a smooth, washable, nonabsorbent surface. 4. Weekly audits of the dumpsters and areas around the dumpsters will be completed by the Dietary Manager and Maintenance Director to ensure trash and refuse is disposed of and the dumpsters are placed on smooth, washable, nonabsorbent surfaces. The results will be reported by the Maintenance Director to the Performance Improvement Committee for further review and recommendations for the next 3 months.	12/2/11

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F 441 SS=E	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 Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	1. Residents number 3 and 28 are no longer in facility. 2. Residents were assessed by the Infection Control Nurse to determine isolation precautions needed on 10/21/11. Culture reports were reviewed by the Unit Managers and infection control nurse on residents who had cultures ordered on 10/21/11, with no other residents affected. Type of isolation precautions for identified residents were update on the certified nursing assistant care card and isolation precaution cards were by the personal protective equipment container by the Unit Managers on 10/21/11.	

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F 441	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to maintain an infection control program to ensure a safe, sanitary environment and to help prevent the development and transmission of disease and infection for one resident (#3), in the select sample of 24 and one resident (#28), not in the select sample. Resident #3 had physician orders for Contact Precautions, however, staff failed to implement the appropriate equipment and precautions. Resident #28 had a sign above the resident's door, indicating "Isolation" precautions, however, the facility failed to ensure staff were knowledgeable of the type of precaution needed and failed to utilize any of the Personal Protective Equipment (PPE) provided. Additionally, the facility failed to ensure staff consistently washed their hands and/or used sanitizer between resident care and during meal service. The findings include: A review of the facility's infection control policy, dated 10/09, revealed the facility utilized Standard Precautions for all residents when providing care, regardless of the diagnosis or suspected infection. In addition to Standard Precautions, the facility utilized Transmission-Based Precautions for residents who were known or	F 441	3. Re-Education on hand washing procedure and the isolation precaution process was provided to the nursing staff by the Staff Development Coordinator on 10/19/2011. Culture reports will be reviewed by the Director of Nursing, Assistant Director of Nursing, Unit Managers or Charge Nurse when obtained from lab to ensure precautions are in place as outlined in facility infection control policy. 4. Observation rounds will be completed weekly to ensure hand washing and isolation precautions are followed by the Director of Nursing and Infection Control Nurse. Observations will continue weekly times 4 weeks then monthly. Findings will be reported by the Director of Nursing monthly to the Performance Improvement Committee for review and further recommendations.	12/02/11

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F 441	Continued From page 16 suspected to be infected or colonized with infectious agents, including pathogens that require additional control measures to prevent transmission. The policy further stated the category of transmission-based precaution determined the type of PPE to be used. The particular type of PPE to be used was to be communicated to staff. Contact Precautions were to be used in addition to Standard Precautions for residents known/suspected to be infected by microorganisms that could easily be transmitted by direct or indirect contact such as Methicillin Resistant Staphylococcus Aureus (MRSA), Vancomycin Resistant Enterococcus (VRE), Herpes (simplex or zoster) or Clostridium difficile. Contact Precautions included: Private room, if possible, if none available, may cohort residents infected with the same microorganism or if cohorting was not possible, maintain a separation of at least three (3) feet between the infected resident and all others. Wear clean gloves and gown when entering the room. Wear gloves and a gown for all interactions that may involve contact with the resident of potentially contaminated areas of the resident's environment. Change gloves and gown after each contact with infective material. Remove gloves/gown carefully and wash hands before leaving the room. Limit resident movement and when possible, dedicate equipment to single or cohorted residents. 1. A review of the medical record revealed Resident #3 was admitted to the facility, on 06/03/10, with diagnoses which included Diabetes Mellitus and Alzheimer's Disease. A review of the Minimum Data Set (MDS) assessment, dated 08/17/11, revealed Resident #3 developed a	F 441		

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F 441	Continued From page 17 pressure sore on the coccyx. Review of the nurses' notes, dated 10/11/11, revealed a wound culture was obtained and the results received by the facility, indicated Resident #3 was infected with Methicillin Resistant Staphylococcus Aureus (MRSA). The physician was notified, orders were received and contact precautions were initiated. An interview with Licensed Practical Nurse (LPN) #1, on 10/21/11 at 8:50 AM, revealed the nurse who received a positive culture report was responsible to notify the physician, family, Infection Control Nurse and to initiate appropriate precautions for the infectious agent. LPN # 1 further stated the nurse was responsible to inform the staff of the additional care needs of the resident and she, "usually just told the aides about it." Observations, on 10/18/11 at 3:45 PM, revealed a container on the resident's door contained gloves, disposable gowns, masks, head covers and shoe covers. However, there was no information regarding the type of precautions to be utilized or the PPE necessary for this resident. Further observation revealed two (2) Certified Nursing Assistants (CNA) were inside the resident's room and in the process of assisting the resident with turning/repositioning and checking the resident for incontinence. Both CNAs were observed to be wearing gloves with no additional PPE in use. An interview with CNA #1, on 10/18/11 at 3:45 PM, revealed Resident # 3 did not require PPE and that the other resident in the room was the resident who was "on precautions".	F 441		

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F 441	Continued From page 18 Observations, on 10/19/11 at 7:50 AM, revealed CNA #2 attempted to feed Resident #3. CNA #2 was observed attempting to feed the resident and did not wear any gloves or additional PPE. An interview with CNA #2, on 10/19/11 at 7:50 AM, revealed the CNA should check the Nursing Assistant Care Card each day, at the beginning of the shift, to identify care needs of the residents and to check for any changes or updates. A review of the Nursing Assistant Care Card, dated 10/11, revealed no documentation of any precautions to be taken during the care for Resident #3. Observations, on 10/19/11 at 10:00 AM, revealed Licensed Practical Nurse (LPN) #2 and a CNA were in Resident #3's room, providing wound care. LPN#2 and the CNA were observed to be wearing full isolation PPE, gown, gloves, mask, head covers and shoe covers. An interview with LPN #2, on 10/19/11 at 8:10 AM, revealed Resident #3 was on isolation precautions, due to MRSA of the resident's wound. LPN #2 further stated the Unit Manager and nurses were to update the Nursing Assistant Care Cards, as needed, whenever a change in care needs occurred. An interview with the Infection Control Nurse (ICN), on 10/20/11 at 2:45 PM, revealed the ICN was to be notified of any resident requiring any additional precautions. The ICN further stated the nurse on duty was responsible to obtain the PPE and inform the staff what type of precautions	F 441		

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F 441	Continued From page 19 were required. The ICN stated the staff knew which PPEs were required, based on the type of precautions ordered. Observations and interviews with the ICN present, on 10/20/11 at 3:10 PM, revealed CNA #3 stated she would use all the equipment in the PPE container, when delivering care. CNA #3 stated during the interview in the presence of the ICN, that she was unaware of the type of isolation precautions Resident #3 required. CNA # 3 stated she would use all included in the PPE kit. An interview with the ICN, on 10/20/11 at 3:35 PM, revealed staff should have known which equipment to use and the nurse on the floor should have added the guidelines to the nursing care plan and the nursing assistant care card. 2. A review of the medical record revealed Resident #28 was admitted, on 10/25/06, with diagnoses to include Alzheimer's Disease and Chronic Airway Obstruction. On 04/30/11, the resident was diagnosed with MRSA, cultured from a wound to the left lower extremity (LLE.) A culture was repeated, on 08/03/11, and revealed, "scant growth" of MRSA. The quarterly MDS, dated 10/03/11, revealed Resident #28 had a venous or arterial (stasis ulcer) and required applications of a nonsurgical dressing and ointments and/or medications. A review of the "potential for alteration in skin integrity" care plan, dated 03/08/10, revealed the resident had a non-healing vascular wound to the LLE and required treatment, as ordered and was placed on contact isolation, effective 05/03/1, and the care plan was updated on 10/20/11.	F 441		

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F 441	Continued From page 20 Review of the "wound infection" care plan, dated 05/05/11 and updated 10/03/11, revealed the nursing staff were to "observe the appropriate precautions." A review of the Nursing Assistant Care Card, for October 2011, required the assistance of two staff members to transfer and the resident was to receive baths per the unit schedule and was incontinent of bowel and bladder. There was no mention of isolation or contact precautions. Observations, on 10/18/11 at 11:26 AM and 3:38 PM; 10/19/11 at 7:40 AM and 12:00 PM; 10/20/11 at 9:00 AM and 3:40 PM and on 10/21/11 at 8:45 AM and 2:53 PM, revealed a small sign above the resident's name at the doorway entrance to the resident room, "Isolation 14 B." A container was hung over the resident's door which held gloves, gowns, masks, head and shoe covers, goggles and red bags. There was no signage to indicate the type of contact precautions to use with the resident or the resident's roommate or whether visitors needed to check with the nurse at the desk, prior to entering the room. An observation, on 10/21/11 at 8:45 AM, revealed CNA #6 exited Resident #28's room, without wearing any protective equipment. An interview with CNA #6, on 10/21/11 at 8:48 AM, revealed, if there was a sign on the resident's door for isolation, she would don a robe, gloves, foot covers, goggles and a head covering and she would do this for all residents who had an isolation sign on the door, no matter what type of isolation was identified. She stated she did not need to do this, at this time, because she only went into the room to ask another staff member a	F 441		

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F 441	Continued From page 21 question. Observation and interview with CNA #7, on 10/21/11, at approximately 8:45 AM, revealed the CNA was assisting Resident #28 with breakfast and was not utilizing any protective equipment. The CNA revealed when residents were on isolation, the staff were to take "extreme precautions," and don a gown, gloves, mask, footwear and a mask. The CNA stated she was unaware the resident she was assisting had a isolation sign on the doorway and stated, "No one has told me," and stated she thought it was against the law to post an isolation sign on the resident's door. An interview with RN #2, on 10/21/11 at 11:05 AM, revealed the nurse was unsure why Resident #28 was still on isolation precautions, as the nurse and the staff members had discussed the resident's legs had healed, yet the sign and the PPE remained on the resident's door. She stated the process for isolation or contact precautions was to obtain the ordered cultures of the bacteria, obtain an order from the physician for antibiotics and isolation, notify the family, put the information on the care plan and the CNA care plan, put cards on the resident's door and place a container of PPE on the door. The RN was unaware why there was no information regarding isolation included on the CNA care plan, and stated the CNA should have been provided information during report at shift change. 3. Review of the policy for hand hygiene, dated 04/11, revealed "To prevent bacteria from being to others, you should wash your hands before treating a resident and after treating a resident,	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	10/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWENSBORO PLACE CARE AND REHABILITATION CENTER	1205 LEITCHFIELD RD. OWENSBORO, KY 42303

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F 441	Continued From page 22 after contact with body fluids, and after contact with contaminated items such as linen and center equipment." Observation during a lunch meal service, on 10/18/11 at 12:05 PM, in the Restorative Dining room, revealed twelve residents being served by Certified Nurse Aides (CNA) #3 and CNA #10. The CNAs were observed serving food trays and opening the residents individual food containers, and touching residents clothing and personal items. The CNAs were observed to continue to serve the meals after touching the resident's personal clothing, without using hand sanitizer or handwashing. Observation revealed CNA #3 touched a blanket with her bare hands, which covered the resident's legs, which was soiled with urine. The CNA was observed to immediately pick up a resident's drinking glass and hand the glass to the resident, without using hand sanitizer or washing hands. An interview with CNA #3, on 10/19/11 at 9:30 AM, revealed she knew she was supposed to wash or sanitize her hands between resident contact. She further revealed she had hand sanitizer in her pocket, but "forgot to use hand sanitizer" and she "should have washed hands after touching the residents wet blanket." An interview with the Assistant Director of Nursing (ADON) , on 10/19/11 at 7:55 AM, revealed "all CNAs should sanitize hands between resident contact." An interview with Director of Nursing (DON), on 10/19/11 at 2:30 PM, revealed "CNAs should	F 441		

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F 441	Continued From page 23 always wash or sanitize hands between assisting residents" Observation during the breakfast meal service, on 10/19/11 at 7:25 AM, in the Restorative Dining room, revealed CNA #4 took a dirty tissue from a resident and threw the tissue away, and did not wash her hands or use hand sanitizer prior to assisting another resident with their meal. CNA #4 continued to assist three other residents prior to sanitizing her hands. An interview with CNA #4, on 10/19/11 at 7:50 AM, revealed she "should have used handwashing or hand sanitizer between assisting each resident." She further stated, she "got nervous and forgot to clean hands" between resident care. An interview with the ADON, on 10/19/11 at 7:55 AM, revealed CNA #4 " should have washed her hands after touching the dirty tissue and before going back to providing care to residents." An interview with DON, on 10/19/11 at 2:30 PM, revealed CNA #4 should not have touched the dirty tissue without washing her hands afterwards and she expected staff to wash their hands and CNAs in the Restorative Dining room should have washed or sanitized their hands between assisting each resident. 4. An observation during the breakfast meal service on the D Wing, on 10/19/11 at 8:00 AM, revealed staff passed trays to residents without proper hand sanitation between the trays. Certified Nurse Aide (CNA) #1 passed eight trays without using hand sanitizer or washing her	F 441		

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F 441	Continued From page 24 hands. CNA #2 passed seven trays without using hand sanitizer or washing her hands. Both staff members were observed setting up trays for the residents and repositioning residents in bed, and did not sanitize or wash their hands between residents. An interview with CNA #1, on 10/19/11 at 8:40 AM, revealed she had been made aware that day to sanitize or wash her hands after every two to three resident trays. She revealed sanitizer was available in the facility, but she "forgot" because she was so "busy." An interview with CNA #2, on 10/19/11 at 8:40 AM, revealed she was aware sanitizer should be used after every resident tray, but it had been a "crazy" morning. An interview with the Director of Nursing, on 10/20/11 at 1:15 PM, revealed she expected staff to use sanitizer after every resident tray.	F 441		

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	185236	A. BUILDING 01 - BUILDING 0101 B. WING	10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWENSBORO PLACE CARE AND REHABILITATION CENTER	1206 LEITCHFIELD RD. OWENSBORO, KY 42303

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1966, 1999 Survey under: NFPA 101 (2000 edition) Chapter 19 Facility type: SNF/NF Type of structure: Type III (200) Smoke Compartment: 6 Fire Alarm: Complete fire alarm. Panel upgraded in 2001 Sprinkler System: Complete automatic sprinkler system Generator: Type II, Natural Gas, facility unsure of installation date. A standard Life Safety Code survey was conducted on 10/20/2011. Owensboro Place Care and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census the day of the survey was one hundred fifty two (157). The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (life Safety from Fire)	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Owensboro Place 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."	
K 025 SS=F	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.	K 025	1. The smoke barrier doors located in the attic for hallways A, B, C, and E South hallways were replaced with self closing doors that comply with the standards of 8.3 by the maintenance department on 11/11/2011. 2. Rounds of the facility were completed on 10/20/11 by the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wendell A. Smith
TITLE: Administrator
(X6) DATE: 11/14/11

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 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 observation and interview, it was determined the facility failed to ensure smoke barriers were maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect four (4) smoke compartments, one hundred twelve (112) residents, staff and visitors. The findings include: Observation on 10/20/2011 at 11:08 AM, revealed the smoke barrier (located in the attic) for Hallway E South, had an unapproved makeshift door. Further observation revealed the same for Hallway B, Hallway C and Hallway A. Doors located in smoke barriers must meet the requirements found in the Life Safety Code. The observations were confirmed with the Maintenance Director. Interview on 10/20/2011 at 11:08 AM, with the Maintenance Director, revealed he was unaware the doors did not meet the Life Safety Code. Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.	K 025	Maintenance Director and no other issues were identified. 3. The maintenance department was re-educated regarding the requirements of maintaining smoke barriers by the Administrator on 10/24/11. The maintenance department will inspect the smoke barriers in the attic for damage or penetrations and correct immediately after any work is completed. 4. The Maintenance Director will complete facility rounds monthly for 3 months to ensure smoke barriers are maintained. The findings will be presented by the Maintenance Director to the facility Performance Improvement Committee monthly times 3 months for review and further recommendations.	12/2/11

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K 025	Continued From page 2 8.3.4.2* Where a fire resistance rating for smoke barriers is specified elsewhere in the Code, openings shall be protected as follows: (1) Door opening protectives shall have a fire protection rating of not less than 20 minutes where tested in accordance with NFPA 252, Standard Methods of Fire Tests of Door Assemblies, without the hose stream test, unless otherwise specified by Chapters 12 through 42. Assemblies, without the hose stream test, unless otherwise specified by Chapters 12 through 42. (2) Fire windows shall comply with 8.2.3.2.2. Exception: Latching hardware shall not be required on doors in smoke barriers where so indicated by Chapters 12 through 42. 8.3.4.3* Doors in smoke barriers shall be self-closing or automatic-closing in accordance with 7.2.1.8 and shall comply with the provisions of 7.2.1.	K 025		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	1. Single button releases will be installed by the David B. Storm group on gates located in the staff	

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K 038	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were maintained to full and instant use, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect six (6) smoke compartments, one hundred fifty seven (157) residents, staff and visitors. The findings include: Observation on 10/20/2011 at 11:54 AM, revealed the three (3) gates located in the paths of egress from the staff smoking area, resident smoking area, and the D Wing Patio areas were secured with locks that could only be opened with a key. Further observation revealed when asked by the Life Safety Code surveyor to show how the locks operated the Maintenance Director needed to work on the locking mechanism before it would unlock with the key. Exits that are allowed to be secured must meet standards found in the Life Safety Code. The observations were confirmed with the Maintenance Director. Interview on 10/20/2011 at 11:54 AM, with the Maintenance Director, revealed the only staff with a key was the Administrator, Maintenance Director and a Maintenance Tech. Observation on 10/20/2011 at 2:09 PM, revealed the facility had fourteen (14) Bathroom doors, two (2) bathroom doors per Hallway, which projected into the corridor when in the fully open position.	K 038	smoking area, resident smoking area and D wing patio areas that will immediately release the magnetic locks allowing rapid egress from the areas by 11/17/2011. The gates remain secured. The 14 bathroom doors opening into the hallways will have self closing mechanisms installed by Maintenance staff by 12/1/2011. 2. Rounds were completed on 10/20/11 by the Maintenance Director and no other issues identified. 3. Staff will receive re-education by the Staff Development Coordinator by 12/1/2011 regarding the gate releases and the requirement of keeping paths of egress clear. The Administrator re-educated the maintenance department on 10/24/2011 regarding maintaining exits to full and instant use.	

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K 038	Continued From page 4 Doors which project into the corridor have the potential to cause problems with egress during an emergency. The observation was confirmed with the Maintenance Director. Interview on 10/20/2011 at 2:09 PM, with the Maintenance Director, revealed he was unaware doors projected into the corridor was against the Life Safety Code. Reference: NFPA 101 (2000 edition) 7.2.1.4.4* During its swing, any door in a means of egress shall leave not less than one-half of the required width of an aisle, corridor, passageway, or landing unobstructed and shall not project more than 7 in. (17.8 cm) into the required width of an aisle, corridor, passageway, or landing, when fully open. Doors shall not open directly onto a stair without a landing. The landing shall have a width not less than the width of the door. (See 7.2.1.3.) Exception: In existing buildings, a door providing access to a stair shall not be required to maintain any minimum unobstructed width during its swing, provided that it meets the requirement that limits projection to not more than 7 in. (17.8 cm) into the required width of a stair or landing when the door is fully open. 19.2.2.2.4 Doors within a required means of	K 038	4. The Maintenance Director and Administrator will complete facility rounds monthly to ensure exits are maintained to full and instant use. Any issues will be corrected immediately. The results of the rounds will be presented by the Administrator to the Performance Improvement Committee monthly times 3 months for review and further recommendations.	12/2/11

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K 038	Continued From page 5 egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. 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.) 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. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. 19.2.2.2.5 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	K 038		

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K 038	Continued From page 6 locking device shall be permitted on each door. Exception No. 1: Locks in accordance with 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. 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.	K 038		

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K 038	Continued From page 7 (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS 7.2.1.6.2 Access-Controlled Egress Doors. Where permitted in Chapters 11 through 42, doors in the means of	K 038		

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K 038	Continued From page 8 egress shall be permitted to be equipped with an approved entrance and egress access control system, provided that the following criteria are met. (a) A sensor shall be provided on the egress side and arranged to detect an occupant approaching the doors, and the doors shall be arranged to unlock in the direction of egress upon detection of an approaching occupant or loss of power to the sensor. (b) Loss of power to the part of the access control system that locks the doors shall automatically unlock the doors in the direction of egress. (c) The doors shall be arranged to unlock in the direction of egress from a manual release device located 40 in. to 48 in. (102 cm to 122 cm) vertically above the floor and within 5 ft (1.5 m) of the secured doors. The manual release device shall be readily accessible and clearly identified by a sign that reads as follows: PUSH TO EXIT When operated, the manual release device shall result in direct interruption of power to the lock -	K 038		

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	185236	A. BUILDING 01 - BUILDING 0101 B. WING _____	10/20/2011

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K 038	Continued From page 9 independent of the access control system electronics - and the doors shall remain unlocked for not less than 30 seconds. (d) Activation of the building fire-protective signaling system, if provided, shall automatically unlock the doors in the direction of egress, and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. (e) Activation of the building automatic sprinkler or fire detection system, if provided, shall automatically unlock the doors in the direction of egress and the doors shall remain unlocked until the fire-protective signaling system has been manually reset.	K 038		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure smoke detectors were inspected, according to National Fira Protection Association (NFPA) standards. The deficiency had the potential to affect six (6)	K 054	1. Sensitivity testing was performed on the fire alarm smoke detectors on 11/11/11 by Vanguard Sales & Service. 2. Rounds were completed by the Maintenance Director on 10/20/11 and no other issues were identified.	

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K 054	Continued From page 10 smoke compartments, one hundred fifty seven (157) residents, staff and visitors. The findings include: Record review of the fire alarm inspection reports on 10/20/2011 at 3:09 PM, revealed the facility last had a sensitivity test performed on the fire alarm smoke detectors in February 2009. Smoke detectors must be tested according to NFPA 72 (1999 edition) to ensure their reliability. The observation was confirmed with the Maintenance Director. Interview on 10/20/2011 at 3:09 PM, with the Maintenance Director, revealed he was unaware the facility did not have a current sensitivity test on the fire alarm smoke detectors. Reference: NFPA 72 (1999 edition) 7-3.2.1* Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be	K 054	3. Re-education of the maintenance department regarding the requirement for bi-annual sensitivity testing of the fire alarm smoke detectors was completed by the Administrator on 10/24/11. 4. The scheduled testing will be entered into the computerized facility preventive maintenance program and audited by the Maintenance Director. The results and schedule of testing will be reported to the Performance Improvement Committee in December 2011 and annually thereafter.	12/2/11

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K 054	Continued From page 11 maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer ' s calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced. Exception No. 2: This requirement shall not apply to single station detectors	K 054		

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K 054	Continued From page 12 referenced in 7-3.3 and Table 7-2.2. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.	K 054		
K 062 SS=F	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: Based on observation, record review and interview, it was determined the facility failed to ensure sprinkler system were inspected and maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect six (6) smoke compartments, one hundred fifty seven (157) residents, staff and residents. The findings include: Observation on 10/20/2011 at 11:29 AM, revealed the sprinkler piping in the Hallway B attic, was being used to support various wiring. Further observation revealed sprinkler piping in the Front Hall attic, was being used to support various wiring. Sprinkler piping cannot be used to support building wiring. The observations were confirmed with the Maintenance Director. Interview on 10/20/2011 at 11:29 AM, with the	K 062	1. The various wiring on the sprinkler piping in the hallway B attic and front hall attic were removed by the maintenance staff and are now supported by other means. An internal pipe inspection of the sprinkler system was performed on November 10, 2011 by Ohio Valley Sprinkler. 2. Rounds were completed by the Maintenance Director on 10/20/11 and no other issues were identified. 3. The maintenance department f was re-educated regarding ensuring that all wires in the attic are clear of the sprinkler system and the five year internal pipe inspection requirement by the Administrator on 10/24/11.	

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K 062	Continued From page 13 Maintenance Director, revealed he was unaware sprinkler piping was being used to support the various wires. Record review of the sprinkler system inspection reports on 10/20/2011 at 11:39 AM, revealed the facility last had an internal pipe inspection on 11/01/05. Sprinkler piping must be inspected to ensure the sprinkler system reliability. The observation was confirmed with the Maintenance Director. Reference: NFPA 25 (1998 edition) 2-2.2* Pipe and Fittings. Sprinkler pipe and fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, corrosion, and misalignment. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. Exception No. 1:* Pipe and fittings installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Pipe installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062	4. The Maintenance Director will complete facility rounds monthly to ensure no wiring on sprinkler piping. The Maintenance Director will track the sprinkler system inspection reports to ensure it is completed every 5 years. The findings will be reported by the Administrator to the Performance Improvement Committee monthly times 3 months for review and further recommendations. The scheduled testing will be entered into the computerized facility preventive maintenance program.	12/02/11

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K 062	Continued From page 14 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections	K 062		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure wiring was maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) smoke compartments, forty eight (48) residents, staff and visitors. Observation on 10/20/2011 at 11:08 AM, revealed one (1) electrical junction box (located in the attic	K 147	1. The electrical junction boxes located in the attic of E and B hallways had a cover installed by the maintenance staff on 11/11/2011. 2. Rounds were completed on 10/20/11 by the Maintenance Director and no other issues were identified. 3. The Administrator provided re-education to the maintenance department on 10/24/11 regarding covers in place on electrical junction boxes.	

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K 147	Continued From page 15 of Hallway E South) did not have a cover in place. Further observation revealed three (3) electrical junction boxes (located in the attic of Hallway B) did not have a cover in place. Electrical junction boxes must have covers in place to prevent risk of electrical shock or fire. The observations were confirmed with the Maintenance Director. Interview on 10/20/2011 at 11:08 AM, with the Maintenance Director, revealed he was unaware of any electrical junction boxes not having covers in place. Reference: NFPA 70 (1999 edition) Refer to NFPA 70 (1999 Edition). 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,	K 147	4. The Maintenance Director will inspect junction boxes to ensure covers are in place monthly. The Maintenance Director will report findings to the Performance Improvement Committee monthly times 3 months for review and further recommendations.	12/02/11